Bundle Public Board Meeting 3 September 2024

0 Agenda
  Final Agenda Public_Board_Meeting_3 September_2024v2
31 09:00 - Welcome, introductions and apologies
32 09:05 - Declarations of interest
33 Questions from members of the public
  Minutes adoption for approval
34 Minutes of previous meeting and matters arising
34.a Minutes of the meetings held on: 7 June 2024 and 19 June 2024
  Item 34ai Public Board Minutes 7 June 2024
  Item 34aiiPublic Board minutes 19 June 2024
34.b Action log
  Item 34b Public Board Action log September 2024v2
35 09:10 - Patient's story: Community Intravenous Antibiotic Service (CIVAS)
36 09:30 - Chief Executive's report: Including System Flow Update
  Item 36 CEO report - Sep 2024 v2 (002) SD V2
37 09:40 - Third Sector Strategy (reviewed by Business Committee July 2024)
  Item 37i Third Sector Strategy - Sept2024
  Item 37ii Appendix I - LCH 3rd Sector Strategy 2024-27
38 09:45 - Health Equity Strategy
  Item 38 Board equity update paper Aug 2024 V3
39 09:55 - Research and Development Strategy (reviewed by Quality Committee July 2024)
  Item 39 R&D Strategy Board Sept 2024
40 10:00 - Quality Committee Chair's Assurance Report: 22 July 2024
  Item 40 Chairs assurance report - Quality Committee July 2024
41 10:05 - Patient Experience Report: Complaints, Concerns and Feedback – reviewed by Quality Committee July 2024
  Item 41 Patient Experience Board Paper Jan -June final cover page
42 10:15 - Infection Prevention and Control Annual Report (reviewed by Quality Committee July 2024
  Item 42 Annual Report IPC 23-24 Version 3 Board Paper
43 10:20 - Safeguarding Annual Report (reviewed by Quality Committee July 2024)
  Item 43i Safeguarding Cover Paper
  Item 43ii Safeguarding Combined Annual Report 2024-25
44 10:35 - Business Committee Chair's Assurance Report: 24 July 2024
  Item 44 Chairs assurance report - Business Committee July 2024 v2
45 10:40 - Charitable Funds Committee Chair's Assurance Report: 18 June 2024
  Item 45 Charitable funds Committee Assurance Report June 2024
46 10:45 - Audit Committee Chair's Assurance Report: 12 July 2024
  Item 46 Audit Committee Chairs Assurance Report July 2024
47 10:50 - Performance report: The development of a published version of the Performance Brief remains in progress. In the meantime key updates and escalations to the Board will be outlined in the Committee assurance reports
48 11:00 - Guardian for Safe Working Hours •Quarter 1 update
  Item 48 GoSWH- Quarter1 report Sep 2024
49 11:10 - Freedom to Speak Up : Annual Report

Item 49 FTSUG Annual Report 2023-24

50 11:20 - Safe Staffing Report (reviewed by Quality Commitee and Business Committee July 2024)

Item 50 Safe Staffing Report June 2024

51 11:30 - Professional registration: Nursing and Allied Health Professions

Item 51 Professional Registration Nursing and AHPs

52 11:35 - Significant Risks and Risk Assurance Report

Item 52 Board Significant Risks report 030924

53 11:45 - Chief Executive Officer and Chair's Action: •Associate NED as member of Nominations and Remuneration Committee

Item 53i CEO and Chair Action (Noms and Rem ToR amend) June 2024

Item 53ii Appendix 1 Nominations & Remuneration Committee TOR V9 June 2024 DRAFT

54 11:50 - Any Other Business. Questions on Blue Box Items and Close

55 Blue Box Item: Health and Safety Annual Plan - reviewed by Business Committee (workshop) June 2024

Item 55 Health and Safety Performance and Annual Plan 2024-25 (Sept 2024 TB) V2

56 Blue Box Item: Board Assurance Framework Process Update – reviewed by Audit Committee July 2024

Item 56i BAF Process update July 2024

Item 56ii BAF Appendix A SR7

57 Workplan

Item 57 Public Board workplan 2024-26 v3 21 08 2024

Agenda:Trust Board Meeting Held In Public
Venue: Meeting Room 10
White Rose Park
Millshaw Park Lane
Leeds LS11 ODL

Date 3 September 2024
Time 9:00am – 12.00noon
Chair Brodie Clark CBE, Trust Chair

AGENDA			Paper
2024-25 31	9.00	**Welcome, introductions and apologies** *(Trust Chair)*	**N**
STANDING ITEMS			
2024-25 32	9.05	**Declarations of interest** *(Trust Chair)*	**N**
2024-25 33		**Questions from members of the public**	**N**
2024-25 34		**Minutes of previous meeting and matters arising** *(Trust Chair)* *For approval*	
34a		Minutes of the meetings held on: 7 June 2024 and 19 June 2024	**Y**
34b		Action log: 7 June 2024 and 19 June 2024	**Y**
2024-25 35	9.10	**Patient story – Community Intravenous Antibiotic Service (CIVAS)** *(Sheila Sorby)*	**N**
STRATEGY AND PARTNERSHPS			
2024-25 36	9.30	**Chief Executive's report** • Including System Flow *(Selina Douglas)*	**Y**
2024-25 37	9.40	**Third Sector Strategy** *(reviewed by Business Committee July 2024)* *(Andrea North)*	**Y**
2024-25 38	9.45	**Health Equity Strategy** *(Dr Ruth Burnett)*	**Y**
2024-25 39	9.55	**Research and Development Strategy** *(reviewed by Quality Committee July 2024)* *(Dr Ruth Burnett)*	**Y**
QUALITY AND SAFETY			
2024-25 40	10.00	**Quality Committee Chair's Assurance Report:** 22 July 2024 *(Helen Thomson)*	**Y**
2024-25 41	10.05	**Patient Experience Report: Complaints, Concerns and Feedback – six monthly report – (***reviewed by Quality Committee July 2024)* *(Sheila Sorby)*	**Y**
2024-25 42	10.15	**Infection Prevention and Control Annual Report** (reviewed by Quality Committee July 2024) – For approval *(Sheila Sorby)*	**Y**
2024-25 43	10.20	**Safeguarding Annual Report** (reviewed by Quality Committee July 2024) – For approval *(Sheila Sorby)*	**Y**

BREAK			
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2024-25 44	10.35	**Business Committee Chair's Assurance Report:** 24 July 2024 *(Rachel Booth)*	**Y**
2024-25 45	10.40	**Charitable Funds Committee Chair's Assurance Report:** 18 June 2024 *(Sheila Sorby)*	**Y**
2024-25 46	10.45	**Audit Committee Chair's Assurance Report:** 12 July 2024 *(Khalil Rehman)*	**Y**
2024-25 47	10.50	**Performance report** The development of a published version of the Performance Brief remains in progress. In the meantime key updates and escalations to the Board will be outlined in the Committee assurance reports. *(Andrea Osborne)*	**N**
WORKFORCE			
2024-25 48	11.00	**Guardian for Safe Working Hours** • Quarter 1 update (Dr Nagashree Nallapetta)	**Y**
2024-25 49	11.10	**Freedom to Speak Up: Annual Report 2023-24** (John Walsh)	**Y**
2024-25 50	11.20	**Safe Staffing Report** (reviewed by Quality Commitee and Business Committee July 2024) *(Sheila Sorby)*	**Y**
2024-25 51	11.30	**Professional registration: Nursing and Allied Health Professions** *(Sheila Sorby)*	**Y**
GOVERNANCE AND WELL LED			
2024-25 52	11.35	**Significant Risks and Risk Assurance Report** *(Selina Douglas)*	**Y**
2024-25 53	11.45	**Chief Executive Officer and Chair's Action:** • Associate NED as member of Nominations and Remuneration Committee – to ratify	**Y**
CLOSING BUSINESS			
2024-25 54	11.50	**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. The Trust Chair will invite questions on any of these items under Item 54.

Blue Box		
2024-25 55	**Health and Safety Annual Plan - reviewed by Business Committee (workshop) June 2024**	**Y**
2024-25 56	**Board Assurance Framework Process Update –** *reviewed by Audit Committee July 2024*	**Y**
2024-25 57	**Workplan**	**Y**

Agenda item:	2024-25 (34ai)

Title of report:	Minutes Trust Board Meeting Held in Public: 7 June 2024

Meeting:	Trust Board Meeting Held in Public
Date:	3 September 2024

Presented by:	Trust Chair					
Prepared by:	Board Administrator					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	√

Executive Summary:	Draft minutes for formal approval by the Trust Board

Previously considered by:	N/A

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	N/A
	Use our resources wisely and efficiently	N/A
	Enable our workforce to thrive and deliver the best possible care	N/A
	Collaborating with partners to enable people to live better lives	N/A
	Embed equity in all that we do	N/A

Is Health Equity Data included in the report?	Yes		What does it tell us?	N/A
	No		Why not/what future plans are there to include this information?	N/A

Recommendation(s)	• The Trust Board is asked to approve the minutes.

List of Appendices:	None

Attendance

Present:	Brodie Clark CBE	Trust Chair
	Selina Douglas	Chief Executive
	Professor Ian Lewis (IL)	Non-Executive Director
	Richard Gladman (RG)	Non-Executive Director
	Helen Thomson Deputy Lieutenant (DL) (HT)	Non-Executive Director
	Alison Lowe (AL) OBE	Non-Executive Director
	Khalil Rehman (KR)	Non-Executive Director
	Sam Prince	Executive Director of Operations/Deputy Chief Executive
	Andrea Osborne	Interim Executive Director of Finance and Resources
	Dr Ruth Burnett	Executive Medical Director
	Steph Lawrence MBE	Executive Director of Nursing and Allied Health Professionals (AHPs)
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
Apologies:	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
In attendance:	Rachel Booth (RB)	Associate Non-Executive Director
	Helen Robinson	Company Secretary
	Dr Nagashree Nallapetta	Guardian of Safe Working Hours for Item 16
	Rhonda Mitchell	Senior Infant Mental Health Practitioner / Systemic Psychotherapist with the Infant Mental Health Service (IMHS) for Item 5
Minutes:	Liz Thornton	Board Administrator
Observers:	Sheila Sorby	Deputy Director of Nursing and Quality (Shadowing the Director of Nursing and AHPs)
	Hannah Beal	Deputy Director of Allied Health Professionals and Clinical Education (Shadowing Director of Nursing and AHPs)
	Wendy Brown	Named Nurse Safeguarding Children, Leeds Community Healthcare NHS Trust
Members of the public:	Rob Hickling	BT

Item 2024-25 (1)
Discussion points: **Welcome introduction, apologies, and preliminary business** The Trust Chair opened the Board meeting and welcomed all those attending to support items on the agenda. **Apologies** Apologies for absence were received from Jenny Allen (Director of Workforce, Organisational Development and System Development).
Item 2024-25 (2)
Discussion points **Declarations of interest** Prior to the Trust Board meeting, the Trust Chair had considered the Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest before the papers were distributed to Board members. The Trust Chair asked the Board for any additional interests that required declaration. No **additional** declarations were made above those on record or in respect of any business covered by the agenda.
Item 2024-25 (3)
Discussion points: **Questions from members of the public** There were no questions from members of the public.
Item 2024-25 (4)
Discussion points: **Minutes of the last meeting, matters arising and action log** **a) Minutes of the previous meeting held on 28 March 2024** The minutes were reviewed for accuracy and agreed to be a correct record. **b) Action log 28 March 2024:** The Board reviewed and noted the progress against the ongoing actions and received an update on: ***2023-24 (Item 124): System Flow Update -*** **options for a Board-to-Board session with Leeds Teaching Hospitals NHS Trust (LTHT)**: the Trust Chair confirmed that options for a Board-to-Board session with LTHT were being pursued and a date would be confirmed when agreed. **Action closed.**
Item 2024-25 (5)
Discussion points: **Patient story: Chris's story** The Executive Director of Nursing and AHPs introduced the story and welcomed Chris, and also Rhonda Mitchell, Senior Infant Mental Health Practitioner / Systemic Psychotherapist with the Trust's Infant Mental Health Service. The Leeds IMHS has been established for 12 years and was one of the first services of its kind in the UK and supports families with children from conception to their 5th birthday. Chris spoke to the Board about his lifelong mental health issues based around severe depression, high anxiety, and a diagnosis of autism in his mid-thirties. He was referred to the IMHS following a conversation between his therapist and the family's health visitor regarding his experience of an 'emotional void' in his relationship with his son Michael. Chris explained that during the pregnancy, birth and the first sixteen months of his son's life, he experienced a complete void of emotion or affection towards him. His treatment started in June 2021 when he began working with Rhonda Mitchell, who helped him understand and implement the concept of 'noticing the moment' as a means of developing a relationship with his son. She worked with the family for 13 months, for a total of 26 sessions, using systemic psychotherapeutic approaches. Eventually, he was able to experience genuine affection for his son, which has continued and for his new daughter. The Trust Chair invited questions and observations from Board members.

Associate Non-Executive Director (RB) noted the flexibility of the programme in terms of meeting the needs of individual patients with complex problems and observed that the Trust's quality and value programme should not impact on services the Trust provided and care should continue to be based on clinical need and not financial restrictions.

Non-Executive Director (IL) said that the IMHS had an impressive record in evidencing the impact of the support it provided which should feed into the outcomes from the quality and value assessments. He asked who had instigated the referral to the IMHS. Rhonda said that Chris was referred to the IMHS by the 0-19 Specialist Public Health Integrated Nurse (health visitor) following a conversation but she acknowledged that more was required to develop the skill of health visitors in recognising complex relationship issues within families.

The Trust Chair thanked Chris and Rhonda for attending the meeting and presenting such a powerful and compelling story.

Trust Chair's opening remarks

The Trust Chair took the opportunity to add some context to the discussions which he said provided the Board with a good opportunity to take stock across a number of areas.

- The Quality and Value Programme - to be clear and active across some key aspects:
  - Staff need to properly understand what the programme is about, the expectations the decision making and the planned and expected outcomes.
  - Clear and proactive messaging and engagement with each and every service including regular updates on progress
  - An assurance framework that has sign off at the right organisational level.
  - As the programme gains momentum to ensure that the Trust has the skills to achieve the required outcomes and when/whether it needs to buy in further support if/as necessary.
- Information Technology - the Innovation conference was excellent and set out the Trust's appetite to make progress and demonstrated powerfully the benefits and the necessity of making progress in this key area.
- The partnership agenda is moving forward. Positive progress on HomeFirst programme; the Community Collaborative is tackling some important cross Integrated Care System packages of work. In the provider arena, conversations will take with Leeds Teaching Hospitals NHS Trust on what more we might do to support each other. Equally, there is more potential for the Leeds 'Place' agenda to make more dramatic progress.

2024-25 Item (6)

Discussion points:

a) Chief Executive's report

The Chief Executive presented her report which included information on:

- Executive Team Recruitment
- Quality & Value Programme
- NHS Oversight Framework Segmentation Review Quarter 4, 2023/24
- Innovation event – May 2024
- Specialist Business Unit Celebration Event
- Collaborating in Partnership
- Planning round 2024/25

She highlighted the following issues:

- Subject to the completion of satisfactory pre-employment checks, Lynsey Yeomans, currently Deputy Director of Nursing at Pennine Care NHS Foundation Trust had accepted the post of Executive Director of Nursing and AHPs. Interviews for the Executive Director of Finance and Resources would take place on 12 June 2024.
- The Quality and Value Programme was launched in April 2024, following extensive engagement with the Board and Committees on how it should be structured and managed. The first service redesigns had started across the business units, with Podiatry,

Neighbourhood Teams, Children and Young People's Mental Health Services (CYPMHS), and Adult Speech and Language Therapy all now live. Progress was being tracked through the Quality and Value Board and monthly update reports made to Business and Quality Committees.

Non-Executive Director (IL) referred to his recent visit to one of the services in the first tranche for service redesign. He said that overall staff believed that a sensible approach had been adopted to determine what level of savings might be achievable but they were concerned about how targets had been allocated and distributed across the Trust's services.

The Executive Director of Operations said that this was a 3-year approach to making savings to ensure patient safety, quality, equity, and sustainability were balanced with a national need for NHS cost improvements. The initial focus was on the largest services in the Trust, ambitious targets were necessary and were based on benchmarking data which had identified where potential savings could be made. She said that she believed that the targets set were achievable over the 3-year programme.

The overall aim was to improve service offers and no changes would be made without the required consultation with the people involved and an Equity and Quality Impact Assessment to ensure clinical safety, quality of delivery of service remained and patient safety was not compromised.

Outcome: the Board

- received and noted the report.

Item 2024-25 (7)

Discussion points:

System Flow: HomeFirst Programme Update

The Executive Director of Operations presented the report.

She reported that currently the system was stable and patient flow well managed with the Transfer of Care Hub functioning efficiently.

The report focussed on a progress update on the Leeds Health and Care Partnership HomeFirst programme. Highlighting progress against the project areas and key performance indicators.

Non-Executive Director (HT) queried whether data would be collected on re-admissions and whether there were plans for collecting information on patient experience.

The Executive Director of Operations confirmed that re-admission data would be reported to the Quality Committee in July 2024 and mini patient stories would be collated to demonstrate patient experience.

Non-Executive Director (IL) asked about the future provision of short-term interim care beds in Leeds.

An invitation to tender for the new model was expected in early June 2024 and the Leeds City Council/Leeds Community Healthcare Alliance would consider its response. The Programme Team was influencing the draft specification to support commissioning of short-term intermediate care beds, with the new model in place from April 2025. A reduction in bed capacity was expected.

Non-Executive Director (RG) asked how the Quality and Value Programme would interact with the HomeFirst Programme.

The Executive Director of Operations said this would be clearer once efficiencies in the Neighbourhood Teams had been identified.

Outcome: the Board

- received and noted the report and took assurance that the Trust is playing a full role in improving system flow through the HomeFirst Programme.

Item 2023-24 (8)

Discussion points:
Quality Committee Assurance Report: 28 May 2024
Non-Executive Director Helen Thomson DL (HT), Chair of the Committee provided a verbal report and highlighted the key issues discussed:

- **EPR / E-prescribing:** the Committee received a presentation on the programme and its impact on risk.
- **Quality Account 2023-24:** the Committee reviewed the Quality Account and recommended it for approval by the Trust Board. Noting that the feedback from the Integrated Care Board and Healthwatch was extremely positive.
- **Quality and Value Programme:** the Committee received and noted the second monthly progress and assurance update from the Quality and Value Board.

Outcome: the Board

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

Item 2024-25 (9)

Discussion points:
Quality Account
The Executive Director of Nursing and AHPs presented the Trust's Quality Account for 2023/24. The report detailed the quality of services offered by the Trust as an NHS healthcare provider

Outcome: the Board:

- reviewed the content of the 2023/24 Quality Account and approved it for publication on the Trust website.

Item 2024-25 (10)

Mortality Report Quarter 4 Update 2023-24
The Executive Medical Director presented the report which provided the Board with assurance regarding the mortality figures and processes within the Trust in Quarter 4 2023/24.

It was noted that the Annual Report on mortality for 2023/24 had not been included on this agenda but had been reviewed by the Quality Committee on 28 May 2024. It was agreed that the Annual Report on mortality would be circulated to all Board members following the meeting.

Action: Annual Report on mortality for 2023/24 to be circulated to Board members>

Responsible Officer: Board Administrator

Outcome: the Board

- received and noted the report.

Item 2024-25 (11)

Discussion points:
Business Committee Assurance Reports: 24 April 2024 (Paper) and 29 May 2024 (Verbal report)
Associate Non-Executive Director Rachel Booth (RB), Chair of the Committee presented the reports and highlighted the key issues discussed:
24 April 2024 (paper)

- **Service Focus – Wharfedale Recovery Hub**: the Committee agreed the Hub was a good example of effective change management and transformation of service redesign.
- **Internal Audit Strategic Annual Plan 2024/25:** – the Committee approved the Plan noting the timing to mitigate against back-ended audits and the use of a reserve list to maximise the use of resources.
- **Management of Non-Healthcare Contracts Internal Audit Report**: the audit had received a limited assurance rating. Progress was being made and the major

recommendations had been addressed. The Committee asked for a full progress report as part of the Procurement Strategy update paper due to be presented in June 2024.

29 May 2024 (verbal update)

- **Sustainability update 2023-24:** the Committee received an update on progress made during 2023/34 – noting the challenges related to achieving the carbon reduction targets.
- **Health and Safety Performance Report and Annual Plan (priorities) 2024/2025:** the Committee received the report noting that overall good progress had been made. Incidents of violence and aggression had risen and the focus for 2024/2025 would be to reduce the figure by 50%.
- **Quality and Value Programme update:** the Committee received and noted the second monthly progress and assurance update from the Quality and Value Board.

The Board noted that all the strategic risks assigned to the Committee had been assigned a **reasonable** level of assurance apart from Risk 5 which had been assigned a **limited** level of assurance due to the Internal Audit 'Limited' assurance report on the Management of Non-Healthcare Contracts

Outcome: the Board

- noted the update reports from the Committee Chair and the matters highlighted.

Item 2024-25 (12)

Discussion points:

Financial Plan Update 2024/25

The Interim Executive Director of Finance and Resources presented the update.

The Trust Board had approved the 2024/25 financial plan at its meeting on the 28 March 2024. Subsequently a further plan submission was requested by NHS England following additional funding received by West Yorkshire Integrated Care Board for depreciation and updated national assumptions on inflation.

The Trust had received additional depreciation funding of £1m and was requested to report a revised plan and surplus of £1m.These changes had been factored into a revised financial plan for the Trust moving from a break-even revenue plan to a surplus of £1m, with the efficiency programme remaining at £15.8m.

Outcome: the Board

- noted the revised 2024/25 revenue plan submission.

Item 2024-25 (13)

Discussion points:

a) Performance Brief April 2024

The Interim Executive Director of Finance and Resources presented the summary of performance for April 2024 which has been scrutinised in detail by the Business and Quality Committees in May 2024.

No questions were raised about performance under Safe, Caring, Responsive, Well-Led and Finance.

In relation to the Effective Domain, Non-Executive Director (IL) suggested that the performance indicators should be reviewed and tightened considering the launch of the Quality and Value Programme to fully reflect effectiveness. He suggested that a review should take place of how the Trust evidenced effectiveness for 2024/25 for this domain.

Action: To consider if a review should take place of how the Trust evidences effectiveness for 2024/25 for the Effective Domain in a Quality Committee workshop.

Responsible officers: Executive Team

Outcome: the Board:

- noted the levels of performance in April 2024.

Item 2024-25 (14)

Discussion points:

Audit Committee Assurance Report: 19 April 2024

Non-Executive Director Khalil Rehman (KR), Chair of the Committee provided a verbal report and highlighted the key issues discussed:

- **Internal Audit updated on the delivery of the 2023/24 plan:** the Committee noted that a limited assurance opinion for a number of audits could have an impact on the Head of IA Opinion for 2023/24. The outcome of all remaining internal audits would be reported through the relevant Committees as early as possible in May and to the Audit Committee in June 2024.
- **Internal Audit**: the Committee welcomed the actions taken to reduce the number of overdue recommendations, and this would be monitored closely during 2024/25. The plan for completion of audits in 2024/25 had been front loaded in Q1 and Q2 to deliver audits in a more balanced way across the year prior to the Head of Internal Audit Opinion being issued.

The Board noted that the strategic risk assigned to the Committee had been assigned a **reasonable** level of assurance by the Committee.

Outcome: the Board

- noted the update reports from the Committee Chair and the matters highlighted.

Item 2024-25 (15)

Discussion points:

Audit Committee Annual Report 2023-24

The purpose of this report is to fulfil the annual review of the Trust's governance processes. A draft of the Audit Committee's annual report 2023/24 was presented for approval.

Outcome: the Board

- received and approved the Audit Committee's annual report for 2023-24.

Item 2024-25 (16)

Discussion points:

Guardian of Safe Working Hours (GoSWH): Quarter 4 report 2023-24 and Annual Report for 2023-24

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

The Guardian drew attention to two issues covered in both reports:

- Child and Adolescent Mental Health Service (CAMHS) on-call rota compliance, payment issues conclusions and plans for next steps.
- Issue related to the impact of on-call work on community paediatric training needs

The Board thanked the Guardian for the significant amount of work she had done to investigate and conclude work related to the CAMHS historic rota and offered the Board's support if necessary to resolve the issues related to on-call work on paediatric training needs as part of their work at Leeds Children's Hospital.

Outcome: the Board

- received this assurance regarding Junior Doctor working patterns and conditions within the Trust
- supported the Guardian with the work in relation to community paediatric training opportunities
- noted the conclusion and next steps of action in relation to CAMHS historic rota issue
- noted the risk to the Trust of potential grievance case that could be raised by Junior doctors affected by CAMHS historic rota issue.

Item 2024-25 (17)

Discussion points:
Workforce Strategy update
The Director of Workforce, Organisational Development and System Development (LS) presented the update report which provided the Board with information about key headlines linked to the Trust's Workforce portfolio. The update had been reviewed and discussed at the Business Committee in April 2024.

Non-Executive Director (AL) raised several questions about the Equality, Diversity and Inclusion ambitions and targets, the requirement for statutory and mandatory training for staff on bullying and harassment and whether clear routes and processes were in place for staff to report bullying and harassment.

The Director of Workforce, Organisational Development and System Development (LS) provided some information in response to each of the questions but said that she would welcome the opportunity to discuss these issues in more detail outside the formal Board meeting.

Outcome: the Board

- noted the workforce headlines presented in this report
- noted the progress achieved in pursuit of the target measures set out in the current Workforce Strategy.

Item 2024-25 (18)

Discussion points:
a) Significant Risks Report
The Chief Executive introduced the report which provided information about the effectiveness of the risk management processes and the controls in place to manage the Trust's most significant risks. She highlighted:

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

Risk movement
There were four risks on the Trust risk register that had a score of 15 or more (extreme), all four had been at 15 for between 3 and 4 months:

- 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
- Impact/Management of Neurodevelopmental Assessment Waiting List

There were a total of seven risks scoring 12 (very high), three of which were new risks and one had been escalated from a lower score of eight.

The Executive Director of Nursing and AHPs informed the Board that since the report had been drafted the score for the risk relating to capacity in the Yeadon Neighbourhood Team had been reduced to 12 and was expected to be reduced further.

Board members suggested that the risk reports made to the Committees could include more information on the mitigations in place to manage the risks and there should be a greater correlation between the information in the risk reports and other reports made to Board particularly the Performance Brief.

b) Board assurance framework (BAF)
Following approval in March 2024 of the Trust's strategic framework for 2024/25, a full review of the BAF had been undertaken by the Trust Leadership Team to ensure that it was reflective of the associated high-level risks aligned to the objectives. The BAF had now been populated with the five strategic objectives and 10 strategic risks for the next year, and Board sub-Committees with responsibility for overseeing strategic risks had reviewed and agreed their proposed risks and sources of assurance during May 2024.
Non-Executive Director (IL) noted that three strategic risks scoring 16.

Executive Directors had carefully considered the scores, and the risks would be reviewed after Quarter 1.

Approval was sought from the Board for the BAF for 2024/25.

Outcome: the Board
- received the 2024/25 BAF and was assured of its completeness, including risk scoring and mitigating actions
- approved the 2024/25 BAF.

Item 2024-25 (19)

Discussion points:
Committees' terms of reference review
Between March and April 2024, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness.

Minor changes had been proposed by each committee and were detailed in the report along with the membership of each committee.

Outcome: the Board
- approved the changes to the terms of reference of Board sub-committees
- noted the membership of each committee.

Item 2023-24 (20)

Discussion points:
Corporate Governance
a) Declarations of interest made by directors for 2023/24
Due to an oversight a declaration had been omitted from the register by a Non-Executive Director. Confirmation had been received that mitigating actions had been in place throughout the year to manage the added conflict and it was concluded that no breach of the Managing Conflicts of Interest Policy had occurred. An updated schedule of disclosures for 2023/24 was presented for inclusion in the Trust's Annual Report for 2023/24.

Outcome: the Board
- noted the declarations of interest made by directors for 2023/24.

b) Compliance with Provider Licence 2023/24 -self certification
The Company Secretary explained that under the revised Provider Licence which came into force for NHS Trusts on 1 April 2023, there was now a requirement for Trusts to self-certify annually against their compliance with one condition set out under Continuity of Services – CoS7: Availability of Resources.

The report outlined the condition and described how the Trust had met the requirements of the provider licence.

Outcome: the Board
- agreed that the self-certification against required NHS provider licence condition CoS7 was accurate.

c) Service Visit Reports The Chief Executive presented the summary of visits made by Board members. **Outcome:** the Board • noted the report.
Item 2024-25(21)
Discussion points: **Any other business Blue Box Items and Close** There were no matters raised. The Trust Chair closed the meeting at 12.10pm.
Date and time of next meeting **Tuesday 3 September 2024 9.00am-12.00 noon**

Additional items (Blue Box)	
2024-25 (22)	**Quality Strategy update–** reviewed by Quality Committee May 202
2024-25 (23)	**Sustainability Annual Report 2023/24** - *reviewed by Business Committee May 2024*

Agenda item:	2024-25 (34aii)

Title of report:	Minutes Trust Board Meeting Held in Public: 19 June 2024

Meeting:	Trust Board Meeting Held in Public
Date:	3 September 2024

Presented by:	Trust Chair					
Prepared by:	Board Administrator					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	√

Executive Summary:	Draft minutes for formal approval by the Trust Board

Previously considered by:	N/A

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	N/A
	Use our resources wisely and efficiently	N/A
	Enable our workforce to thrive and deliver the best possible care	N/A
	Collaborating with partners to enable people to live better lives	N/A
	Embed equity in all that we do	N/A

Is Health Equity Data included in the report?	Yes		What does it tell us?	N/A
	No		Why not/what future plans are there to include this information?	N/A

Recommendation(s)	• The Trust Board is asked to approve the minutes.

List of Appendices:	None

Attendance

Present:	Brodie Clark, CBE	Trust Chair (via virtual link)
	Selina Douglas	Chief Executive
	Helen Thomson, DL (HT)	Non-Executive Director and Trust Vice Chair (via virtual link)
	Richard Gladman (RG)	Non-Executive Director (via virtual link)
	Professor Ian Lewis	Non-Executive Director (via virtual link)
	Alison Lowe, OBE (AL)	Non-Executive Director (via virtual link)
	Khalil Rehman (KR)	Non-Executive Director (via virtual link)
	Sam Prince	Executive Director of Operations
	Steph Lawrence, MBE	Executive Director of Nursing and Allied Health Professionals
	Andrea Osborne	Interim Executive Director of Finance and Resources
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
Apologies:	Ruth Burnett	Executive Medical Director
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
In attendance:	Rachel Booth (RB)	Associate Non-Executive Director (via virtual link)
	Helen Robinson	Company Secretary
Minutes:	Liz Thornton	Board Administrator (via virtual link)
Observers:	None	
Members of the public:	None	

Item 2024-25 (24)
Discussion points **Welcome introduction, apologies, and preliminary business** The Trust Chair opened the Trust Board meeting held in public. Information about the meeting had been published on the Trust's website. Access the meeting and copies of the papers had been made available upon request. The Company Secretary confirmed that no requests had been received. **Apologies** Apologies were received and accepted from Ruth Burnett, Executive Medical Director and Laura Smith, Director of Workforce, Organisational Development and System Development.
Item 2024-25 (25)
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. Non-Executive Director (KR) declared that the Trust's External Auditors, Forvis Mazars were the External Auditors for East Lancashire Hospitals NHS Trust where he held a position as Non-Executive member on the Trust Board. No additional conflicts of interest were declared at the meeting.
Item 2024-25 (26)
Discussion points: **Questions from members of the public** There were no questions to address.
Item 2024-25 (27)
Discussion points: **Update from the Chair of the Audit Committee on end year Committee meeting on 18 June 2024** Non-Executive Director and Chair of the Audit Committee (KR) provided a verbal update on the deliberations of the Audit Committee on 18 June 2024. He informed the Board that the Committee had given full and proper scrutiny to the Trust's accounts for 2023-24. The Committee had also reviewed the draft letter of representation and the audit completion report on the Trust's financial statements issued by the external auditors, Forvis Mazars. He reported that he was satisfied with the opportunity the Committee had had to review the annual report and accounts and he extended his thanks to the Company Secretary, Head of Communications, the Finance Team and the External Auditors for their efforts in maintaining a robust process both throughout the year and for the year-end processes. He added that in relation to the Head of Internal Audit Opinion for 2023/24 an overall opinion of Significant Assurance had been provided. It was noted that the Head of Internal Audit Opinion was one of the sources of assurance used by the Board to produce the annual governance statement included in the annual report. The Committee was recommending that the Trust Board adopt the annual report and accounts for 2023-24. This conclusion had been supported by the External Auditors' opinion on the accuracy of the financial statements.
Item 2024-25 (28a, b and c)
Discussion points: Annual report and accounts 2023/24 On 18 June 2024, the Audit Committee had received the Audit Completion Report and reviewed the draft letter of representation on the Trust's financial statements issued by the external auditors, Forvis Mazars. The Interim Executive Director of Finance and Resources confirmed that, as noted in the draft letter of representation, directors had provided written confirmation that, to the best of their knowledge,

all information relevant to the financial statements had been disclosed. The External Auditors had confirmed their confidence that this had been the case.

Referring to the external auditors' opinion on the accounts, the Interim Executive Director of Finance and Resources said she could report that the auditors would issue an unqualified opinion on the Trust's accounts. She highlighted that two late changes to the annual report had been suggested by the External Auditors but she was able to confirm that the changes would **not** impact on the primary financial statements or the financial results and would not preclude the Trust Board signing off the annual report and accounts at this meeting.

The Board placed on record its thanks to all members of the Trust who had contributed to the timely completion of the annual report and accounts for 2023/24.

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

- adopted the draft annual report and accounts (as supported by the external auditors' opinion)
- approved the letter of representation, which, amongst other matters, required that the Trust Board considered and agreed that there are no "events after the reporting period" to include in the accounts and bring to the auditor's attention
- following the Trust Board approval, the Chief Executive and Interim Executive Director of Finance and Resources' e-signatures would be applied to relevant documents for submission to NHS England on or before the 28 June 2024.

Item 2023-25 (29)

Discussion points:
Any other business
No matters were raised.

Item 2024-25 (30)

Discussion points:
Close of the public section of the Board
The Trust Chair thanked everyone for attending and closed the Board meeting at 9.15am.

Date and time of next meeting
Tuesday 3 September 2024 9.00am-12.00 noon

AGENDA ITEM 2024-25 (34b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) action log: 3 September 2024

Agenda Item Number	Action Agreed	Lead	Timescale	Status
19 June 2024				
None to note				
7 June 2024				
2024-25 (10)	**Mortality Reports:** • Annual Report for 2023-24 to be circulated.	Board Administrator	Post meeting	Circulated by email 13 June 2024
2024-25 (13)	**Performance Report-Effective Domain:** • to consider a review of how the Trust evidences effectiveness for 2024/25 for the Effective Domain as part of a Quality Committee workshop.	Executive Director of Nursing and AHPs/ Executive Medical Director	Quality Committee workshop 28 October 2024	To be considered at Quality Committee workshop 28 October 2024
28 March 2024				
2023-24 (123)	**Chief Executives Report:** • Tier 3 Weight Management service waiting times update to Quality Committee and Board in Autumn 2024.	Executive Director of Operations	Quality Committee October 2024	Trust Board 6 December 2024
2 February 2024				
2023-24 (98)	**Patient Story: Community Neurology Service (CNRS):** • 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	Trust Board 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	Strategy update to be presented to Quality Committee in July and Board on 3 September 2024	Trust Board 3 September 2024- agenda item

Key	Colour
Actions on log completed since last Board meeting on 7 June 2024	Blue
Actions not due for completion before 3 September 2024: progressing to timescale	Green
Actions not due for completion before 3 September 2024: agreed timescales and/or requirements are at risk or have been delayed	Amber
Actions outstanding at 3 September 2024: not having met agreed timescales and/or requirements	Red

Agenda item:	2024-25 (36)

Title of report:	Chief Executive's report

Meeting:	Public Board
Date:	3 September 2024

Presented by:	Selina Douglas (Chief Executive)					
Prepared by:	Selina Douglas (Chief Executive)					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	

Executive Summary:	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: • System flow • Visit by Secretary of State for Health and Social Care • Update on the Developmental Well-Led Review • Quality & Value Programme • Collaborating in Partnership

Previously considered by:	N/A

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	y
	Use our resources wisely and efficiently	y
	Enable our workforce to thrive and deliver the best possible care	y
	Collaborating with partners to enable people to live better lives	y
	Embed equity in all that we do	y

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	y	Why not/what future plans are there to include this information?	N/A

Recommendation(s)	Board notes the contents of this report and the work undertaken to drive forward our strategic goals.

List of Appendices:	N/A

Chief Executive's Report

➢ 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 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:

- Working with communities to deliver personalised care
- Enabling our workforce to thrive and deliver the best possible care
- Collaborating with partners to enable people to live better lives
- Embedding equity in all that we do
- Using our resources wisely and efficiently both in the short and longer term.

➢ 2 System Flow

The system has been relatively stable over the summer period with only occasional escalations. A reflective session on Winter 2023/24 was held to inform preparations for this year.

The Home First programme continues to make improvements across the five workstreams: Active Recovery at Home, Rehabilitation and Recovery Beds, Transfers of Care, Enhanced Care at Home and System Visibility and Active System Leadership. In late July a delegation from the Department of Health and Social Care visited Leeds to understand the successes and challenges of implementing the Home First Programme. They heard about LCH's ambitions and potential for Community Services; the importance of the Third Sector in system flow with a spotlight on Enhance; our work on the Home Ward and joint work with Adult Social Care on Active Recovery. They also visited St James' University Hospital to see the Transfer of Care work in action. Feedback was extremely positive and there has been follow up interest in terms of Enhance.

➢ 3 Visit by Secretary of State for Health and Social Care

The Rt Hon Wes Streeting MP visited Leeds on 6 August 2024 and the Executive Director of Operations represented the Trust at a meeting with him and a group of leaders from NHS, Public Health and Social Care leaders from across the North East and Yorkshire. Mr Streeting summarised his objectives for the NHS and Care sector:

- A shift from diagnosis and treatment to a model where more services are delivered in local communities
- A greater focus on prevention throughout the entire healthcare system and supporting services
- A shift and greater focus on digital transformation and capability
- He also referenced the aspiration to create a National Care Service, underpinned by national standards, delivering consistency of care across the country.

4 Update on the Developmental Well-Led Review

The Trust last underwent a full CQC inspection in 2019, with an overall rating of Good, including a rating of Good for Well led. Prior to this a Well-led peer review had been carried out in 2018 by Cambridgeshire Community Services NHS Trust, with good practice and areas for improvement identified.

In order to remain compliant with the new Code of Governance which came into force on 1 April 2023, NHS 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. As a result of this, the Trust Leadership Team has agreed that an external review be commissioned during 2024/25.

A tender process has been completed and the contract awarded to Mersey Internal Audit Agency (MIAA). The intention is for the review to take place during the Autumn, and it will deepen the Trust's understanding of its leadership and governance through objective and constructive review and challenge, informing further targeted development work to secure and sustain the Trust's future performance as part of continuous improvement.

We are excited to start working with MIAA and will share further updates on this once the review has got underway.

5 Quality & Value Programme

Our three year Quality and Value Programme continues to progress well in its aim for us to achieve financial balance and do this in a way that is safe, responsible and sustainable. Our deficit equates to approximately 7% of our organisational budget, and we have established a number of workstreams so that we can manage this by looking at all aspects of the organisation. This includes:

- Redesigning our services – currently our Neighbourhood Teams, CYPHMS, MSK, Speech and Language Therapy, Children's Community Nursing, Podiatry, and Community Intravenous services are being taken through a service-led quality improvement methodology to reduce costs whilst mitigating against any untoward impact on quality and equity. A number of services are also in the pipeline waiting to start.
- Reviewing our corporate services – we are committed to protecting our frontline services as much as possible and so are requiring our corporate services to provide a larger proportional contribution to savings. All corporate services have been given a savings target and are now working through a self assessment process to determine short, medium, and long term transformational ideas. In addition, a number of business processes are being reviewed to ensure they are as lean as possible, for example procurement and temporary staffing. We have also established firmer grip and control around our vacancy processes and discretionary spend.
- Rationalising our estate – as a result of reducing leases in buildings that are not fit for purpose or which we underutilise, we have already met our target in this workstream.
- Developing our business – we have been bidding to retain three of our existing services this summer. We also have a plan for future income generation which could offset any future savings we have to make.

- Implementing digital enablers – as a result of digital innovations money from NHS England, we are excited to be launching a new Patient Information Hub; we are digitising patient letters; and we are piloting a wound care app. All of which should make patient's, and staff's lives much easier.

As a result of all of the above we are forecasting to achieve financial balance this year.

6 Collaborating in Partnership

The Community Collaborative across West Yorkshire met in July to discuss how community providers work together to share best practice, offer resilience and develop community services. We had an insightful presentation from community dentistry services, include Leeds Community Healthcare services, highlighted the valuable work they do supporting the most vulnerable in our communities. Discussions have also been had around how the delegation of dentistry commissioning across West Yorkshire could help with a longer-term development strategy.

Leeds Place is reviewing the existing partnership arrangements to ensure there is joined up strategic planning and delivery across the city. The newly created Partnership Leadership Team (PLT) will be created with a monthly face to face meeting. The meetings focus is on the Healthy Leeds Plan and how the system works together across the Leeds Place

7 LCH response to riots and support for staff

LCH has responded to public disorder events recently across the city including an incident in Harehills and the impact of rioting by far-right groups nationally. This has had an impact on the organisation due to the nature of our work, going into people's homes and police custody, and the impact on our staff from the global majority. A meeting has been held with staff network chairs to discuss how we support affected members of the team, and we are actively encouraging individuals affected to speak to their line managers and networks. This has been reiterated in the CEO's Monday message and will further work will be developed over the coming months.

LCH is currently reviewing its social media policy to ensure we have effective safeguards in place. The outcome of this will available at the next board.

Finally, I wanted to acknowledge and put on record our thanks to Steph Laurence who has retired from the NHS. Steph has been an exemplary Director of Nursing and AHP's and lead proactively during covid and beyond. We all wish her well for whatever she does in the future.

8 Recommendations

The Board is recommended to:
Note the contents of this report and the work undertaken to drive forward our strategic goals.

Selina Douglas
Chief Executive
August 2024

Agenda item:	2024-25 (37i)

Title of report:	Third Sector Strategy 2024-27

Meeting:	Trust Board Held in Public
Date:	3 September 2024

Presented by:	General Manager (SBU) on behalf of Executive Director of Operations					
Prepared by:	LCH Partnership Development Manager, Volition Director (on behalf of Forum Central)					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval ✓	

Executive Summary:	LCH's first Third Sector Strategy, 2020-23 was co-produced with Forum Central (FC) and approved by LCH Board in August 2020. Three years on, the LCH Third Sector Strategy Steering Group directed a light touch refresh of the 2020-2023 strategy resulting in this updated strategy for the period 2024-27. The Steering Group decided that whilst the strategy aim remains relevant, it was appropriate to consolidate from 7 to 4 objectives: 1. Drive culture change in LCH where our people fully recognise the value of the 3rd sector and pro-actively seek to optimise 3rd sector partnerships 2. Adopt a strategic approach to developing 3rd sector partnerships that enables left shift, develops inclusive accessible services and reduces health inequalities 3. Champion and support 3rd sector resilience 4. Champion a '1 health' system where infrastructure is aligned to enable all partners to successfully contribute

Previously considered by:	Third Sector Strategy Steering Group – 29 April 2024 Trust Leadership Team – 17 July 2024 Business Committee – 24 July 2024

	Work with communities to deliver personalised care	✓

Link to strategic goals: (Please tick any applicable)	Use our resources wisely and efficiently	✓
	Enable our workforce to thrive and deliver the best possible care	
	Collaborating with partners to enable people to live better lives	✓
	Embed equity in all that we do	✓

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No		Why not/what future plans are there to include this information?	The strategy is our underpinning approach to engaging with all communities

Recommendation(s)	The Board is asked to approve the LCH Third Sector Strategy 2024-2027

List of Appendices:	Appendix I – Third Sector Strategy 2024-27

LCH 3rd Sector Strategy: 2024-2027

LCH's first Third Sector Strategy, 2020-'23, was co-produced with Forum Central (FC) through wide engagement with LCH staff and third sector organisations and approved by LCH Board in August 2020. The aim of the strategy was:

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

Strategy implementation has been directed and overseen by a bi-monthly joint LCH third sector steering group co-chaired by LCH Director of Operations and Volition Direction on behalf of FC.

Steering Group meetings have a focus on significant current and anticipated challenges, risks and developments to enable responsive support, and implementation and development of the implementation plan.

1. Current Context

The 2020 – 2023 strategy was developed before the pandemic. This strategy refresh is at a time of unprecedented pressures and challenges for communities, NHS providers, the wider public sector and the third sector due to the combined impact of the pandemic, prolonged austerity and cost of living pressures resulting in:

- significant increase in people living in poverty
- deterioration in physical and mental health and well-being and widening health inequalities
- increased and more acute and complex demand for statutory and 3rd sector services, much longer waiting times
- the combined effect of the above has resulted in significant reduction in the number of 3rd sector organisations, employees, trustees and volunteers and difficulty retaining and recruiting staff. Click here to see the State of the Sector Report infographic
- reduction in funding across all health and care partners statutory and 3rd sector for 24/25, and forecast for the following 2 / 3 years, will result in a reduction in workforce and services, and combined with government focus on reducing hospital waiting lists risks
- further widening health inequalities - LCH Quality and Value programme aims to ensure no adverse impact on health inequalities; there will be an EQIA for all proposed changes
- shift in funding to provision in the community and for prevention, earlier intervention and self-management – left-shift - not materialising In 2023 a city Third Sector Strategy was approved which sets out how all partners need to work to ensure a resilient third sector that continues playing a vital role in supporting communities in Leeds to thrive: Case study pack - TSS (b-cdn.net)

2. Progress Implementing the 2020-23 Strategy Objectives - Alignment with the Implementation Plan

Objective1: Optimise integrated working, co-delivery that recognises the collective role in achieving left shift

Objective2: Utilise health inequalities expertise

Objective 3: LCH offer supports 3rd sector resilience

Objective 4: Champion a 'one health system' - infrastructure

Objective 5: Fair and equal approach to business development

Objective 6: Develop shared agendas

Objective 7: Enable navigation and links

N.B This does not include 3rd sector partnership development progressed separate to the Implementation Plan.

Objectives	Implementation Plan Action	Progress at end of March 2024
23/24 WORKSTREAM		DEVELOP INCLUSIVE, ACCESSIBLE SERVICES
2,3,	i. Support people with sensory impairment (PSI) to bridge the last 10 metres	• LCH supported BID's successful application to NHS Charities Together to provide a be-friending service for PSI and work with NHS partners to improve access for PSI. • BID has provided sensory awareness training for all LCH front of house (FoH) plus Admin staff, SMT and some clinical staff. Focus was then FoH new starters. Exceptionally positive feedback. Posters displayed in Health Centres advise PSI that staff have been trained. • Work underway to ensure there are functioning and maintained hearing loops in all LCH retained facilities • BID linked with PLACE inspection lead about participating in 24/25 PLACE inspections to provide PSI perspective • Work to establish a process to meet and greet PSI arriving at health centres by taxi when project management capacity is available.

2,3,7	ii. Better meet vulnerable groups communication needs	• LCH funded 3rd sector support for the 1st round of Quality Improvement Communication projects through the Community of Interest Network: supported the March '23 celebration and learning event, providing insight into patient and community experience of communication, training and input into programme evaluation.
2	iii. Develop Easy Read service information	• LCH LD Project manager established links with several 3rd sector groups, through Forum Central Health Task Group and LYPFT Health facilitation team, and has worked with those groups to co-produce Easy Read resources. Groups gave very positive feedback about their involvement and appreciated the opportunity to understand LCH's services better.
1,2,3	iv. Deliver more services in / co-deliver with 3rd sector partners	• ABU established an Ambulatory Clinic at OPAL and a leg club with NET Garforth and LS25/26PCN, both run alongside 3rd sector social activities creating opportunities for people to connect with the 3rd sector organisation and develop social connections. OPAL also provide transport. • LCH-Forward Leeds wound clinics were piloted in 3 Forward Leeds premises for people who are homeless, drug users and sex workers: Forward Leeds supported people to attend. Due to low attendance an alternative model is being tested that enables attendance at any Ambulatory Clinic, with appropriate adjustments. Forward Leeds support people to attend where necessary and their capacity permits.
23/24 WORKSTREAM		CONNECT BETTER
1,2,3,4,7	v. Invest in 3rd sector capacity to enhance capacity in NTs and better support people	• In year 2 Enhance support offered to wider ABU teams, LTHT hospital discharge teams and where 3rd sector delivery partners (DPs) had capacity, Adult Social Care, Primary Care and referrals from the Enhance delivery partners. • Falls avoidance referral pathway developed with LCH Community Falls lead, Leeds ICB, West Yorkshire Fire and Rescue Service (WYFRS) and Enhance to enable WYFRS to refer to LCH Falls service / Enhance as appropriate. • NT referrals increased as a result of DPs having a regular presence in NT bases, however still low for some teams. Impact on people evaluated positively, 53% of people supported live in IMD1/2. • December '23 Board approved funding for year 3: LCH referrals only - NTs and other ABU, SBU services where enables greatest time savings and ensure robust evaluation

2,7	vi. Enable 2-way info flows with vulnerable communities	• Patient Engagement Team re-established links with the Communities of Interest Network (COIN) and regularly attend, enabling 2-way sharing of information.
2,6,7	vii. Strengthen links to Local Care Partnerships (LCPs)	• Seacroft NT engaged in Seacroft LCP work around Frailty, End of Life, Domestic Violence and Abuse. Most NTs not able to attend LCP meetings due to operational pressures. CBU involved in work in South Leeds LCP on children and young people's mental health. Range of services attend HATCH meetings and engaged in Domestic Violence and Abuse workstream. Diabetes service worked with HATCH LCP to explore alternative models to improve access and engagement with diverse communities. Focus in some LCPs on Enhance. • LCP Development Team have had stalls at BU and organisational events.
7	viii. Re-establish a central point to support NT focus on developing local 3rd sector links	• Not progressed in 23/24 due to operational pressures, focus on the Neighbourhood Transformation Programme, establishing Triage Hubs and Enhance. • Exploring how this fits with the Admin Quality & Value programme.
3,7	ix. Develop intranet pages to support navigation and links	• Intranet partnership pages launched in June to encourage and facilitate partnership working with the 3rd sector, Local Care Partnerships and Primary Care Networks. • 3rd sector content includes links to 3rd sector directories and networks to enable navigation and links; case studies, videos and vlogs to inspire; link to city volunteering opportunities (Be Collective website) and LCH staff testimonials to encourage and enable volunteering
3,7	x. Enable links through • LCH 3rd sector networking event • Holding Steering Group meetings in 3rd sector venues	• LCH and FC jointly planned and delivered the 1st LCH 3rd sector networking event, November '23. The event was well attended and had over 20 3rd sector and LCH market place stalls. 3rd sector partnership working showcased through joint presentations: CBU: Mindmate SPA and The Market Place, Community Stroke Service and the Stroke Association, NTs and Enhance. Table discussions informed the refresh of the strategy. Many attendees requested further events. • From January '23 – March '24 Steering Group most meetings held in 3rd sector venues across the city to widen 3rd sector links and support those organisations: some venues provided at no cost.

23/24 WORKSTREAM			CO-PRODUCE SERVICES
1,2,3	xii.	Co-produce the remote monitored virtual ward	• After early planning discussions with Forum Central this was not progressed due to LTHT leading phase 1, and more recently the review of the Home First programme
2,7	xiii.	Develop CBU 3rd sector Involvement links	• 3rd sector links have expanded significantly. Young Lives Leeds publicise Youth and Parent Board and other involvement opportunities through their website and bulletins e.g. Community Eye Service Review. Youth and Parent Board membership has grown and is now more diverse. • Strong link with GATE developed: work has focussed on raising awareness of mental health support and developing timely, safe communication with gypsy and traveller communities
1,2,3,5,7	xiv.	Co-produce Specialist Business Unit service delivery models with the 3rd sector	• Sexual Health Service tender - ahead of the tender being published engaged with 19 3rd sector organisations to develop links and co-produce pathways to enable access, reach and meeting the needs of specific populations. Forum Central will lead a 3rd sector network to guide ongoing service development and are members of the service Board.
23/24 WORKSTREAM			• ENABLE MORE EFFECTIVE SELF-MANAGEMENT
1,2,6,7	xv.	Promote digital inclusion by linking services with 100% Digital and Digital Health Hubs	• 100% Digital presented at Leaders Network, ABU forums, Digital Champions Network and have had a stall at Trust and BU events to raise awareness about digital inclusion and support from 100% Digital and the Digital Health Hubs for clinicians, patients and carers. Services and Business Units were keen but due to competing pressures, only the Stroke Service followed through: digital inclusion awareness team training. CBU have strong links with 100% Digital CBU.
1,2,3,7	xvi.	Expand self management Health Hubs in 3rd sector premises	• The self-management team have established 4 Health Hubs, provided in Enhance 3rd sector partner premises which are well utilised. Enhance partners support people to attend, connect them to social activities and provide wider support. Expansion was paused due to ABU restructuring.

23/24 WORKSTREAM			SUPPORT 3RD SECTOR GROWTH, SUSTAINABILITY
1,2,3,4,5,7	xvii.	3rd sector funding & contracting support resilience	• Focus at March'24 Board workshop on supporting 3rd sector resilience through our approach in relation to being a lead provider and contracting. Agreed: • Review alignment of length of 3rd sector contracts with LCH contracts – as a result extended Northpoint contracts in Mindmate SPA, • Commitment to review objectively opportunities for third sector partners to lead • Be more proactive about how partnerships and lead provider arrangements are agreed when services go out to tender to avoid rushed decisions being made due to tight timescales. Pipeline of opportunities being scoped • Where LCH is the lead provider ensure more rigour in mapping corporate infrastructure requirements from the start • Introducing focus at contract review meetings with 3rd sector partners on the impact of contracts on partner's resilience, share and implement good practice - not fully embedded
3,6	xviii.	Steering Group focus on key challenges, risks and opportunities	• Focus on impact of cost of living pressures on communities and the 3rd sector enables 2-way support in population boards, PEG and other system forums e.g. raising concern about impact of de-funding resulting in closure of the Bereavement service. • LCH Population Board forum met for the 1st time in March – supports shared understanding, joined up comms and greater influence comms on key issues at Population Boards
23/24 WORKSTREAM			DEVELOP A 'ONE HEALTH SYSTEM' INFRASTRUCTURE
1,4	xix.	Enable information-sharing with 3rd sector partners to support partnership working	• LCH request for Age UK access approved: will facilitate partnership working, particularly with the Home Ward, Recovery Hubs and NTs. Timeframes reliant on TPP. • Providing Enhance 3rd sector partners with NHSmail: ensures all referrals are secure and is more efficient for LCH referrers and Enhance 3rd sector partners. • Linked LOPF to work instigated by Home First and Anticipatory Care Programmes to develop a Recovery Plan on Leeds Care Record to support joined up timely discharge from hospital and enable information sharing. Will initially share information between LCH and LTHT. Early planning looking at enabling sharing with PC and key third sector partners • Board level action to seek support from Leeds and WY systems to lobby nationally for greater flexibility with definition of direct care not progressed due to competing priorities

3. Refreshed 2024 – 2027 Strategy

- The Third Sector Strategy Steering Group led a light touch review of the strategy, mindful of work underway to review the organisational strategy. The review was informed by:
    - wider LCH and 3rd sector views about priority focuses through discussions at LCH 3rd sector networking event in November 2023 and subsequent testing of priority focuses with attendees
    - reviewing whether 2020-23 Implementation Plan actions remained a priority to continue with action leads
    - consideration of alignment with the city Third Sector Strategy.
- The Steering Group decided:
    - no change in the strategy aim.
    - to consolidate the 7 objectives down to 4 objectives
- The refreshed Implementation Plan was agreed at April '24 Steering Group. There is significant continuity from the 23/24 Implementation Plan.
- Assurance on progress implementing the strategy will continue to be provided through 6-monthly updates to Business Committee

Objective 1: Drive culture change in LCH where our people fully recognise the value of the 3rd sector and pro-actively seek to optimise 3rd sector partnerships and enable 2-way navigation and connections

- ✓ Enable 2-way connections and navigation across LCH and the 3rd sector
- ✓ Ensure effective 2-way information flows with vulnerable communities
- ✓ Enable sharing and spread of good models, practice, ways of working and learning
- ✓ Celebrate and raise awareness internally and externally of 3rd sector partnership models, good practice, contribution and impact
- ✓ Optimise LCP and social prescriber links

Objective 2: Strategic approach to developing 3rd sector partnerships that enable left shift, develops inclusive accessible services and reduce health inequalities

- ✓ Strategic approach to identifying potential for greater role of 3rd sector through:
  - ✓ Trust strategy development and the Quality and Value programme
  - ✓ Ensuring effective 3rd sector engagement and partnership working when developing and implementing tender bids & service models
- ✓ Enhance capacity in LCH services through investing in 3rd sector capacity to provide holistic person centred support
- ✓ Optimise NT ability to connect service users, carers to local services, support
- ✓ Deliver more services in 3rd sector premises / co-deliver with 3rd sector partners: Integrated (Ambulatory) Clinics and self-management Health Hubs
- ✓ Co-produce Specialist Business Unit service delivery models with 3rd sector
- ✓ Co-produce the remote monitored Home Ward solution & mobilisation
- ✓ Childrens services engaging more inclusively
- ✓ Develop strategic approach that drives awareness of digital inclusion across BUs, enables staff to directly support, signpost or connect people to support and embeds focus in change processes
- ✓ Support People with Sensory Impairment (PSI) to 'bridge the last 10 metres' when attending health centres
- ✓ Better meet vulnerable groups communication need
- ✓ Encourage collaboration with the 3rd sector in research around shared agendas to enable co-design, community focus and responsiveness to those with the greatest needs

Objective 3: Champion and support 3rd sector resilience

- ✓ 3rd sector funding and contracting support resilience
- ✓ Maintain an honest, open dialogue internally and with system partners to understand and address challenges and threats to 3rd sector sustainability and resilience
- ✓ Increase the number of LCH staff volunteering with 3rd sector organisations, especially as Trustees
- ✓ Potential role for 3rd sector in managing LCH volunteers

Objective 4: Champion a 'one health system' where infrastructure is aligned to enable all statutory and 3rd sector partners to successfully contribute

- ✓ Enable information sharing with the 3rd sector
- ✓ Share learning around Leadership / OD support.

Agenda item:	2024-25 (38)

Title of report:	Health Equity Strategy

Meeting:	Trust Board meeting
Date:	3 September 2024

Presented by:	Ruth Burnett, Medical Director					
Prepared by:	Anna Ray, Public Health Consultant and Em Campbell, Health Equity Lead					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	The trust's work to identify and address inequity in its care and pathways are a combination of statutory requirements and priority actions identified through our Health Equity strategy. This paper provides an update on that work, the contribution to Quality and Value and consideration of the risks to scale and pace of delivery.

Previously considered by:	Trust Leadership Team

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	✓
	Use our resources wisely and efficiently	✓
	Enable our workforce to thrive and deliver the best possible care	
	Collaborating with partners to enable people to live better lives	✓
	Embed equity in all that we do	✓

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes	✓	What does it tell us?	Average waiting times are longer for people in IMD1
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	Board are recommended to note the progress on delivery of the Health Equity Strategy and risks to the scale and pace of delivery.

List of Appendices:	None

Health Equity Strategy

1. Introduction

As an NHS Trust, LCH has statutory requirements to address inequity. Alongside this, the trust has made an ongoing commitment to identifying and addressing inequity in its care and pathways that contribute to wider inequity in health. This is delivered through our trust strategic goal to embed equity in all that we do and through our health equity strategy, with the priorities agreed in the Board health equity workshop in March 2024.

This paper provides an update on the progress against these statutory and trust actions and considers how to achieve a balance in progressing them, particularly in the current financial context.

2. Current position

2.1 Statutory requirements

Six separate statutory requirements come under the health equity team to coordinate or significantly contribute to deliver. Three of these duties have been new to LCH this year and have taken significant capacity to deliver on. Although important, these duties alone are insufficient to meet our organisational ambitions around health equity.

Requirement	Deadline	Current position
Equality Act, including Public Sector Equality Duty	2010	EQIA process well-established with further work being undertaken on the resources and understanding of cumulative impact, supported by new EQIA officer role.
Accessible Information Standard (AIS)	2016	Revised communication template in place. Further work to be undertaken to increase recording. Linking to digital workstream around patient information in accessible formats.
Statement on information on health inequalities (Health and Care Act)	2024	Data reviewed and statement included in Annual Report. Health inequalities measurement framework developed which includes statutory indicators.
Armed Forces Covenant	2024	Accreditation achieved. Steering group established to oversee delivery of improvement plan towards one-year review.
Reasonable Adjustments	2024	Digital flag to be implemented. Options appraisal being developed to bring together with Communications, EDI and Armed Forces template into one 'About Me' template.
Patient and Carer Race Equality Framework (PCREF)	2025	Work underway to scope existing practice and identify priority actions with LMWS and CYMHS. Working with LYPFT to support meeting of requirements and competencies.

2.2 Priority activity for 2024/5

2.2.1 Strengthen monitoring and evaluation

Measuring health equity is a challenging and emerging field. Whilst LCH are seeking to improve our measurement of outcomes and impact of our health equity work, we recognise that many factors that drive health inequality are beyond our control (see diagram below). Through our health equity strategy, we are seeking to maximise our contribution to reducing inequality in the populations we serve. It is important that our measures reflect key processes and outcomes LCH have in their gift to improve contributing in part to an overall reduction in health inequalities across the city.

Modifiable determinants of Health

40%
10%
30%
20%

Social & Economic Factors
- Education
- Employment
- Income
- Family & Social Support
- Community Safety

Environment
- Air & Water Quality
- Housing
- Transportation

LCH can influence these through our role as an anchor institution and a system partner

Health Behaviours
- Alcohol, Tobacco & Drug Use
- Diet & Physical Activity
- Sexual Activity

LCH can impact these through preventative programmes, services and making every contact count

Health & Social Care
- Access to Care
- Quality of Care

LCH has direct control over this through service delivery

A measurement framework has been developed which will act as a starting point for equity measurement across the trust. The indicators within the framework will be developed into an equity dashboard and incorporated within other trust dashboards such as the inclusion of access measures in the performance brief. It is proposed that future Board updates will focus on certain elements of data and the annual report will report across the whole framework (including the indicators we are mandated to report on through the Health Inequalities Statement).

Access	Referral rate per 1,000 population
	Average length of patient waiting lists
	Proportion of people waiting longer than 52 weeks
	Number and rate of missed appointments per 1,000 population
	Average number of sessions treatment
Experience	Rate of complaints per 1,000 LCH referrals
	Proportion of complaints or concerns received by LCH relating to the 3C's (communication, compassion, and co-ordination).
Outcomes	Incident rate per 1,000 LCH referrals (falls and pressure ulcers)
	Patient mortality rate per 1,000 LCH referrals
	Mean age of patient death

These indicators will be available and analysed by:

- Deprivation
- Ethnicity
- Communication needs
- Learning Disability
- Autism
- Age
- Sex
- Armed Forces

Note that the health equity team will work closely with board members to ensure the equity measurement framework data reporting to board is insightful and efficient going forwards.

2.2.2 Bolster governance and accountability for health equity

The new Board cover paper includes equity and will enable a measure of inclusion of equity data within Committee and Board papers.

EQIAs have been embedded as a vital part of the Quality and Value programme, with processes and governance structures established for this. An EQIA officer has been appointed to support their ongoing use and meaningful application to decision making.

We recognise that service changes LCH makes have equity implications on patients and partners across the system. We are exploring how, for significant changes, we can use EQIAs to convene a conversation with our partners about system implications and mitigating actions. As a starting point, our Medical Director convened a partners forum to discuss implications of changes to our musculoskeletal services.

2.2.3 Ensure alignment of our activities with partners and the citywide approach

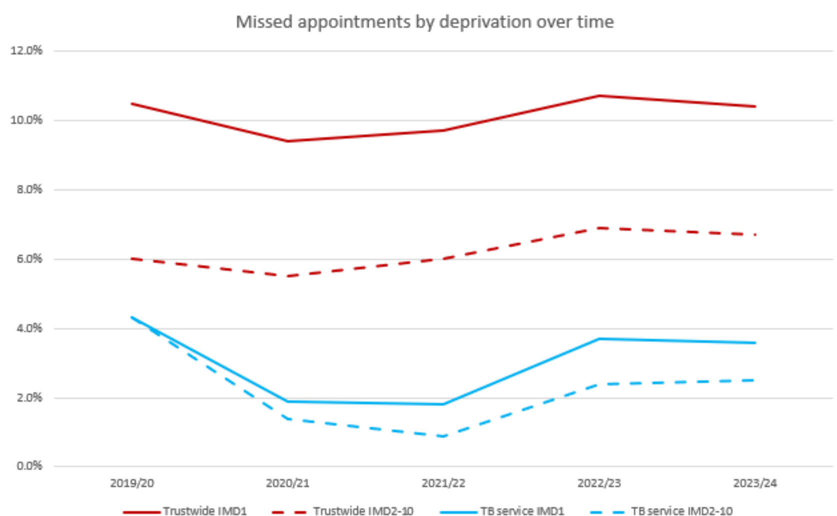
Currently structures for planning and delivering health inequalities activities at a citywide level are complex and unclear. Our public health consultant has been leading a process with key stakeholders across the city to clarify and simplify health inequalities structures across the city. The paper documenting the outcome of this process will shortly be discussed at relevant citywide forum for feedback before finalising. The intention is new structures will enable a clearer definition of our collective ambition, examination of collective progress and joined up working to embed tackling health inequalities into business as usual across the city.

In July we co-hosted a workshop with Leeds City Council and Leeds Health and Care Academy thinking through a citywide approach to reducing inequalities and ill health prevention in and through our workforce. LCH will benefit from the opportunities that have arisen from this workshop to take a citywide approach to building the capability of our workforce to tackle inequity, starting with registered professionals. Further details will be provided within the next board update.

2.2.4 Scale up good practice

Addressing inequity in missed appointments and waiting times have been selected for focus this year due to their connection with the Quality and Value programme and a tangible ‘to do’ to tackle inequity for our services.

Missed appointments



The aim of this work is to reduce missed appointments for people in IMD1 (currently 10.7%) to be in line with IMD2-10 (6.8%). This would improve access to services and contribute to improved health outcomes for people in our most deprived areas, saving over 8,000 missed appointments each year and reducing the overall missed appointment rate. Data from the TB service provided for comparison.

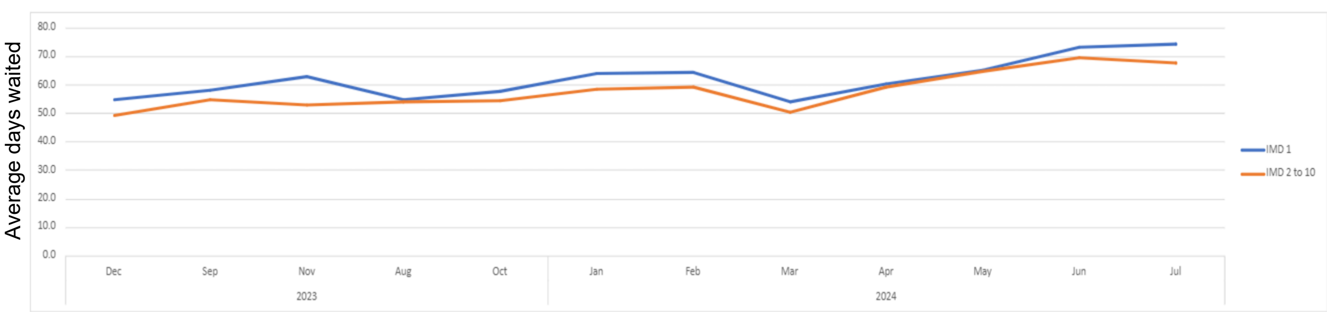
Citywide and trust workshops have been held to identify some of the causes and solutions to inequity in missed appointments. Common themes identified from this work include:

- Communication - using required communication methods, awareness of health literacy
- Reasonable adjustments
- Accessible reminders
- Digital inclusion
- Practical support: directions, access to buildings and finding way once inside
- Patient experience: communication, compassion and coordinated care supporting positive experience and patient reattendance.
- Rebooking appointments - framing discussion as how can we support attendance next time?

This work is combined with learning from the TB service about actions they have taken to minimise missed appointments and maximise engagement with a patient cohort that experiences some of the greatest barriers to health.

A patient with active TB in his spine, experiencing severe pain and having mobility issues, was struggling to attend frequent hospital appointments for bloods / medical review. Also having no recourse to public funds.	✓ Assessment includes socioeconomic factors and referral to other agencies for support with housing, food, data etc ✓ Regular contact in first few weeks of treatment to monitor side effects/symptoms and develop a trusted relationship ✓ Recognising financial barriers of increased face-to-face appointments to manage pain and medication side effects ✓ Appointment times or methods to not clash with other commitments eg housing/immigration appointments ✓ Flexible clinic model in times, venues, telephone assessments or home visits for phlebotomy, Mantoux skin readings etc ✓ Secured charitable funds for food vouchers, bus tickets and phone data to support patients' nutrition, attend appointments and digital access

Waiting times



Across LCH, people in IMD1 wait on average 4 days longer than people in IMD2-10. The services where the difference in average length of wait (5-25 days) is greater than the trust average will be supported to identify the cause and mitigation for this variation. Using 'success cause analysis' methodology, we will also work with the services where the average length of wait for people in the most deprived areas and those with additional communication needs is lower to identify where learning and best practice can be scaled up.

3. Impact

- **Resources**

There is huge potential to reduce missed appointments and reduce inequity but that requires input across the trust for this benefit to be realised. To reduce inequities in missed appointments our current equity resource will contribute to understanding good practice elsewhere, leadership sessions, engagement with services and development of Quality and Value training sessions. However, leadership and input across LCH is required to ensure equity is embedded improvement work amid focus on financial challenge.

- **Risk and assurance**

BAF risk 9 describes the risk of failure to prevent harm and reduce inequalities experienced by our patients. If the trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently causing harm,

delivering unfair care and exacerbating inequalities in health outcomes within some cohorts of patients.

Health equity resource is small (only 1.3 WTE). Over the past few months the team has lost its project support. The health equity lead has also been required to lead and expand their contribution to the delivery of equity related statutory requirements across the organisation. The very limited capacity of the team increases the risk that the organisation is unable to deliver at the scale and pace required to reduce inequity or mitigate against worsening inequity.

4. Next steps

Business cases are being put forward for project support (B4) for the public health and equity work and for project manager (B6) support jointly with Learning Disability to enable implementation of a coordinated approach with patient and community engagement to support delivery of reasonable adjustments and accessible information.

Next steps include:

- continuation of work to address inequity in missed appointments and waiting lists
- development of dashboard to monitor evaluation measures

5. Recommendations

The Board is recommended to:

- Note the progress on delivery of the Health Equity strategy and risks to the scale and pace of delivery
- Note that the health equity team will work closely with board members to ensure the equity measurement framework data reporting to board is insightful and efficient going forwards.

Anna Ray and Em Campbell
Consultant in Public Health and Health Equity Lead
14 August 2024

Agenda item:	2024-25 (39)

Title of report:	Research and Development Strategy

Meeting:	Trust Board Held in Public
Date:	3 September 2024

Presented by:	Dr Ruth Burnett, Executive Medical Director					
Prepared by:	Dr Jill Halstead-Rastrick PhD, Clinical Lead for Research					
Purpose:	Assurance	☑	Discussion		Approval	

Executive Summary:	This report provides an update regarding the Research Strategy 2020-2025. Notable achievements since the last update in January 2024: • A joint full time LCH and LTHT research manager post This post will explore workforce portability and working across boundaries to support community-based research and optimise research inclusion. • Promoting innovation and research collaborations with university partners. • A trust wide research capacity and capability survey has been completed alongside interviews of trust and service leaders (publication in progress). • The research team have linked with third sector partners to support alternative models of research engagement and delivery. This includes supporting studies in under-served groups.

Previously considered by:	**QAIG, Quality Committee**

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	
	Enable our workforce to thrive and deliver the best possible care	☑
	Collaborating with partners to enable people to live better lives	☑
	Embed equity in all that we do	☑

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes	☑	What does it tell us?	We have supported studies that aim to address health inequalities.
	No		Why not/what future plans are there to	

			include this information?	

Recommendation(s)	Receive report and note the work undertaken to date: To build research capacity and innovation, investment by LCH is needed. Added financial support could support - Increase time of the research lead - Increase research fellow time to write grants and generate income. - Increase time from finance team to support income generation.

List of Appendices:	Appendix 1 – Milestone for research 2021 to 2024 Appendix 2 – Research capacity and capability results

Research and Development (R&D) Strategy

1 Introduction

The Research and Development 5-year strategy was approved in February 2020 by the Trust board. While the initial implementation was limited by the pandemic, since 2023 and the appointment of the new Clinical Lead for R&D, many of the key milestones have been delivered. In last 6 months the research team have been engaging with collaborators, clinical leaders and aligning research with service innovation. Supporting the uptake of research will improve patient care and help find solutions to meet the financial challenges ahead.

2 Current position/main body of the report

This is a summary and update of the milestones in the final year of the strategy. The R&D Strategy lists 4 strategic aims and workstreams:

Workforce Culture; **Patients and Communities**; **Partnerships**; **Sustainability**.
Appendix 1 outlines the updated key milestones and a summary of progress in each of these is described below.

2.1 Workforce Culture

Strategic Aim 1 *LCH's workforce culture becomes one in which in which Research (in all its guises) is an accepted and expected aspect of life, visibly apparent within all the contexts that the Trust operates'*

Over the last 18 months, the research department has changed the workforce model to provide clinical leadership, governance and clinical administration. Feedback from services has been positive.

As a small team, most of the workforce milestones have been achieved, but due to limited capacity, research has not been embedded into all services as part of trust culture. The research team have a mapped research activity across the trust and spoken to 72% of all service and senior leaders (see appendix 2). The greatest concentrations of research activity are in specialist followed by children's business units.

To support research culture, the research team have completed staff focus groups, a developed research framework and are launching research champion roles with the ambition to have one in each service.

2.2 Patients and Communities

Strategic Aim 2 LCH Patients, members of the communities whom we serve and the public of the Leeds region are actively involved in driving and shaping our research activities and our wider research agenda

In 2023-24, the Trust has supported research opportunities for 324 patients across 13 research projects. The spread of the research studies include many of the specialist services and childrens' services, led by allied health professionals, psychologists, psychiatrists and paediatricians with research interest and expertise.

Patient and community engagement opportunities are evidenced by:

- Patients and staff engaging in national research survey and local research survey.
- Providing opportunities for patients and staff to be involved in research.
- Engaging with third sectors partners in research.

- Engaged and actively supporting research for under-served groups.
- Research supporting LCH community initiatives EG Home first and Enhance.

2.3 Partnerships

Strategic aim 3 LCH has working research partnerships with key local and national organisations

There is now a joint post with LTHT and LCH support 'out of hospital' community driven research models and collaborations including primary care.
The research team are supporting collaborations with university partners and National institute health research (NIHR) initiatives.
To support this ambition further, the research team are mapping research priorities for the trust in each business unit to focus resource and attract research partners.
In the last 6 months the research team have supported new collaborative links with ICB, strategic regional partners and academic partners focused around city wide priorities (e.g. long term conditions and anti-microbial resistance).

2.4 Sustainability

Strategic aim 4 Research is a sustainable aspect of the LCH core business

The research team have been building research momentum, increasing the number of services who are research active, talent management, developing research in advanced practice roles, creating academic career pathways and supporting the retention of new and experienced staff. An example is the investment in neurology service research, this has enabled increase participation in suitable studies. There has been limited commercial research activity, however further growth is an ambition with hospital partners.

3 Impact

- **Quality**

In the last 18 months, LCH has been building the research profile and increasing collaborative opportunities with academic and third sector partners. The research team has been able to deliver many of the milestones in the workforce, communities and partnerships objectives.
The research team have supported 12 national studies, recruited 327 patients and supported 6 local studies.
Taking on new studies has been a challenge in clinical services that lack experience and expertise. Across LCH the number of research active services are limited, this is particularly apparent in adult nurse led services (in line with the national picture).

- **Resources**

Currently the research team (3.2 wte) is funded by the clinical research network (annual budget 200-220K a year) and LCH funds the clinical lead role (0.5 wte).
With this resource, LCH staff are supported to submit personal fellowships and some small project grants.
With more capacity the team could support larger project grants and create commercial partnerships, which would generate a larger income and help embed research across the organisation for greater patient benefit.
This is challenging to achieve due to the time, pace and expertise required to submit nationally competitive grants with staff and on behalf of the trust.

- **Risk and assurance**

Research staff

With the aim to increase the research expertise across the trust, we have created 2 internal research posts (0.4 wte) and 2 external research posts (0.4 wte) with research grants and funding. In the last 6 months, uptake of this has been limited due to the secondment policy and service pressures.
We are currently exploring options with HR to overcome these challenges.

Leeds Sexual Health Research agreement (MOU)

Leeds Sexual Health service undertakes research, which is planned and delivered by LTHT consultants and nurses. With recent re-location of services to LCH sites, the research governance and medicines trials are being reviewed alongside the contract.
While this is being addressed, a risk assessment is underway to provide assurance and controls until a memorandum of understanding can be agreed to support research that has benefit for the people of Leeds.

- **Equity**

- The joint post with LTHT will provide new ways of working and research opportunities for community inclusion.
- Supporting studies to provide sites of research in areas of deprivation
- We have collaborations with universities and submitted 2 research grants, 1 in progress that support research in deprived areas of Leeds and underserved groups: *Understand and improve Chronic Low Back Pain Management in UK Black Communities*.

4 Next steps

Work over the next six months will focus on:

- Shaping the next research strategy through patient engagement and clinical themes that align with the trust's future ambitions.
- Invest in priority areas that are under-researched like community nursing and mental health with under-served groups, while also building upon strengths in rehabilitation.
- Create a clear research roles and career pipeline for staff and services to engage in research.
- Working with Leeds Sexual Health Service to agree a MOU

To build research capacity and innovation, investment by LCH is needed. This can be achieved with added financial support to:

- Increase time of the research lead
- Increase research fellow time to write grants and generate income.
- Increase time from finance team to support income generation.

5 Recommendations

The Board is recommended to Receive this report and note the work undertaken to date. To note the plan for the next research strategy (2025) will support the trust strategic goals, the quality and value corporate review and align with clinical innovations.

Authors
Dr Ruth Burnett, Executive Medical Director
Dr Jill Halstead-Rastrick PhD, Clinical Lead for Research

Date: 14/8/2024

Appendix 1 Milstones to July 2024 and detailed narrative

Research Development Strategy (2020 to 2025) July 2024 update

Short (April 2021 to March 2022)

☒ Development of structural research offer for retirees and part time staff through CLASS.

☒ Implementation of clinical research advisor posts.

Medium (April 2022 to March 2024)

☑ Launch of resarch offer as part of retirement planning package and CLASS offer

5 staff on CLASS providing research support and one approach from retiree

☑ Progression of clinical research advisor posts.

2023-24 3 x posts (1 Physio & 1 OT in SBU and 1 x Physio ABU)

2024-25 2 posts (1 OT & 1 Nurse ABU)

☑ Scoping how research can be included in appriasal and job planning.

** Capability and capability completed.*

***Research champion pipeline being developed.*

**** Advanced practice framework validation with national community research group*

☑ Implement research mentoring programe and supporting innovation

** Clinical fellow employed another 12 months leading on staff support and mentoring.*

Long (April 2024 to March 2025)

☑ Review of research strategy underway. Planned launch mid 2025.

Include:workforce theme

EG workforce portability (cross boundary working)

☑ Use intelligence gathered in mapping to promote research opportunities as positive reason for joining LCH

☑ Development of research champion and research advisor and research associate roles with

* Launch staff pipeline and champions

** Create framework for embedding research into appraisal and job planning for staff

☑ Support staff with innovation and research including clinical research advisors, research applications and collaborations

Short (April 2021 to March 2022)

Patients and communities

☒ Refinement of the patient experience survey

Medium (April 2022 to March 2024)

☑ User experience of research will be measured by increased participation in patient research survey from all research active services

** Representaion from all intervention trials.*

☑ Patients can get actively involved in developing research

Parnership with

University of Leeds

- Living lab partnerships
- Health tech development
- Living well with arthritis and metabolic conditions
- People living with multi-morbidity – SEISMIC
- Living with foot arthritis

University of Bradford

- Co-produced back pain treatment model for black people in Leeds

☑ Enabling community groups to be involved in resarch development

Long (April 2024 March 2025)

Explore novel ways for patient engagement including

Patient research engagement to incorporate question about research department.

Ensure new strategy includes patient involvement that is representative of our community, including linking with third sector to support community driven research

** As part of the Leeds collaborative research group (ICB led) we exploring city wide patient involvement groups to optimise participation and co-production opportunities.*

*** Regular meetings with forum central to explore collaborations and resarch involvement, expressions from:-*

Older Peoples Forum

Leeds Black Health Initiative

Short (April 2021 to March 2022)

☑Scoping of additional clinical academic posts.

Medium (April 2022 to March 2024)

☑Scoping of existing primary care research infrastructure and opportunities for development
**A joint post with LTHT and LCH Started Feb 2024, working with ICB - models being developed.*

☑Appointment of additional clinical academic posts
2 PhD CAMHS (Leeds),
2 PhD in TVN (Huddersfield),
2 pre-PhD posts (Leeds).
3 in funding stages.
**Pre-PhD post neurology*
**Pre-PhD support community nursing*
**Dental reesarch fellow trauma informed care*

☑ Funding collaborations with universities and joint staff posts
**4 staff have national collaborations*
** 3 joint posts in process*

☑ Collaborative links made with community trusts Hull, SWYFT, YAS and LYPFT and Birmingham and Medway.

Long (April 2024 to March 2025)

☑ Scope clinical academic roles in LCH and feed this into the next 2025 strategy.
Options appraisal completed
Explore support mechanisms with managers and HR

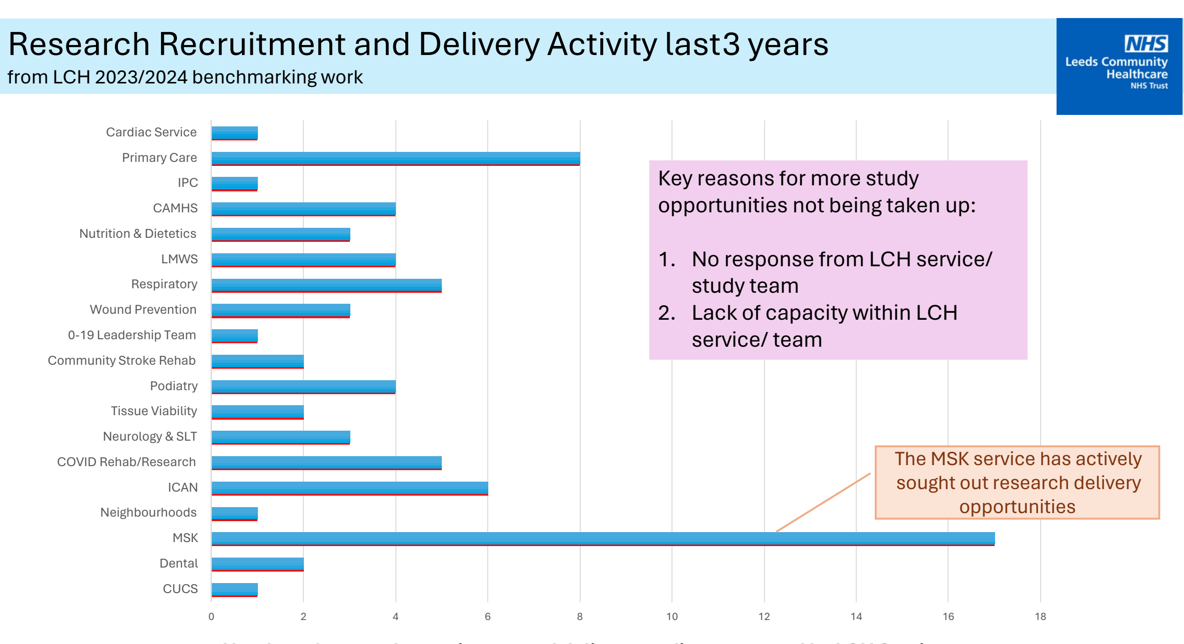
☑ Active participation in the ICB led Leeds NHS research collaboration group to develop and deliver on a Leeds place research model that promotes a left shift in research focusing on people, place and processes.
**Joint post progressing this with examples in Respiratory, Diabetes and vaccines*

☑ Create opportunities with university partners that allign with the community values.
York St John with childrens therapy
University of Bradford - equity

☑ Scope the Data opportunities for research across Leeds, to improve equtable access to research participation
Working with Leeds Data Centre and ICB to support representation.

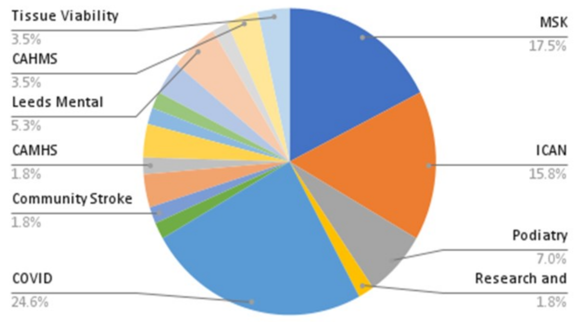
Short (April 2021 to March 2022)	**Medium (April 2022 to March 2024)**	**Long (April 2024 to March 2025)**
Sustainability		
☒ Identification of potential non-NHS partners to offer research management of studies *Not taken forward	☑ Development of research management service offer ** we have operationalised our processes to ensure we can offer clinical and governance support for research.* ** We have partnered with primary care Agile team to support 2 studies in frailty and MSK*	☑ Grow key areas of clinical and research strength – Rehabilitation, mental health and frailty *Rehabilitation* *ICAN 2 studies being led by new ACPs with another in planning and 1 in the grant process.* *Working with LYPFT to allign with dementia studies.*
☑ Evaluation of green shoots physio pilot with MSK service & scoping of further areas for green shoots funding. ** Output -2 staff went onto submit pre-doctoral applications and 1 is submitting a PhD grant application*	☑ Working with information governance and to recognise the research team as part of the wider clinical team ** Enabled research admin to offer direct study support and improve research uptake*	☑ Highlight research topics and fields that allign with LCH that support health equity *Meeting with leaders in CBU, SBU and ABU to allign with clinical priorities* *ABU Support Home First and Enhance (to support independence and frailty)* *CBU Linking with Leeds childrens research forum, Born in Leeds and Neurodivergence research* *SBU leaders meeting planned in August*

Appendix 2



Research Outputs over last 5 years

from LCH 2023/2024 benchmarking work



publications from LCH Staff in each service

Currently lacking organisational intelligence on

- Prospective Masters research studies
- Ongoing Research posters/ conference presentations
- Future Research collaborations/ partnerships

Research capability/capacity perceptions at organisational & team-level

From LCH Survey 2023/2024

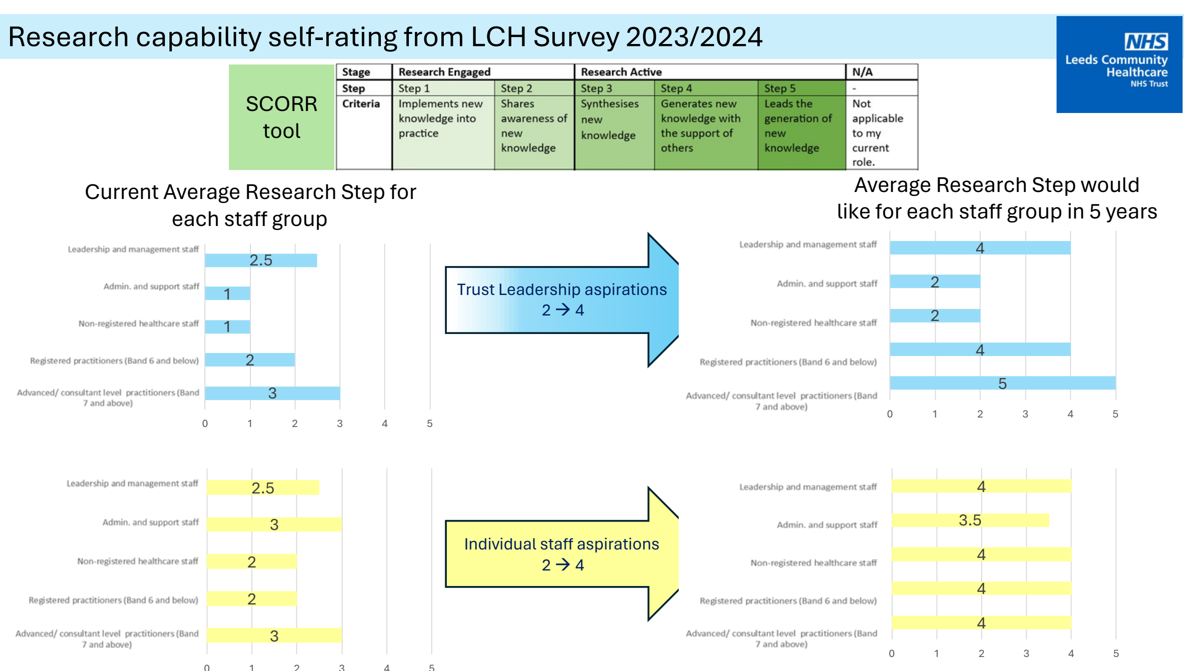
Rated highest	LCH rating	national rating
Senior managers/ team leaders that support research	7.0	4.0
Organisational and clinical planning guided by evidence	7.0	4.0
Multidisciplinary approach to research is supported	7.0	3.5

Rated lowest	LCH rating	national rating
Software for analysing research data/ to support research activities	3.0	1.5
Funds/ equipment/ admin to support research activities	3.0	2.5
Research planning and policy for research development	3.0	2.5

Higher ratings on average from Trust leaders (6.5); Lower ratings on average from Service managers(4.5)

Greatest discrepancies For survey questions answered by both participant groups		LCH rating difference	national rating
	Research planning and policy for research development	7.5 vs 2.0	3.0
	Accesses/ applies for external funding for research	7.0 vs 2.0	2.5

National benchmarking data estimated from survey of NHS AHPs.Comer, C, et al. BMC Health Services Research22.1 (2022)


Research capability self-rating from LCH Survey 2023/2024
NHS
Leeds Community Healthcare
NHS Trust
SCORR tool
Stage
Research Engaged
Research Active
N/A
Step
Step 1
Step 2
Step 3
Step 4
Step 5
-
Criteria
Implements new knowledge into practice
Shares awareness of new knowledge
Synthesises new knowledge
Generates new knowledge with the support of others
Leads the generation of new knowledge
Not applicable to my current role.
Current Average Research Step for each staff group
Average Research Step would like for each staff group in 5 years
Trust Leadership aspirations
2 → 4
Individual staff aspirations
2 → 4
Leadership and management staff
Admin. and support staff
Non-registered healthcare staff
Registered practitioners (Band 6 and below)
Advanced/ consultant level practitioners (Band 7 and above)
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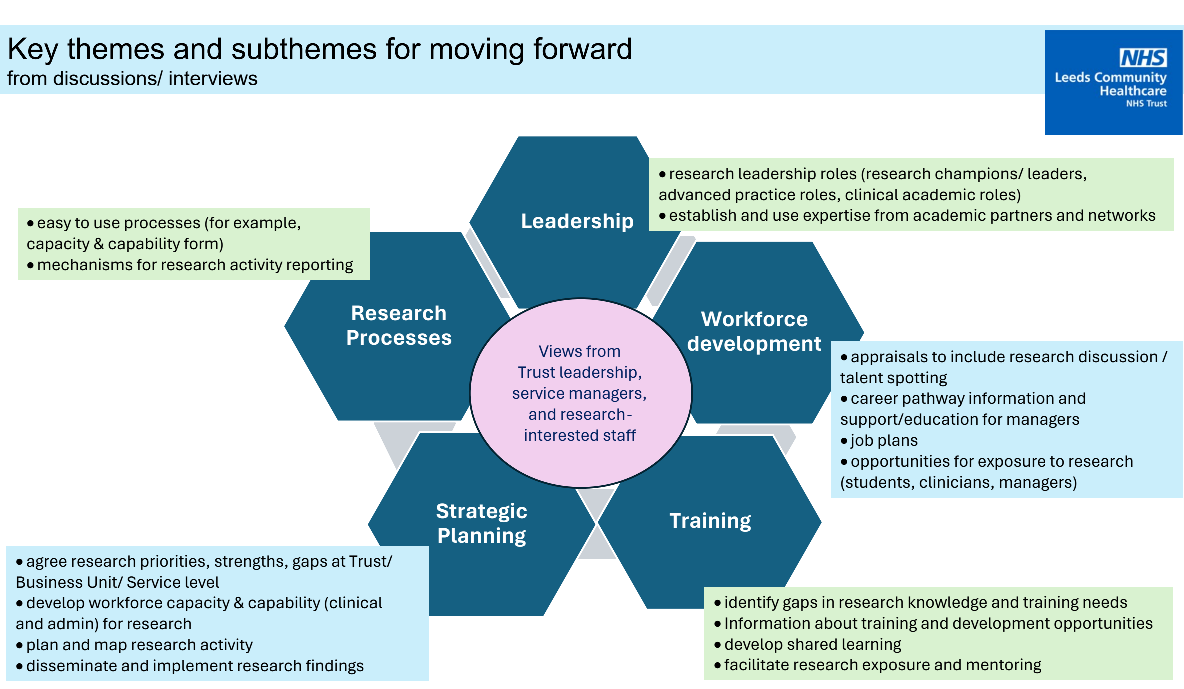
Key themes and subthemes for moving forward
from discussions/ interviews
NHS
Leeds Community Healthcare
NHS Trust
Leadership
• research leadership roles (research champions/ leaders, advanced practice roles, clinical academic roles)
• establish and use expertise from academic partners and networks
Research Processes
• easy to use processes (for example, capacity & capability form)
• mechanisms for research activity reporting
Workforce development
• appraisals to include research discussion / talent spotting
• career pathway information and support/education for managers
• job plans
• opportunities for exposure to research (students, clinicians, managers)
Views from Trust leadership, service managers, and research-interested staff
Strategic Planning
• agree research priorities, strengths, gaps at Trust/ Business Unit/ Service level
• develop workforce capacity & capability (clinical and admin) for research
• plan and map research activity
• disseminate and implement research findings
Training
• identify gaps in research knowledge and training needs
• Information about training and development opportunities
• develop shared learning
• facilitate research exposure and mentoring

Leeds Community Healthcare NHS Trust

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	Report to:	Trust Board 2nd September 2024
Date of Meeting:	22nd July 2024	Date of next meeting:	23rd September 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**
• Performance Brief and domain reports – Committee members did not feel assured around the risks associated with the waiting lists.	An updated position statement, including risks broken down by areas of concern to be shared with the Committee at its September meeting.
Advise	
• Home First System visibility dashboard – the Committee received an overview and demo of the dashboard, and learnt how it was used across the system. It was noted that it would shortly be rolled out to Neighbourhood Teams. • Tuberculosis Service spotlight – a presentation was shared on how work had been undertaken within a cluster of cases in under-served and high-risk populations, and the partnership working involved. • Neighbourhood Teams – the Committee was updated on work on aligning the triage function, the ongoing therapy waiting list work, patient assessment and the process, and a specific update on the Yeadon Neighbourhood Team. • Paediatric Audiology Service inspection – the service had been assessed as having 'significant' risk from a desktop review in Autumn 2023, but a de-escalation of this rating was expected following a very positive review in June 2024. • Quality & Value Programme – progress against target and workstream updates were reported. Concerns shared regarding limited capacity within the team, alongside bridging the gap with as yet unidentified savings. It was noted that the CAMHS Q&V savings target had been set at £1.5, although this figure had matched their underspend from 2023/24. The output from the CAMHS Q&V work reflected the considerable investment the service had received previously, and hence identified opportunities within the service. • Two significant Internal Audit reports were reviewed - Clinical Risk Triangulation Final Report and Preparations for CQC.	
Assurance	

Committee Escalation and Assurance Report

- Safe Staffing Report - Safe staffing had been maintained across both inpatient units over the last six month period.
- Mortality Report – the Committee received assurance regarding Trust mortality processes during Q1 of 24/25.
- Research and Development Strategy report – Committee received an update on the implementation of the 2020-25 strategy, and noted that the new strategy would support the Trust's strategic goals, the quality and value corporate review and align with clinical innovations. More work was needed to mainstream research within the Trust.
- Patient Experience Six Monthly Report – decrease in complaints noted between Jan-June 2024, and a slight increase in the number of potential claims.
- Safeguarding Annual Report, and IPC Annual Report received for assurance.

Risks Discussed and New Risks Identified

- Waiting list pressures
- Q&V team capacity and as yet unidentified savings

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 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.	16 (extreme)	Reasonable	N/A
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.	16 (extreme)	Limited	Still lacking assurance around waiting lists and the risks associated with those waiting for various services. Would welcome a position statement in September 2024.

Committee Escalation and Assurance Report

Risk 3 Failure to implement the digital strategy. If the Trust fails to implement the agreed digital strategy, then, 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.	12 (high)	Limited	Concerns were expressed about the meaningfulness of the Quality, Assurance and Improvement Group (QAIG) assurance report in the context of providing assurance of quality. It was noted that work to address this was ongoing.
Risk 4 Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation, and adverse media attention**.**	9 (high)	Reasonable	N/A
Risk 9 Failure to prevent harm and reduce inequalities experienced by our patients. If the trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently causing harm, delivering unfair care and exacerbating inequalities in health outcomes within some cohorts of patients.	12 (high)	Reasonable	Reasonable assurance overall but Committee agreed it was limited assurance for the data presented in the QAIG Mortality Reports.

Author:	Helen Robinson/Helen Thomson
Role:	Company Secretary/Committee Chair
Date:	07/8/2024

Agenda item:	2024-25 (41)

Title of report:	Patient Experience: Complaints and Feedback: Six Monthly Report

Meeting:	Trust Board Meeting Held In Public
Date:	3 September 2024

Presented by:	Sheila Sorby Interim Executive Director of Nursing and AHPs					
Prepared by:	Patient Experience and Engagement Manager					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	

Executive Summary:	The report provides a review of complaints and concerns, feedback via surveys, engagement activity, and wider feedback for the six-month period 1 January 2024 and 30 June 2024; providing an overview of themes, learning and action. It compares the data and qualitative information with previous years.

Previously considered by:	Quality Committee July 2024

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	
	Enable our workforce to thrive and deliver the best possible care	√
	Collaborating with partners to enable people to live better lives	
	Embed equity in all that we do	

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	√	Why not/what future plans are there to include this information?	Not sufficient data to provide this. We have gained access to the spine system to pull this data for complaints for future reporting. Improvement to current survey to gather such data.

Recommendation(s)	• Receive this report • Note the updated information

Executive summary

Purpose:

1. This report provides the six-monthly update of Patient Experience within Leeds Community Healthcare NHS Trust (LCH) between 1 January 2024 and 30 June 2024.
2. The report incorporates the information required for the complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).
3. The report provides a review of complaints and concerns, feedback via surveys, engagement activity, and wider feedback for the six-month period 1 January 2024 and 30 June 2024; providing an overview of themes, learning and action. It compares the data and qualitative information with previous years.
4. The report includes Friends and Family Test (FFT) information.

Main points:

1. There has been a decrease in complaints (69 complaints) received between January and June 2024, compared to the 76 complaints received in the previous 6-month period between July and December 2023.
2. The main themes of complaints were clinical judgement and treatment, appointment issues and attitude, conduct, cultural and dignity issues.
3. LCH has received 15 potential claims between 1 January and 30 June 2023, an increase compared to the previous reporting period of July to December 2023, where 3 potential claims were received. The number of claims received does fluctuate a lot.
4. Work continues to focus on review of the process of managing concerns and complaints in line with national best practice.

Recommendations

The Board and Quality Committee is recommended to:

- Receive this report
- Note the updated information

PATIENT EXPERIENCE (Complaints and Concerns) SIX MONTHLY REPORT

1. INTRODUCTION

This report provides the six-monthly update of Patient Experience within Leeds Community Healthcare NHS Trust (LCH) between 1 January 2024 and 30 June 2024. The report incorporates the information required for the complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).

2. BACKGROUND

LCH collects patient experience feedback through a variety of channels, and this is recorded centrally between two different systems. Complaints, concerns, enquiries and compliments are recorded within the Datix® system held by the Trust. The Friends and Family Test (FFT), and the comments provided with it, are collected via an external system provided by the Membership Engagement System (MES) provided by Civica.

3. COMPLAINTS, CONCERNS & COMPLIMENTS

3.1. From 01 January to 30 June 2024, LCH received 69 complaints which were. There has been a decrease in complaints received in comparison to the previous 6-month period between 1 July 2023 and 31 December 2023 where 76 complaints were reported.

3.2. 64 complaints out of the 69 complaints made have been acknowledged and responded to within 3 working days in this period. Four complaints out of the 69 complaints made have been acknowledged and responded to within 7 working days. This delay was due to reduced staffing within the Patient Experience Team affecting output during this period. One complaint was acknowledged within 12 working days, this was due to oversight of a complaint that was received via email. Any complaint that is not acknowledged within the agreed timeframe, an apology is provided to the complainant for the delay.

3.3. The highest number of complaints were from services in the Children's Business Unit 38% (26), followed by 28% (19) from the Specialist Business Unit and Adult Business Unit 28% (19) and 7% (5) for Corporate Services. Teams with the highest number of complaints include CAMHS with 14% (10) complaints, ICAN with 13% (9) complaints, Wharfedale with 9% (6) complaints, and MSK with 7% (6) complaints.

3.4. Of the 69 complaints received between 1 January and 30 June 2024, 54 have been closed. All closed complaints were responded to within 180 days of receipt. Four complaints were closed and passed on to organisations (not for LCH). Two complaints were withdrawn by the complainant.

3.5. The average length of time to provide a response to a complainant was 43 days. Several complaints were responded to well within the internal 40-day timeframe, 61% (33/54) of closed complaints were closed within 40 working days of receipt, the Trust standard. Of the 21 complaints closed after 40 days all timeframes were negotiated and agreed with the complainant, and were either due to staff leave within services, the record being re-opened and closed, time for the service to meet with or speak to the complainant in line with best practice, the complaint being on hold for some time or on the request of the complainant.

3.6. The Trust has received 189 concerns between 1 January to 30 June 2024, this is lower than the number of concerns received in the same period in 2023 where 214 were received.

3.7. The Trust has received a total of 458 compliments between 1 January to 30 June 2024. This shows a similar reporting pattern to our previous report where we received 465.

4. PATIENT EXPERIENCE (COMPLAINTS) TRAINING

4.1. The Complaints, Claims and Patient Experience Officer (CCPEO) has delivered two sessions of Level 1 Complaints and Concerns Training via Microsoft Teams to a total of 17 staff members, further sessions are booked in. The CCPEO has also attended Parliamentary Health Service Ombudsman Early Resolution Training and plans to attend the Closer Look training. The Patient Engagement Team has benchmarked against the Parliamentary and Health Service Ombudsman Standards and has developed an action plan to align the standards against our current standards. We have identified an action to further develop the complaints training, to include investigation, response writing and resolution meetings for complaints.

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

5. OVERARCHING THEMES FROM CLOSED COMPLAINTS

5.1. The top three subjects for LCH's complaints closed during period 1 January – 30 June 2024 were: Clinical judgement/treatment, attitude, conduct, cultural and dignity issues and appointments.

All three themes are consistent with the previous six months and the same period last year.

5.2. Complaints citing Clinical judgement and treatment

5.2.1 "Clinical judgement and treatment" continues to be one of the top three subject areas for complaints at LCH for the past 5 years. Between 1 January

and 30 June 2024, 29% (20 out of 69) of complaints received were due to issues around clinical judgement and treatment.

5.2.2. The most complaints citing 'clinical judgement and treatment' were closed within the Adult Business Unit with 55% of the complaints (11 out of 20). Specialist Business Unit accounted for 25% (5 out of 20) of the complaints closed citing clinical judgement and Adult Business Unit 20% (4 out of 20) of these complaints.

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

5.3. Complaints citing appointment issues

5.3.1. Of the received complaints between 1 January – June 2024, 20% (14 out of 69) cited issues concerning appointment issues and was the second most common area for complaints received.

5.3.2 The Childrens Business Unit had 71% (10 out of 14) of complaints citing appointment issues, and Specialist Business Unit had 29% (4 out of 14) of these complaints. The Adult Business Unit had zero complaints citing appointment issues.

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

5.4. Complaints citing attitude, conduct, cultural and dignity.

5.4.1 For the period 1 January to 30 June 2024 19% (13 out of 69) of all complaints received highlighted appointment issues, this was the third most common area for complaints received.

5.4.2. The Specialist Business Unit had 54% (7/13) of complaints citing Attitude, conduct, cultural and dignity issues, and Adult Business Unit had 23% (3 out of 13) of these complaints. Corporate services had 15% (2 out of 13) complaints, and Children's Business Unit had 8% (1 out of 13) complaint citing attitude, conduct, cultural and dignity issues.

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

6. CLAIMS

6.1. LCH has received 15 potential claims between 1 January 2024 and 30 June 2024, this is an increase compared to the previous reporting period of 1 July 2023 to 31 December 2023 where 3 potential claims were received.

6.2. Of these fifteen potential claims, seven are being handled by the Clinical Negligence Scheme for Trusts.

The remaining seven potential claims are a request for records to Information Governance by a solicitor.

7. Patient Engagement

7.1. During the reporting period of 01st January and 30th June 2024 there have been 6552 Friends and Family Test (FFT) responses, this is an18.6% increase on the previous six months (5524). The overall percentage of patients or their carers reporting a very good or good experience was 92.6% this is a 2% decrease in satisfaction from the previous reporting period (94.6%). 2.9% of responses reported the experience was poor or very poor and 0.8% neither good nor poor. 3.7% answered 'Don't know' to this question.

7.2. The FFT can be shared through a weblink, QR code, postcard, and SMS text. 81% (5329) of our FFT surveys were completed online from 1 January - 30th June 2024, and 18% (1192) were completed in paper/postcard form either via post or in service.

7.3. The Patient Engagement Officer is collaborating with the Clinical Systems Team to streamline the FFT process via SMS. A specific service pathway FFT link will be provided to all services to send via SMS through the System One platform, aiming to increase the number of feedback responses.

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

A new question has been added to the FFT, this is directly related to the three c's, which is widely used throughout Leeds linking the patient/carer experience to three themes, either communication, compassion and coordination.

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

7.6. An Engagement and Involvement module has been developed as part of the Quality and Value Programme. This module aims to enhance staff awareness and knowledge about the importance of engaging and involving patients in service changes and delivery. It will also support embedding the newly developed Engagement Principles within the Trust. The training sessions will be held bi-monthly, consisting of a 30-minute session followed by 30 minutes for questions.

7.7. Complex Communication Assessments for autism have been paused due to staffing issues and a significant increase in referral numbers. The service assesses pre-school children aged between two and four across Leeds, encompassing a diverse population. This includes parents who are neurodivergent and have learning needs themselves. The service is aware that due to health inequalities, some families may struggle to share feedback. The service has dedicated some time from Speech and Language Therapy students to contact families who require interpreters directly using the Language Line Interpreting line, to ask if families would like the opportunity to complete the survey together with an interpreter over the phone.

The team's aim is to gather feedback from these families and carers to understand what they truly want from their assessments and the support they require. They would like to achieve a strong response rate so the service can use this feedback to guide their service-level decisions.

7.8. The unplanned care survey focuses on patient satisfaction, the speed of patient visits, and areas for improvement. The survey has been developed by the service and Patient Engagement Officer and has been added to the Civica survey platform. Administrative staff have conducted the surveys with patients via telephone. The collected feedback will be included in the Equality Impact Assessment (EQIA) process. This update reflects ongoing commitment to enhancing patient engagement and ensuring their feedback shapes our service delivery, marking significant progress in integrating patient voices into care strategies.

7.9. The Patient Engagement Officer has continued to work in partnership with the 3rd Sector see further examples in Appendix 5

RECOMMENDATIONS

The Board and Quality Committee is recommended to:

- Receive this report
- Note the updated information

Appendices

Appendix 1

The family of a patient who received care at Wharfdale, reported that the service didn't seem concerned about the patient's weight loss, following previous history of weight loss. The service advised they had not been made aware of the patient's weight loss prior to being admitted to the hospital. Lessons learned have been shared with the team and measures are now in place to review the process of identifying patient's previous weight loss prior to admission to the units. The risk assessment tool has now been updated prompting clinicians to check previous weight with families/carers, GPs and/or the discharging acute ward.

Appendix 2

In a complaint regarding the neurodevelopmental waiting list, the patient's parent felt that misinformation was provided by the service to the family regarding the waiting times. The service has advised they will write to families to provide an update on the current length of waiting times every six months and remind them of the support they can access while they wait.

Appendix 3

A complaint was made by family members about the Palliative Care Team, regarding end-of-life care provided to their mum, they felt a lack of support from some staff members, leaving their mum in a lot of pain. They felt there were unnecessary delays in training the family to administer some of the medication. They advised they were denied the opportunity to demonstrate the procedure for administering subcutaneous medication by administering water for injection. As learning, the Practice Development Lead investigations identified differing interpretations and understanding of our guidance within the Palliative Care Team. This guidance is being taken to the a review group for further consideration and to discuss potential areas for improvement. The revised guidance will be shared at ABU Quality Development meeting and palliative care leads to share at individual NT meetings.

Appendix 4

"Sahil was on time, polite, professional and personable. His assessment was thorough. He listened and was able to paraphrase back well. He demonstrated the exercises well and then I did them. He offered weights and bands for me to use at home which was excellent. He was clear with the action plan and offered a follow up in a months time. Thank you." – **Comment from MSK - Meanwood**

"I am grateful for Dr. Hannah. She was amazing and very professional. I can sense how knowledgeable she is in handling cases like my son. I really felt the passion she has for her profession and the love for her patients and patient's family. I hope there will be more doctors like her who show compassion not only with the patient but with their families as well. She deserves to be recognise for all her hard work

and efforts in making sure children with special needs are being look after well”.- Comment from **ICAN Doctor – Reginald Centre**

“Helen was a breath of fresh air with her excellent advice on simple things like getting up and down. She taught me so much and gave me the confidence that I needed to keep on trying and not worry about falling all the time. I am determined to keep up the good work. Thank you, Helen for your friendliness and good humour, -and patience!”- Comment from the **Community Falls Service.**

Appendix 5

The Patient Engagement Officer was involved in last year's Carers Roadshow, collaborating with LCH staff, Leeds City Council, Carers Leeds, and NHS England for the event which took place in December 2023, at Leeds Kirkgate Market. The event showcased the excellent partnership work in Leeds to support carers and provide unpaid carers with information and advice about available support. Staff members involved have included the event in an HSJ Award application. This year, the roadshow will take place in August at the White Rose Centre, with an additional focus on reaching working carers employed at the shopping centre to provide them with information on support for unpaid carers.

In collaboration with Beth Wilson, Learning Disability Project Manager. An easy-read Patient Experience Team (PET) leaflet has been developed to improve accessibility for patients with learning disabilities. Beth Wilson engaged with patient groups within the third sector at Hamara to co-produce the leaflet. The leaflet is now available for staff to download through the MyLCH intranet pages and will soon be available for ordering through stores. This initiative supports the implementation of the Ask Listen Do framework in patient experience.

Agenda item:	2024-25 (42)

Title of report:	Infection Prevention and Control (IPC) Annual Report 2023-2024

Meeting:	Board Meeting
Date:	3 September 2024

Presented by:	Sheila Sorby: Interim Director of Nursing & Quality					
Prepared by:	Liz Grogan: Deputy DIPC and Head of IPC					
Purpose: (Please tick ONE box only)	Assurance ☒		Discussion		Approval ☒	

Executive Summary:	To inform the LCH Board of the achievements within Infection Prevention and Control during 2023-24 and provide assurance of the overall compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, inline with the 10 criterion. The report provides an overview of the collaborative work throughout the Leeds system, as part of the cooperation partnership agreement with Leeds City Council.

Previously considered by:	Quality Committee: July 2024

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	☒
	Use our resources wisely and efficiently	☒
	Enable our workforce to thrive and deliver the best possible care	☒
	Collaborating with partners to enable people to live better lives	☒
	Embed equity in all that we do	☒

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes	☒	What does it tell us?	Data around HCAI is provided within the report for example MSSA and some of the activities we undertake within the service around system work and engagement with underrepresented communities, with specific emphasis on our upstream approach to support those living in the most deprived communities, having a greater risk of infection and

				increased usage of antibiotics.
	No	☐	Why not/what future plans are there to include this information?	To develop more on staff equity as part of the IPC Annual Report.

Recommendation(s)	• Continued expansion to the 'Cooperation Partnership Agreement' between LCH and LCC for IPC provision and restructuring of the IPC Service. • The continuation of surveillance of HCAI's including methicillin-resistant *Staphylococcus aureus*, *Clostridioides difficile* and *Escherichia coli.* • The continuation of evolving health inequalities throughout the population we serve that impact on the health promotion in relation to IPC. • Continuation of the collaborative working that IPC have made with partners across the city and wider, inclusive of the Partnership Cooperation Agreement with Leeds City Council and the support in relation to adult social care within the system. • The continuing difficulties that the team face in achieving the 90% target for the seasonal staff influenza programme. • Work completed around antimicrobial resistance, sustainability and sepsis prevention.

List of Appendices:	• Appendix 1: Business Unit Overview 2023/24 • Appendix 2: External work Cooperation Agreement – Care Home Audits and Education package • Appendix 3: I-Spy AMR and other materials • Appendix 4: IPC Board Assurance Framework and annual plan

Executive summary

The report covers the period 1st April 2023 to March 31st 2024 and provides information on:

- Compliance with the outlined criterion of the Health and Social care Act 2008.
- Healthcare Associated Infections (HCAI) statistics and surveillance.
- IPC activities undertaken within the organisation and collaboratively with partners across the healthcare economy inclusive of the cooperation partnership agreement and additional commissioned services.
- Description of the (IPC) arrangements.
- Forthcoming IPC programme 2024/25.

The following are key elements of the infection prevention activity and performance during the period of April 2023 to the end of March 2024.

- The Trust has had zero methicillin-resistant *Staphylococcus aureus* (MRSA) assigned bacteraemia cases during the year.
- The Trust has had zero assigned *Clostridioides difficile* case during the year.

- The Trust has had zero assigned *Escherichia coli* (E. Coli) gram negative bacillus bacteraemia case during the year.
- The Trust has achieved 92% of all staff members being up to date with statutory and mandatory Infection Prevention and control training for level 1 and level 2.
- The Trust achieved 58% of front-line staff vaccinated against influenza and 48% for Covid-19.

Main issues for consideration

- Continued expansion to the 'Cooperation Partnership Agreement' between LCH and LCC for IPC provision and restructuring of the IPC Service.
- The continuation of surveillance of HCAI's including methicillin-resistant *Staphylococcus aureus*, *Clostridioides difficile* and *Escherichia coli.*
- The continuation of evolving health inequalities throughout the population we serve that impact on the health promotion in relation to IPC.
- Continuation of the collaborative working that IPC have made with partners across the city and wider, inclusive of the Partnership Cooperation Agreement with Leeds City Council and the support in relation to adult social care within the system.
- The continuing difficulties that the team face in achieving the 90% target for the seasonal staff influenza programme.
- Work completed around antimicrobial resistance, sustainability and sepsis prevention.

Recommendations

The Board and Quality Committee is recommended to note the contents of this report and approve its publication

Infection Prevention and Control (IPC)

Annual Report

2023 – 2024

Figure 1: Images of vaccination, filming IPC e-learning, vaccination work, Healthcare support workers and vaccination of Director of Nursing.

Report compiled by Head of IPC and Deputy DIPC with contributions made by members of the IPC Team.

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Executive Summary

This document forms the Infection Prevention and Control (IPC) annual report on Healthcare Associated Infections (HCAI) within Leeds Community Healthcare NHS Trust (LCH).

The publication of the IPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability, in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance.

The aim of this report is to provide information and assurance to the Board that the Infection Prevention and Control Team (IPCT) and all staff within the Trust are committed to reducing HCAI's and that LCH is compliant with current legislation, best practice and evidenced based care in line with Care Quality Commission (CQC) criterion and the Health and Social Care Act (2008, 2022) and the National Infection Prevention and Control Manual (NIPCM).

Key Achievements 2023/2024

During the past year the Trust has maintained and achieved in the following areas:

- Continuing compliance with the CQC criterion relating to Infection Prevention and Control (IPC) and Board Assurance Framework.
- Hugely successful collaborative working across the healthcare system and working towards the Partnership Cooperation Agreement with Leeds City Council.
- Permanent increased funding capacity from Leeds City Council to deliver the Cooperation Partnership Agreement.
- Increased activity with the winter vaccination programme of work for influenza and Covid-19. We vaccinated 58% of frontline staff in the Seasonal Staff Influenza Campaign and being recorded as highest uptake in West Yorkshire, and 48% for Covid-19.

Key Risks

- Major infection/outbreak/pandemic – this is a risk for any service. There were several outbreaks of infection this year throughout the healthcare economy including scabies, measles, and CPE.
- Compliance with fit testing of staff as outlined in the NIPCM and method of recording on the electronic staff record.
- Assurance around effective cleaning in line with the National Cleaning Standards from third party organisation where LCH provide healthcare services (Risk 1066)

Key plans for 2024/25

The IPC programme aims to continuously review and build on existing activity. This is driven by local needs, whilst incorporating and complying with the latest Department of Health (DH), UK Health Security Agency (UKHSA) and relevant strategy and/or regulation(s).

- Continued education on the standards relating to antimicrobial stewardship guidance in line with the UK's five-year national action plan – 'Tackling antimicrobial resistance 2019–2024 from the Department of Health'.

- Co-ordinating the winter vaccination campaign.

- Collaborate with the Leeds Healthcare economy on the implementation of a work plan to reduce the number of Gram-negative E. coli bacteraemia and aim to reduce incidence by 10% in accordance with Department of Health and NHS England / Improvement programme. We continue to maintain a zero tolerance to preventable healthcare associated infections such as MRSA *and Clostridioides difficile*.

- Continue to promote knowledge and compliance with hand hygiene practice and other standard infection control precautions through education, increased audit activity, risk assessment and planned action in relation to environmental or cleanliness issues.

- Work collaboratively across the Leeds Healthcare Economy to support staff to identify correct detection, reporting and management of sepsis: with an emphasis on improving awareness of sepsis signs, symptoms and management.

- Continued support and guidance in relation to key risks identified: fit testing, assurance in line with the national cleaning standards and building upon pandemic preparedness with LCH emergency planning.

Cooperation Agreement with Leeds City Council main deliverables 2024/25:

- To deliver a safe, integrated and effective system of IPC in place for the wider community across Leeds
- To ensure LCH is meeting its statutory obligations regarding Infection Prevention control as detailed in the Health and Social Care Act 2008)
- To establish and maintain effective partnerships ensuring a robust, flexible and responsive IPC across LCH and wider community of Leeds
- To deliver a timely and effective response to outbreaks or incidents of infectious disease as directed by the outbreak control team
- To support a year on year reduction in Health Care Associated Infections (HCAI) both within LCH provided services and the wider community healthcare economy, in line with locally / nationally agreed performance targets
- Outcome
- To deliver a continued improvement in IPC standards both within the wider community healthcare economy and LCH managed activities.
- To enable both parties to work with partners across the whole health and social care economy to reduce and manage incidents and outbreaks of infection with the intention of reducing the adverse impacts of HCAI and communicable disease both to the individual and wider community
- To work flexibly and ensure the ability to respond to emerging infections and health care associated infections in line with national policy and guidelines

- Increase capacity and capability of existing LCH Infection Prevention Service to ensure there is sufficient capacity to implement contact tracing alongside partners in the system and provide expert resource and safely manage outbreaks in the Leeds community.
- Local outbreak management of Covid-19, influenza and other infections in complex settings (for example, care homes/ schools / hostels) in line with system partners.
- Outcome
- Collaboratively provide direct infection prevention and wider support to complex groups and households.
- Preventative proactive training, advice & guidance (e.g., care homes, schools/ workplaces, hostels) regarding infection control.
- Local engagement & intelligence gathering (e.g., Voluntary Community Sector/ LA front-line e.g., home carers).
- Participate and play a lead role in system wide discussion around roles and responsibilities in relation to Covid-19 and other outbreaks of infection of concern such as influenza
- Increased provision of Infection Prevention and Control (IPC) training (increased frequency and additional training requirements including PPE, COVID specific topics, new updated evidence) to care homes using innovative ways of ensuring delivery.
- Outcome
- Monitor and report monthly on numbers training and evaluations in addition to the core contract.
- Increased provision of IPC training to homecare and other community settings such as luncheon clubs using innovative ways of ensuring delivery.
- Continue the development and deliver an IPC package for schools and early year's settings and engaging with existing work across the city.
- Provide IPC expertise to the management of covid-19 outbreaks, influenza outbreaks and other infections of concern which are likely to be higher post pandemic.
  (Appendix 3)

Annual Infection Prevention and Control Report

1. Background

This report is a requirement under the 'Code of Practice' of which Criteria 1 states *that 'the nominated Director for Infection Prevention and Control (DIPC) is to prepare an annual report on the state of healthcare associated infections HCAI) in the organisation for which he or she is responsible and release it publicly.'* This report has been produced by the Head of Infection Prevention and Control and Deputy DIPC on behalf of the DIPC.

Leeds Community Healthcare NHS Trust recognises the obligation placed upon it by the Health Act 2006, (updated 2008, 2012, 2015 and 2022), that the prevention and control of infection continues to be a high priority for the Trust. There is a strong commitment throughout the organisation to prevent all avoidable HCAIs. In addition:

- Reporting requirements for the annual report are pre-set by the Department of Health.
- The Trust has registered with the CQC as having appropriate arrangements in place for the prevention and control of healthcare associated infections.

1.2 Infection Prevention and Control Board Assurance Framework (BAF)

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 10 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 (Appendix 4)

The compliance rating column allows for the selection of a RAG rating for each criteria:

Criterion 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
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
Criterion 3	Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance
Criterion 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
Criterion 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.
Criterion 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
Criterion 7	Provide or secure adequate isolation precautions and facilities
Criterion 8	Provide secure and adequate access to laboratory/diagnostic support as appropriate
Criterion 9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections
Criterion 10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

2.0 Criterion 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

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for Infection Prevention and Control. The DIPC has overall responsibility for the control of infection and this role is undertaken by the Executive Director of Nursing and Allied Health Professionals. The DIPC attends Trust Board meetings with detailed updates on infection prevention and control and escalations as required.

The Trust Infection Prevention and Control Group (IPCG) is held quarterly and is chaired by the head of IPC and Deputy DIPC. IPC performance and concerns are escalated at the quarterly 'Quality Assurance Information Governance' (QAIG) meeting. The IPC service is provided through a structured annual programme of work which includes expert advice, audit, teaching, education, surveillance, policy development and review as well as advice and support to staff, patients and visitors. The main objective of the annual programme is to maintain the high standard already achieved and enhance or improve on other key areas. The programme addresses national and local priorities and encompasses
all aspects of healthcare provided across the Trust. The annual programme is agreed at the IPCG.

The 'Partnership Cooperation Agreement' and annual IPC plan will be monitored through quarterly cooperation review meetings with a governance structure in place, as well as the Infection Prevention and Control Committee (IPCC) and the Quality Assurance and Improvement Group (QAIG). Table 1 outlines several internal and external IPC related meetings.

Quarterly Meetings	**Monthly Meetings**
IPCG (LCH)	Clinical and Corporate Policy Group (CCPG)
Attendance at HCAI Meeting (Citywide)	
Attendance at Health Protection Board (LCC led)	**Annual**
Cooperation Review Meeting (LCC/LCH)	IPC Annual Report for approval
Attendance at Quality Assurance Information Governance (QAIG) LCH	IPC Annual Plan for approval
Attendance at Health and Safety Group (LCH)	Cooperation Agreement Governance Annual Review (LCC/LCH)
Attendance at Water Safety Group (LCH)	
Antimicrobial resistance (LCC/ICS)	

Figure 1: Governance Meetings

The IPC Board Assurance Framework has been completed by the Head of IPC and shared with Quality Committee and the Board on a six monthly basis. Gaps in compliance to be highlighted with clear actions in addition to the annual programme of work.

Performance

2.1 Surveillance of Healthcare Associated Infections (HCAIs)

This section of the annual report provides insight into the current Healthcare Associated Infection (HCAI) burden actions taken to improve practice and patient safety. The following organisms are subject to NHSE mandatory reporting: Methicillin-resistant

Staphylococcus aureus bacteraemia (MRSA), Methicillin-sensitive Staphylococcus aureus bacteraemia (MSSA), Clostridioides difficile, and Gram-negative bloodstream infections (Escherichia coli, Klebsiella species, Pseudomonas aeruginosa) linked to:

Although there are no specific government mandatory targets for individual community care organisations for the incidence of meticillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridioides difficile* infection (CDI), LCH has worked with in locally agreed targets for a number of years. These targets included no more than 2 cases of MRSA bacteraemia and 3 cases of CDI being directly attributed to LCH where a multiagency review identifies lapses in care that have directly contributed to the infection episode.

2.1.1 Meticillin-resistant *Staphylococcus aureus* (MRSA)

The purpose of the PIR is to deliver zero tolerance on MRSA BSI, to identify how each case of MRSA BSI occurred and identify any actions that may prevent infection reoccurring in the future.

During the report period a total of three MRSA bacteraemia cases classed as Community Onset, have been reviewed by the Leeds Community IPC Team, this is the lowest levels of MRSA bacteraemia LCH has seen since recording commenced in 2011 (Fig. 2).

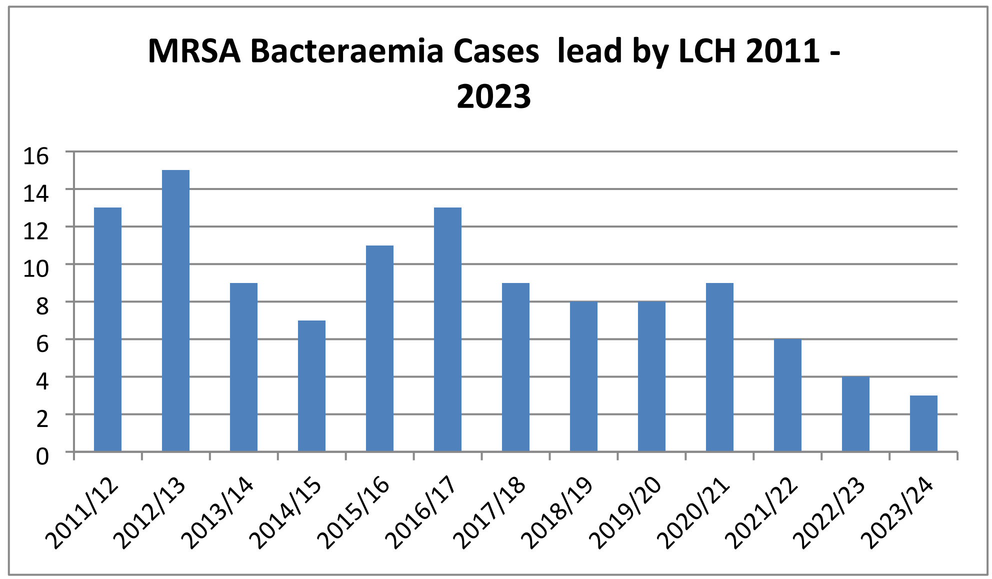


Figure 2: Annual MRSA Bacteraemia cases identified within 48 hours of admission to Secondary Care (2009 – 2024)

Out of the three MRSA bacteraemia cases two were identified to have LCH involvement and identified learning has been shared.

During the report period there have been no cases of MRSA bacteraemia assigned to LCH in which lapses in LCH care have directly contributed to the infection episode.
All learning and subsequent actions are recorded within the PSIRF documentation and shared with meeting attendees. The document is also uploaded to Datix for future reference if required, this enables the IPC team to easily review actions throughout the year, ensuring completion dates are met.

2.1.2 Clostridioides difficile (CDI)

All community apportioned CDI cases identified as Community Onset, Community Associated (COCA) or Community Onset, Intermediate Associated (COIA) are reviewed by the LCH IPCT. IPC team provides all patients, who have been sampled by the GP, with a CDI information leaflet and identifying card to share their status with health care professional.

Where prescribing deviates from Leeds Health Pathways, the Leeds Branch, West Yorkshire ICB Medicines Optimisation Team will also review the case and liaise directly with the respective GP practices.

A rapid review is undertaken where the episode of infection is identified as part of an outbreak, when the patient is identified within an LCH inpatient area, or when CDI is a contributing factor (1a,b,c) in the death of the patient.

Within the report period, 60 CDI cases were identified as community onset. This shows a decrease of 30 cases when compared to 2022/23. This is the lowest level of cases for Community CDI since 2015 (Fig. 3).

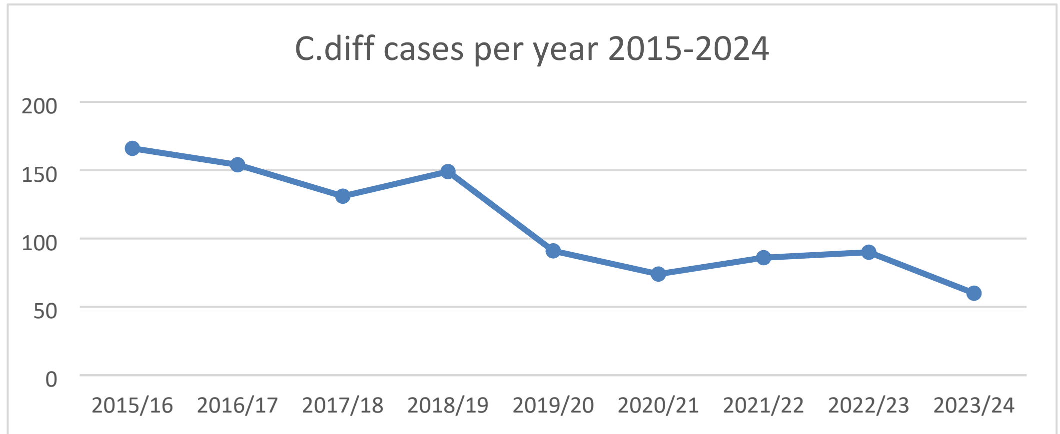
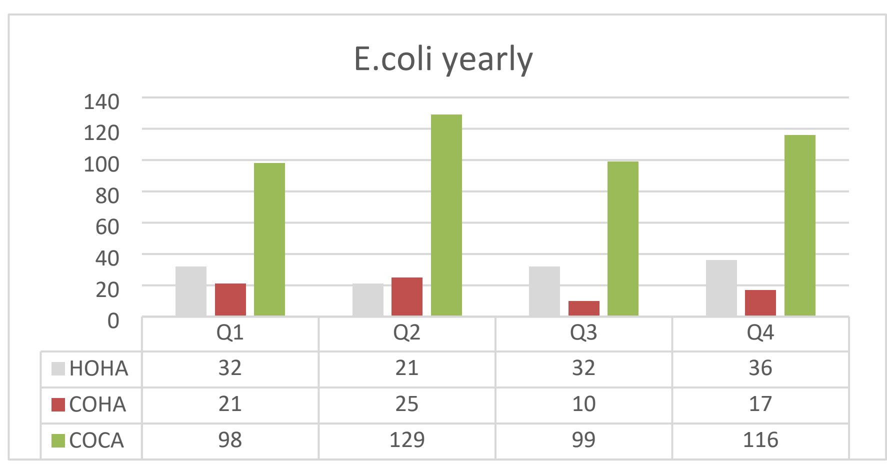


Fig. 3: Community onset CDI cases identified each year 2015 – 24

In 2024/25, LCH IPC are looking to develop a new approach to CDI data gathering. The team will now only conduct RCAs for any community onset cases where the patient has involvement from LCH services or are a care home resident. This change in data gathering will hopefully allow the team more capacity to undertake proactive reduction work. The team will continue to gather information such as geographical location and age, which can be used on a local level to identify trends and patterns which can influence reduction work.

2.1.3 Gram Negative Blood Stream Infections (GNBSI)

LCH continues to work towards the national ambition of reducing the number of healthcare-associated Gram Negative BSI by 50% by 2024 as per The UK's five-year national action plan (HM Government, 2019, 2022).



	Q1	Q2	Q3	Q4
HOHA	32	21	32	36
COHA	21	25	10	17
COCA	98	129	99	116

Fig. 4 E.coli combined figures 2023/24.

All community onset community acquired (COCA) E. coli BSI cases are subject to some information gathering (likely source, geographical location, age, community care involvement). Any E.coli BSI cases where a patient has died and E.coli is listed as either 1a or 1b on their death certificate and that patient is known to either LCH services or a resident of a care home undergo further investigation.

In 2023/24 27 cases underwent RCAs of which 6 were progressed to further investigation and identified learning was shared.

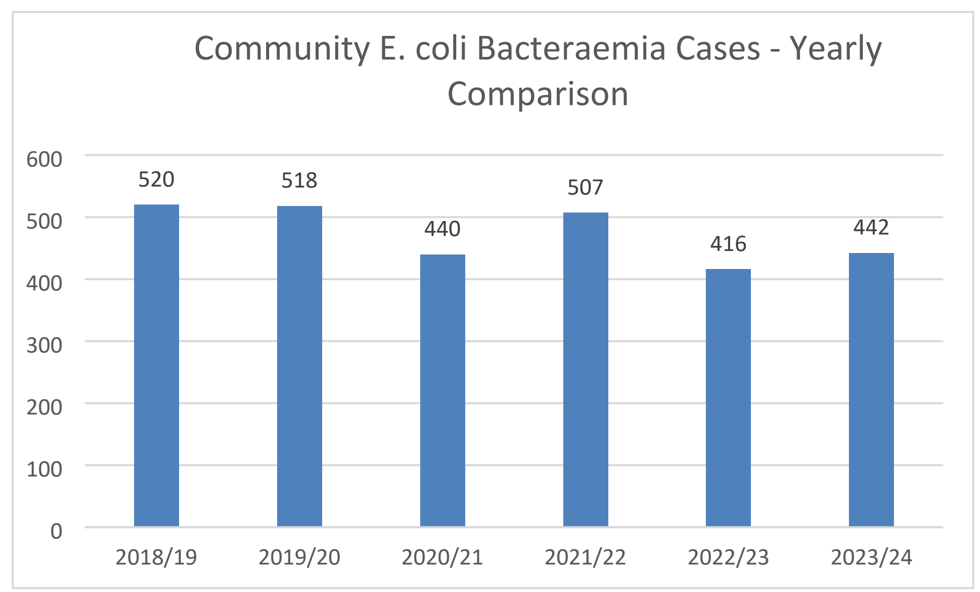


Fig. 5: Community onset E. coli bloodstream infections per year 2018/19 - 2024

During 2023/24 we saw a total of 442 cases recorded, which is an increase of 26 cases when compared to 2022/23.

2.1.4 Discussions and Actions of HCAI activity

PIR's conducted in 2023/24 have continued to identify a concern in which some primary care physicians appear to be missing soft signs of sepsis and deteriorating patients. LCH IPC team have recruited a community sepsis and deterioration nurse who will work with community services to improve recognition of the signs and symptoms of sepsis.

HCAI team have had considerable involvement in the adaptation and application of PSIRF for HCAI investigations throughout Q3. Discussions have been held between IPC colleagues, the Clinical Governance/ Patient Safety Team, and the Deputy Director of Nursing and Quality around how we can implement PSIRF into the HCAI PIR process and make this more streamlined and patient specific but less time consuming. Within Q3 and Q4 two MRSAb cases have been undertaken using PSII documentation.

In March, LCH IPC colleagues supported with a community hydration event taking place in Harehills. As part of the event LCH IPC spent time with the Roma community discussing the importance of hydration and also oral health in preventing infections.

Following on from the WY ICB highlighting the region as an outlier for MSSA bacteraemia, data gathering has been taking place to identify any patterns or trends which may be considered a likely causation for this increase. Discussions have started to take place with Leeds City Councils Health protection team as to how we can use this data to create a community reduction plan. Most cases did not have any LCH or community care involvement, however of those who did, the most common team involved was either the Neighbourhood

Teams or Podiatry. This corresponds with high incidence of septic arthritis and wounds as a likely source as Neighbourhood Teams and podiatry would potentially be involved in managing chronic wounds.

2.2 Leeds Health Care Record / PPM+

The reporting of laboratory specimen results from Leeds Teaching Hospitals is informed via the Leeds Care Record (LCR) – PPM+. All MRSA positive, E.coli and *Clostridioides difficile* (CDI) positive samples for patients in the LCH community setting are reported to the IPC team on a daily basis through this electronic platform.

Each result was processed by adding a high priority alert/reminder on SystemOne. An IPC information task was sent to any LCH services currently involved with the patient, identified by any services with an open referral. The result was flagged up to the patient's GP by either a task on SystemOne, or a telephone call to those using a different healthcare record system, requesting that the patient be reviewed in light of the result. If the patient was a resident in a care home or nursing home the facility was contacted to inform of the result and offered appropriate infection control advice. GPs were signposted to the MRSA decolonisation guidance, available at Leeds Health Pathways.

Leeds Care Record is a joined-up digital care record which enables clinical and care staff to view real-time health and care information across care providers and between different systems. It is a secure computer system that brings together certain important information about patients who have used services provided by their GP, at a local hospital, community healthcare, social services or mental health teams.

2.3 Communicable Disease Control (CDC)

The CDC Team consists of 3 nurses fulfilling 1 WTE role and is based with Leeds City Council's (LCC) Environmental Health Food and Health Team. The team's purpose is to investigate, act and report on all individual cases and larger outbreaks of notifiable gastric diseases within the population of Leeds.

The team investigate, confirmed and suspected food poisonings and coordinate outbreaks of viral gastroenteritis within any establishment including Care Homes, Childcare settings, Schools, Day Centres, food premises, etc. Following a risk assessment, we might be required to visit premises who report outbreaks of gastrointestinal illness, people's own homes, and hospital wards if necessary. To provide information regarding specific illnesses, collect information and complete questionnaires to try to establish the source of the illness and where necessary, arrange faecal samples for cases and contacts for clearance and screening. The team work closely with partner agencies including Leeds City Council and UK Health Security Agency (UKHSA).

Total number of outbreaks during 2023 – 2024 = 99

There has been a slight decrease in the total number of outbreaks of gastrointestinal illness over the last year throughout all premises (120 last year).

The service reviewed the value of visiting each premise, providing them with faecal sample pots and laboratory forms for sample submission to try to identify the cause of symptoms. During an audit in December 2023, we established that 63.60% of Care Homes, 81.20% of Childcare Facilities and 66.60% of schools did NOT submit any faecal samples using the equipment we provided. Also, where samples were submitted, some of the premises had them rejected at the laboratory due to incorrect labelling, despite this being discussed with a senior member of staff at the time of each visit.

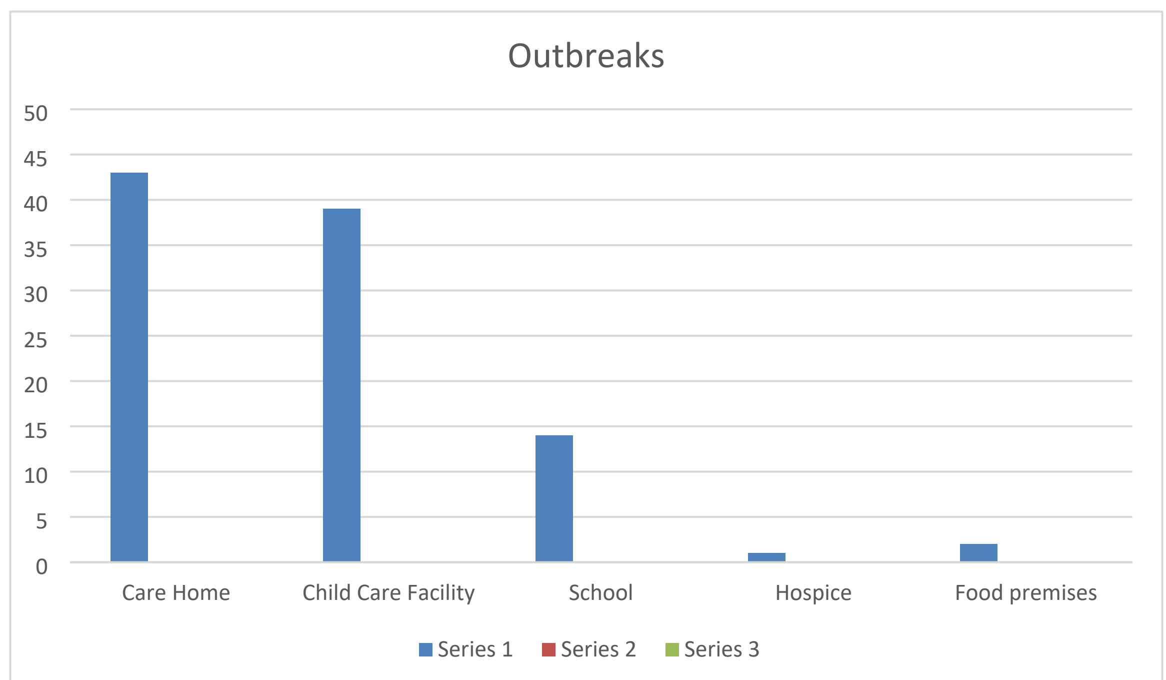


Fig.6: Total number of CDC Gastrointestinal outbreaks per location 2023/24

There were 300 reports of suspected food poisoning which were reported electronically, via the FSA, or LCC self-service reporting systems, slightly less than last year's figure of 335. All suspected food poisoning reports are reviewed each day by the CDC nurse to detect any potential food poisoning outbreaks, and cases are responded to accordingly.

There were 2 outbreaks of gastrointestinal illness associated with 2 food establishment using this process. All cases for each outbreak were contacted and faecal samples arranged with Norovirus identified as the causative organism for both outbreaks.

The overall number of positive isolates was slightly higher than last year, 1113 compared to 1053 last year. There was a significant rise in cases of Cryptosporidia from the beginning of September with 43 cases being reported between 1/9/23 and 31/10/23, compared to 13 cases for the same period in the previous year. We were able to make contact with the majority of cases and individual questionnaires were completed. These were all shared with UKHSA's epidemiology team to try to determine a source. There has been no update regarding any potential source for this increase in cases although the majority of Leeds cases were travel related with no particular Country/Resort being prevalent.
The table below incorporates the confirmed positive isolates identified via faecal testing at Local laboratories and Colindale Central Surveillance Centre.

ORGANSIM	NUMBER OF CASES
E.coli (STEC)	18
Hepatitis A	5
Cholera	1
Typhoid/Paratyphoid	10
Cryptosporidia	87
Shigella	29
Salmonella	105
Campylobacter	781
Listeria	2
Giardia	73
Yersinia	2
TOTAL	1113

Fig 7: Organisms identified through Notification of Infectious Disease Reporting 2023-24

Positives isolates are all contacted by telephone to offer advice, information and completion of a questionnaire which is disease specific. Any connection between cases is reported to the Environmental Health response officer for further discussion/investigation as this may indicate an outbreak or poor food hygiene practices at establishments.

Significant outbreaks with IPC response

External to LCH

During 2023/4 the IPC team has managed and supported with 75 Covid-19 outbreaks within care home settings throughout Leeds. This activity represents a 47% reduction in comparison with the previous year. This decrease could be related to reduced circulating virus burden and the endemic nature and “living with Covid” strategy adopted with Covid infection.

During the report period, a total of 6 outbreaks of Influenza were reported. This was the same as the previous year. Significant issues were identified in relation to the mobilisation of antiviral medication, both for treatment and prophylaxis purposes. Work is being done with LCC and the ICB to ensure a timely and robust response from Primary Care services during outbreak situations.

Six scabies outbreaks were reported during Q3. This mirrored a noted national increase in cases. IPC team provided bespoke advice and site visits.
The elements of learning related to outbreak situations has been integrated into the training programme previously described. This has enabled a “real time” responsiveness, which has added value to the training resource.

2.4 Incident Reporting – Datix

All incidents or near misses occurring in LCH must be reported through Datix® system. Those categorised under Infection Control, Sharps, or Environment (including clinical waste, domestic waste, unsafe environment), are reviewed by both a team leader/manager within the reporting area, and a specialist reviewer from the IPC team.

There were 43 incidents reported during the reporting period. This is a small increase on the total reported in 2022/23.

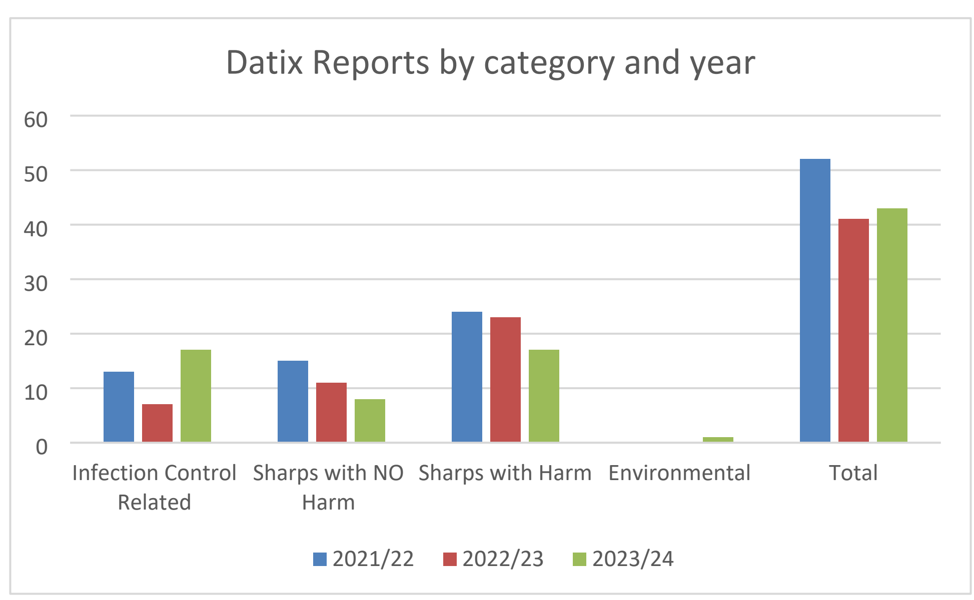


Fig. 8: Incidents in 2023/24 per category

Incident type	Q1	Q2	Q3	Q4	Total
Total Sharps Injuries (breakdown below)	7	5	5	8	25
Sharps with no harm	2	1	1	4	8
Sharps with harm	5	4	4	4	17
Infection control related incident*	3	2	7	5	17
Environmental	0	0	0	1	1
Total IPC related Datix reports	10	7	12	14	43

Fig.9: Distribution of incidents reported in 2023/24 by quarter (table).

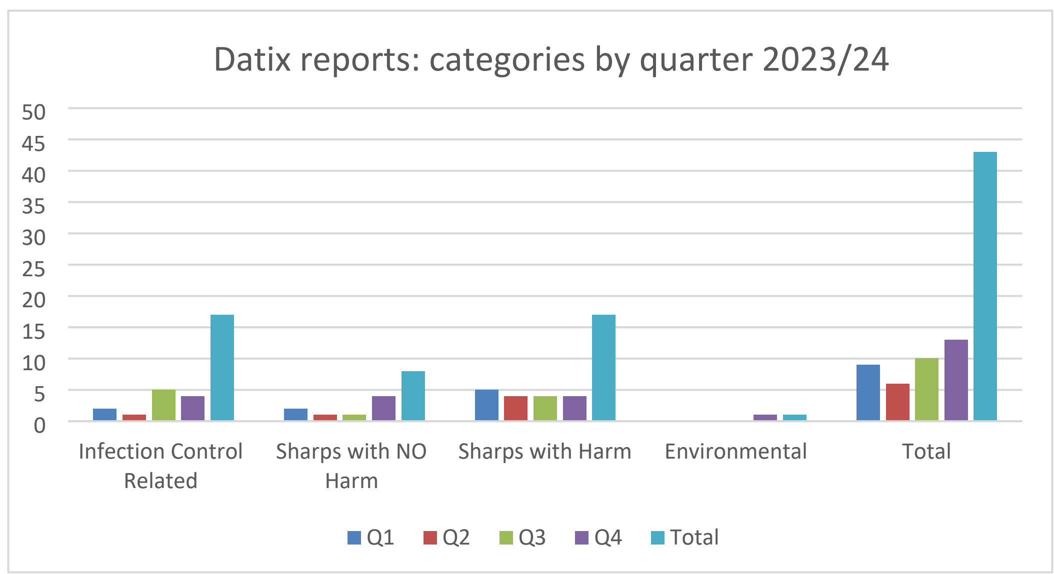


Fig 10. Datix reports categories per quarter 2023/24 (graph)

A total of 17 infection control related incidents were reported. This is a general category and incidents arise from a broad range of clinical issues. The category also includes blood stream infections arising from specific organisms which are deemed to be community onset. 7 such incidents were reported during 2023/24. Analysis of these incidents is outside the scope of this report.
Other incident themes within the category included incorrect use of personal protective equipment, clinical waste, delay or failure to monitor/failure to follow up and catheter related UTI.

2.5 Headstart

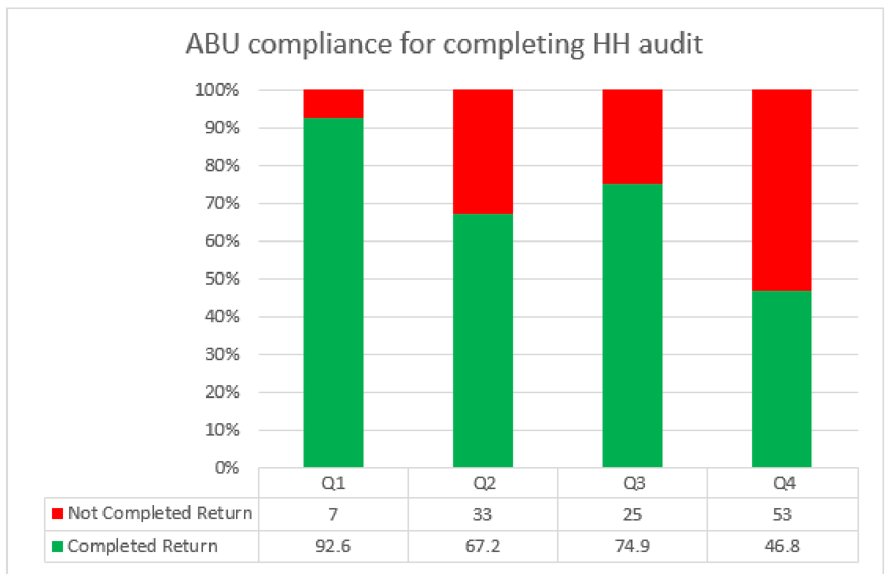
The IPC team continues to provide a specialist service for the management of head lice infestations within the community. The service offers advice, support, and treatment in cases of persistent head lice infestation, to families with social services involvement and when the carer of a child is unable to complete treatment due to a disability or condition. The main sources of referral come through health visitors and school nurses, with additional referrals via social workers, schools, community paediatricians and GPs.

The Headstart service has seen fluctuations in referrals throughout the year, with 20 referrals received during 2023-24 which resulted in 17 treatments. This referral rate is more in line with 2021-22 at 15 referrals, with the 22-23 year seeing a 300% increase at 53 referrals.

2.6 Hand Hygiene Audits

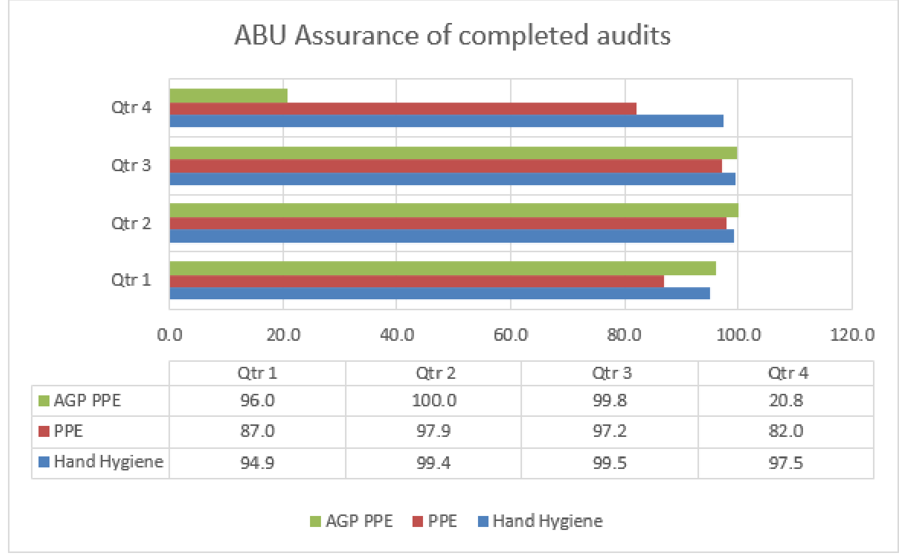
LCH teams complete a quarterly hand hygiene audit for a quarter of their team using the standards for hand hygiene linked to the 5 moments and PPE. In 2023 -2024 overall we saw 95.5% assurance and 81.3% compliance in total across the organisation.

The IPCT have worked on the tool to ensure it is compliant to the health and social care act, but also to understand levels of assurance and how these reflect day to day practice. Challenges ensuring correct practice, procedure and techniques can be influenced by to the community environment, however, this is not specific to our Trust and work is underway to provide the best assurance. The IPCT is looking future direction to ensure that assurance is accurate and this may be digital approach using the best technology.



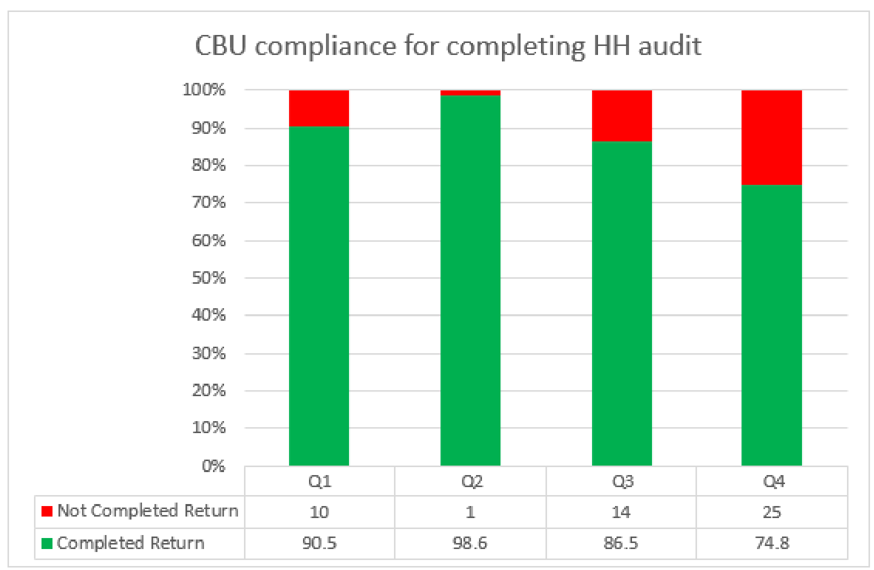
	Q1	Q2	Q3	Q4
Not Completed Return	7	33	25	53
Completed Return	92.6	67.2	74.9	46.8

Fig. 11: Adult Business Unit Hand Hygiene Audit Compliance



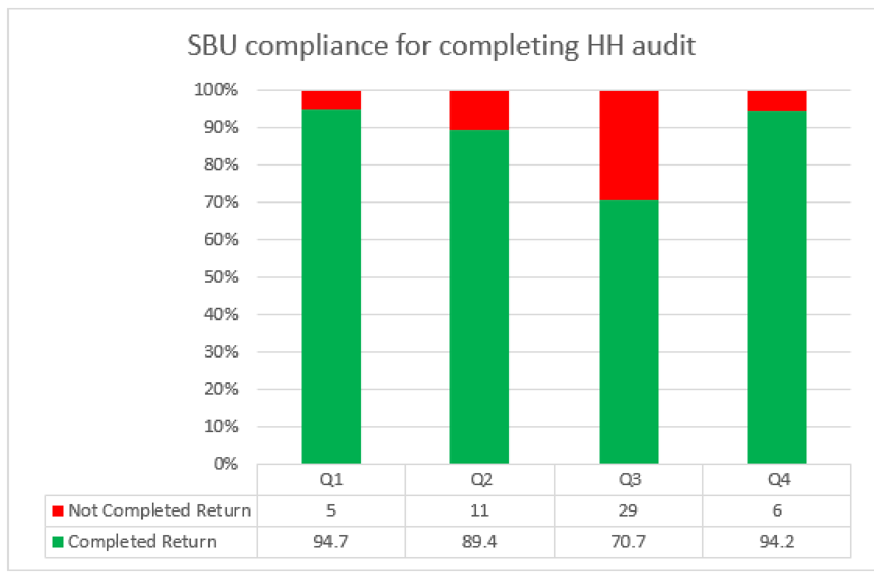
	Qtr 1	Qtr 2	Qtr 3	Qtr 4
AGP PPE	96.0	100.0	99.8	20.8
PPE	87.0	97.9	97.2	82.0
Hand Hygiene	94.9	99.4	99.5	97.5

Fig. 12: ABU completed audits per quarter.



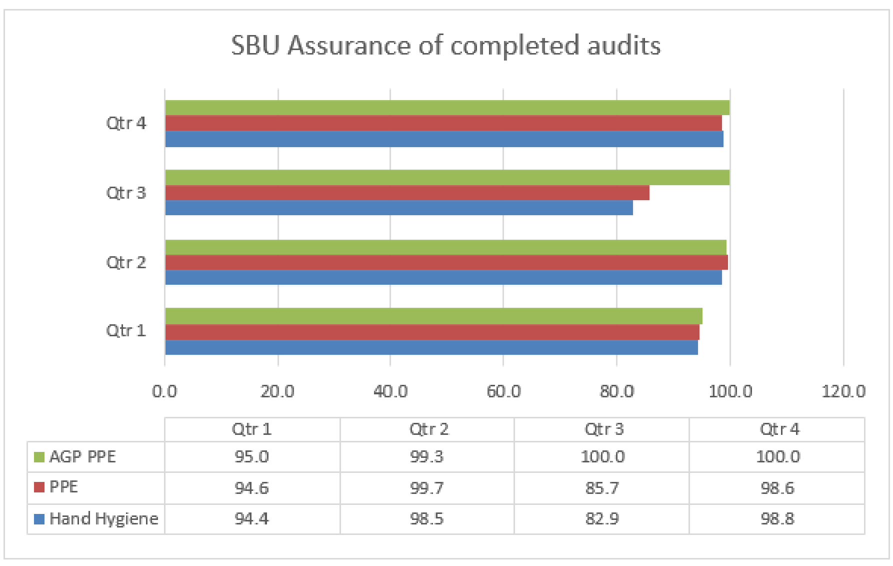
	Q1	Q2	Q3	Q4
Not Completed Return	10	1	14	25
Completed Return	90.5	98.6	86.5	74.8

Fig. 13: Children's Business Unit Hand Hygiene Audit Compliance



	Q1	Q2	Q3	Q4
Not Completed Return	5	11	29	6
Completed Return	94.7	89.4	70.7	94.2

Fig. 14: Specialist Business Unit Hand Hygiene Audit Compliance



	Qtr 1	Qtr 2	Qtr 3	Qtr 4
AGP PPE	95.0	99.3	100.0	100.0
PPE	94.6	99.7	85.7	98.6
Hand Hygiene	94.4	98.5	82.9	98.8

Fig. 15 SBU completed audits per quarter.

2.7 Mattress audits

Mattress audits are completed quarterly in the units, during 2023 – 2024 these have been completed and actions addressed should the mattress have failed this audit.

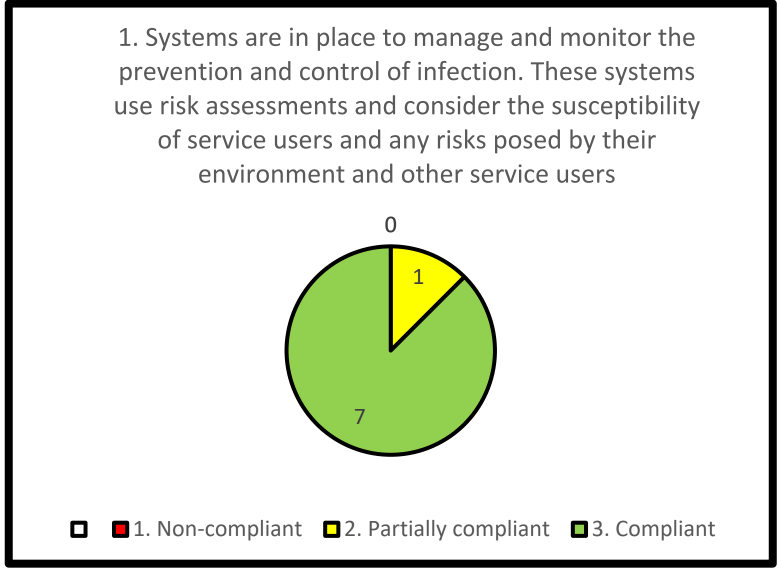


Fig. 16: BAF compliance to Criterion 1

Partial Compliance elements:

They implement, monitor, and report adherence to the NIPCM: The current policy manual for IPC is being updated to reflect the National IPC Manual.

3.0 Criterion 2:

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

3.1 Implementation of the National Cleaning Standards

In November 2021, Leeds Community Healthcare NHS Trust (LCH) were required to implement the new NHS national cleaning standards, with full implementation by May 2023. Within LCH this requires us to fully implement the standards within the buildings we own/ clean (including tenant areas) and to ensure that our landlords have implemented the standards in the buildings where LCH are the tenant.

The audit team consisted of members of the Domestic services management team, Ops support manager and IPC staff. The audits consisted of a mixture of FR4 (clinic room) and FR6 (office) areas in line with national guidance. The results were captured on to the spreadsheets provided by NHS England and followed the guidance around blended scores.

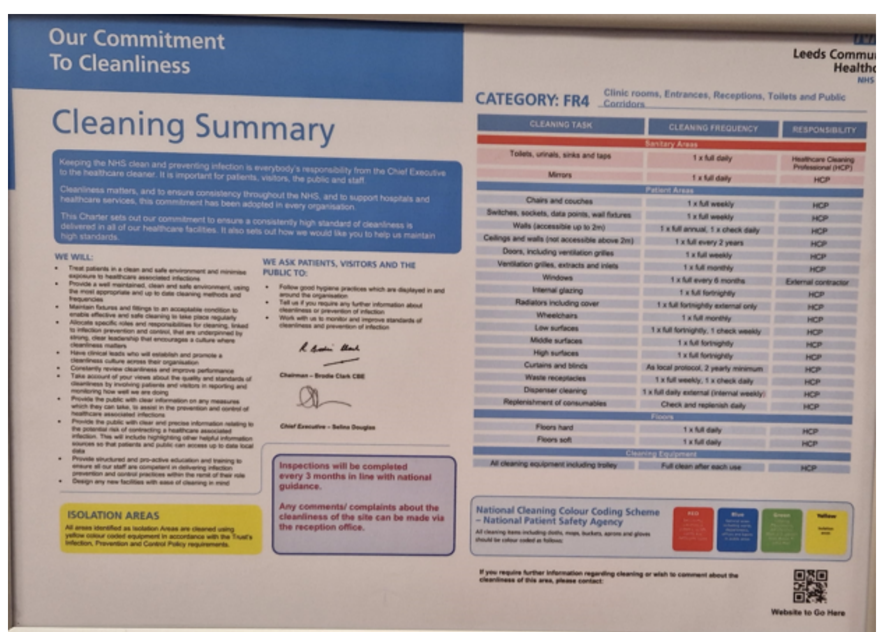


Fig. 17 and 18 example of scores on the doors

The current % average score across all sites is 85%, which for our clinical rooms is a 5-star rating. This obviously also exceeds the target for the blended scores (including FR6 areas). The cleaning standards group has refocused several times in the new year to ensure that improvement plans were in place for the sites that did not achieve 4- or 5-star ratings. The 2 sites identified below standard have been identified as Burmantofts and Morley both have action plans for improvement and will be overseen by the cleaning team. There will also be further work carried out to prepare for the efficacy audits and annual review.

3.2 Environmental Audits

Auditing is a requirement of the Health and Social Care Act 2008, Code of practice for registered providers on the prevention and control of health care associated infections and related guidance. The code states that registered providers must audit compliance to key policies and procedures for infection prevention.

Data from the LCH auditing activity is used to applaud good practice, identify concerns and themes which are used to improve LCH environments, services and staff performance. These improvements will reduce the risk of transmission of healthcare associated infections to patients, staff and visitors.

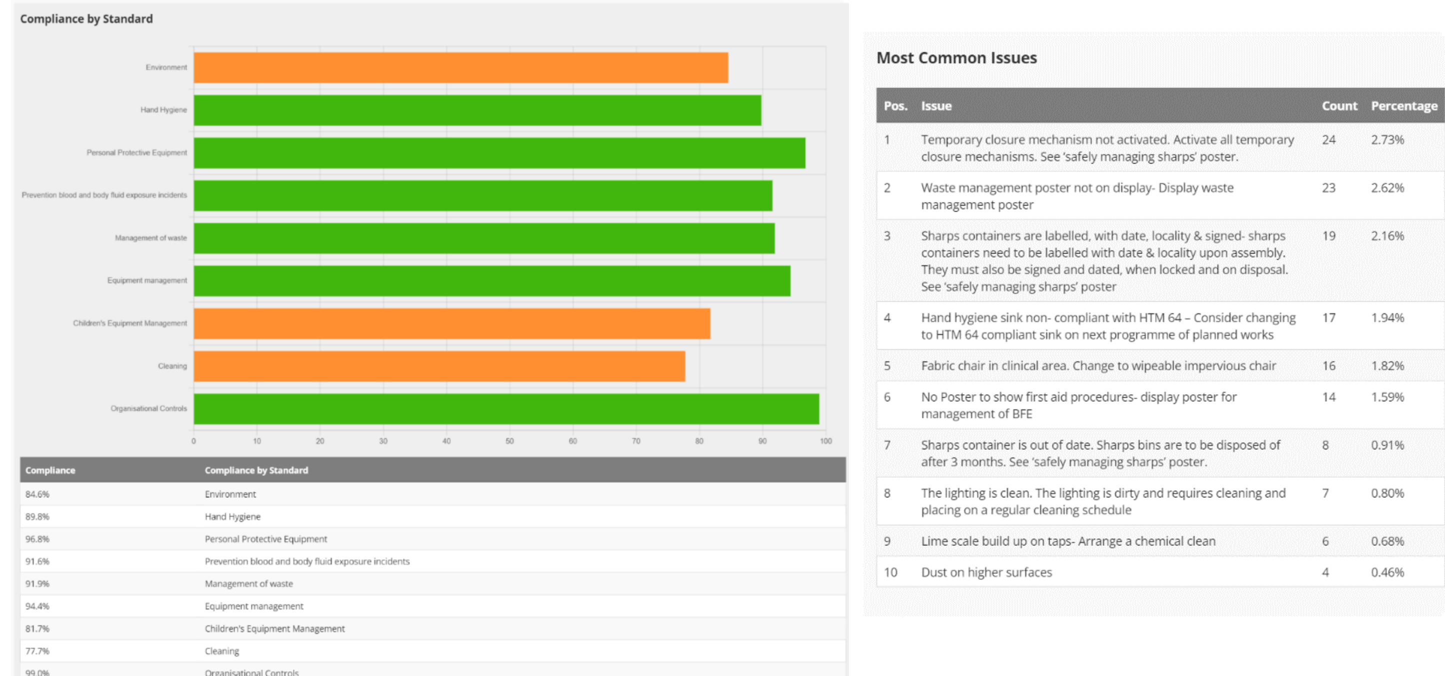
3.2.1 Audit activity 2022-2023 – LCH premises

Environmental auditing is a requirement of the Health and Social Care Act 2008, Code of practice for registered providers on the prevention and control of health care associated infections and related guidance. The code states that registered providers must audit compliance to key policies and procedures for infection prevention.

Data from the LCH auditing activity is used to applaud good practice, identify concerns and themes which are used to improve LCH environments, services and staff performance. These improvements will reduce the risk of transmission of healthcare associated infections to patients, staff and visitors.

The aim for 2023-2024 was to audit all 61 LCH premises which comprise of 27 Health Centres and 33 other sites making 60 in total as listed below:

- 27 Health Centres
- David Beevers Day Unit - Dental Suite
- Leeds Sexual Health Centre
- Hannah House Residential Unit for children with complex health needs
- St George's Centre for Musculoskeletal (MSK) and Children's Outpatients
- Leeds Assisted Living Centre
- Wetherby Young Offenders Institute (WYOI) and Adel Beck Secure Children's Home (HMPs)
- 16 Police custody suites in South, East and West Yorkshire
- Community Neurological Rehab Unit - St Mary's Hospital
- 4 Special inclusion learning centre (SILC) schools.
- 3 Recovery hubs
- 1 MSK unit: Wharfedale Hospital



Compliance	Compliance by Standard
84.6%	Environment
89.8%	Hand Hygiene
96.8%	Personal Protective Equipment
91.6%	Prevention blood and body fluid exposure incidents
91.9%	Management of waste
94.4%	Equipment management
81.7%	Children's Equipment Management
77.7%	Cleaning
99.0%	Organisational Controls

Most Common Issues

Pos.	Issue	Count	Percentage
1	Temporary closure mechanism not activated. Activate all temporary closure mechanisms. See 'safely managing sharps' poster.	24	2.73%
2	Waste management poster not on display- Display waste management poster	23	2.62%
3	Sharps containers are labelled, with date, locality & signed- sharps containers need to be labelled with date & locality upon assembly. They must also be signed and dated, when locked and on disposal. See 'safely managing sharps' poster	19	2.16%
4	Hand hygiene sink non- compliant with HTM 64 – Consider changing to HTM 64 compliant sink on next programme of planned works	17	1.94%
5	Fabric chair in clinical area. Change to wipeable impervious chair	16	1.82%
6	No Poster to show first aid procedures- display poster for management of BFE	14	1.59%
7	Sharps container is out of date. Sharps bins are to be disposed of after 3 months. See 'safely managing sharps' poster.	8	0.91%
8	The lighting is clean. The lighting is dirty and requires cleaning and placing on a regular cleaning schedule	7	0.80%
9	Lime scale build up on taps- Arrange a chemical clean	6	0.68%
10	Dust on higher surfaces	4	0.46%

Fig. 19: Overall compliance to the different standards. Fig.20: most common issues identified

3.3 Patient Led Assessment of Care Environment (PLACE)

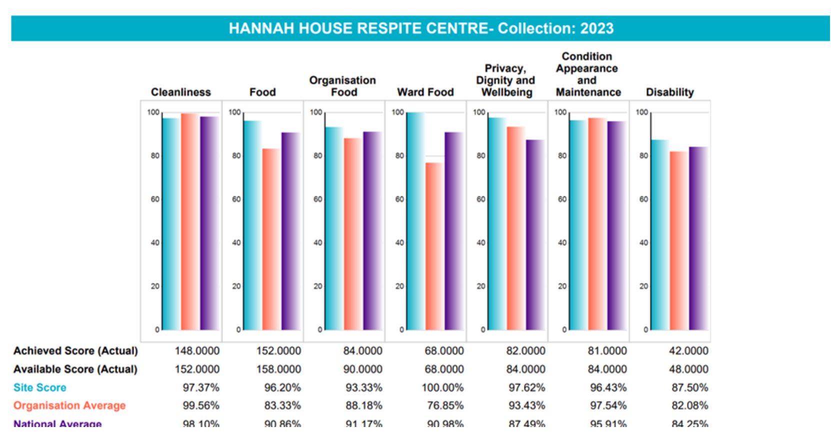
Leeds Community Healthcare NHS Trust had a responsibility to undertake an assessment at Hannah House, which is a purpose built self-contained 'home from home' style facility which provides planned or emergency short break care for children with complex health needs.

During October and November 2023, a group of patient representatives and members of the Youth Board visited and completed PLACE inspections at Hannah House and the two Leeds Community Healthcare (LCH) rehabilitation units, Billberry and Heather based at Wharfdale Hospital.

For the 2024 PLACE Programme, the LCH Facilities and Estates Team will be taking over coordination of the inspection process. Figures 18 and 19 outline the combined results of the 2023 PLACE Programme.

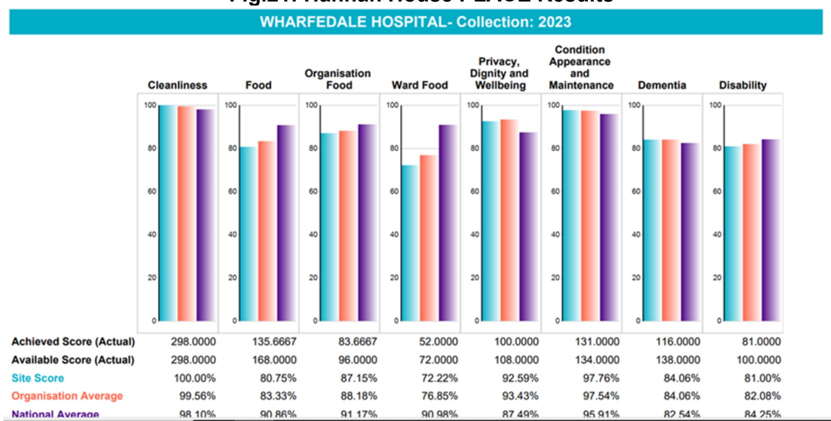
The primary focus of the assessment activity was to review the condition and cleanliness of the care environment as well as elements relating to privacy, dignity, wellbeing, food quality disability and dementia care (Wharfdale only).
Results

- All standards relating to food provision at Hannah House were significantly above the national average, with the quality and taste of food receiving 100%. The results for the quality and variety of food provided on the Heather Unit was significantly below the national average and work is being done to review and improve meal provision within the area.
- The results for privacy and dignity in all areas were above national average, as was environmental condition, appearance, and maintenance. This is testament to the significant infrastructure investment seen at Hannah House
- Although the dementia standard result was marginally above the national average, some issues relating to ward signage, especially on Heather Unit on the overall result score for the area.



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Disability
Achieved Score (Actual)	148.0000	152.0000	84.0000	68.0000	82.0000	81.0000	42.0000
Available Score (Actual)	152.0000	158.0000	90.0000	68.0000	84.0000	84.0000	48.0000
Site Score	97.37%	96.20%	93.33%	100.00%	97.62%	96.43%	87.50%
Organisation Average	99.56%	83.33%	88.18%	76.85%	93.43%	97.54%	82.08%
National Average	98.10%	90.86%	91.17%	90.98%	87.49%	95.91%	84.25%

Fig.21: Hannah House PLACE Results



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	298.0000	135.6667	83.6667	52.0000	100.0000	131.0000	116.0000	81.0000
Available Score (Actual)	298.0000	168.0000	96.0000	72.0000	108.0000	134.0000	138.0000	100.0000
Site Score	100.00%	80.75%	87.15%	72.22%	92.59%	97.76%	84.06%	81.00%
Organisation Average	99.56%	83.33%	88.18%	76.85%	93.43%	97.54%	84.06%	82.08%
National Average	98.10%	90.86%	91.17%	90.98%	87.49%	95.91%	82.54%	84.25%

Fig. 22: Wharfdale PLACE Results

Waste, water and ventilation management

There is a waste manager in post for LCH who takes the lead with support from IPC on ensuring that as an organisation we are 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. A waste and ventilation report comes to the IPCG and escalations can be raised through QAIG and the HSG.

A six monthly Water Safety Group meets which is chaired by the Senior Estates Manager. The aim of the group is to provide the framework to ensure that the Trust complies with current legislation and best practice guidelines for control of water quality and water systems across the Trust. A water engineer/specialist is contracted by LCH to provide subject matter expertise.

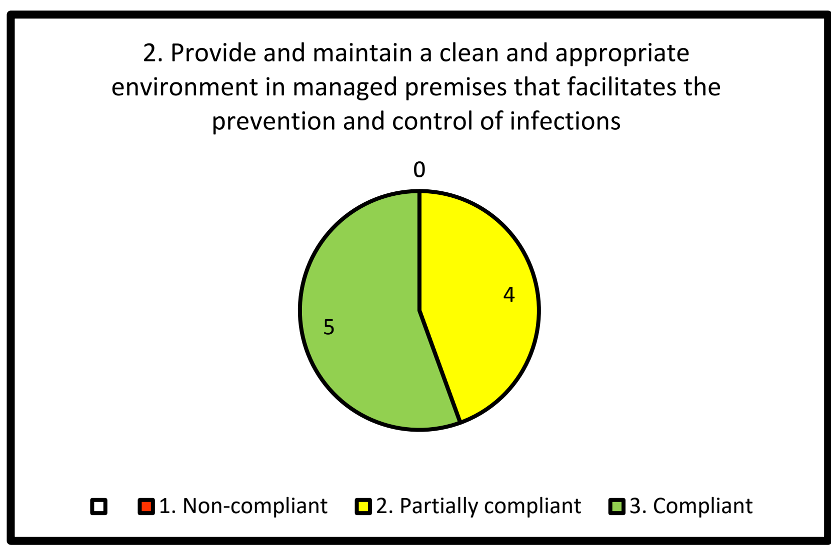


Fig. 23: BAF compliance to Criterion 2.

Partial Compliance elements:

There is evidence of compliance with National cleanliness standards including monitoring and mitigations – there continues to be limited assurance from third party organisations for cleaning efficiency where Leeds Community Healthcare provide services for example: SILC Schools, Adel Beck, St Georges Centre, Wetherby Young Offenders and Custody Suites.

There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan - there continues to be limited assurance from third party organisations for waste and ventilation where Leeds Community Healthcare provide services for example: SILC Schools, Adel Beck, St Georges Centre, Wetherby Young Offenders and Custody Suites.

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 – a more defined process on how we capture planned maintenance work though IPC environment audit that highlights non-compliance, as well as an action plan that is risk assessed on the changes that are required and timescales.

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 – following an external audit a number of elements have been identified for improvement, for example an updated Waste Management Policy, the appointment of a waste manager for LCH and a new waste provider through a tendered process.

4.0 Criterion 3:

Ensure appropriate antimicrobial stewardship to optimize service user outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial Resistance

Antimicrobial resistance is a global public health threat, and the UK has responded to this global campaign with a series of National Action Plans and national surveillance

of antimicrobial resistance patterns with key aims around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics. Leeds Sexual Health generally accounts for the majority of oral antibiotics prescribed within LCH (average 86%) per quarter.

A number of NICE guidelines have been updated during 2023/2024 including:

- NG 237 Suspected acute respiratory infection in over 16s – threshold for treatment or referral amended. Relevant to HMYOI Wetherby.
- CG 191 Pneumonia in adults: diagnosis & management – recommendations on severity assessment outside of hospital updated. Relevant to Home Ward (Frailty) & Wharfedale Recovery Hub.
- NG 191 COVID-19: management – two recommendations on managing acute cough replaced. Relevant to Wharfedale Recovery Hub.
- NG 198 Acne vulgaris: management – recommendation on oral isotretinoin updated. Relevant to HMYOI Wetherby.

LCH IPC work closely with the WY ICB and have attendance at the many different work streams including; AMR and Sustainability, AMR Sepsis and Bacteraemia's etc. LCH IPC are actively involved with the collaborative approaches with LCC AMR group that is a place based meeting to identify AMR actions from all providers, discuss surveillance and share ongoing reactive work.

An AMR Flash report is jointly written between medicines management and the Head of IPC for the IPCG and QAIG meeting that provides a highlight of the antibiotics prescribed and the reactive IPC elements that are implemented. Appendix 1 shows some of the material that has been designed and shared with staff around safe usage of antibiotics as part of the I-Spy AMR branded approach.

AMR features as part of the National IPC Week in October 2023, where the IPC team provide key messaging.

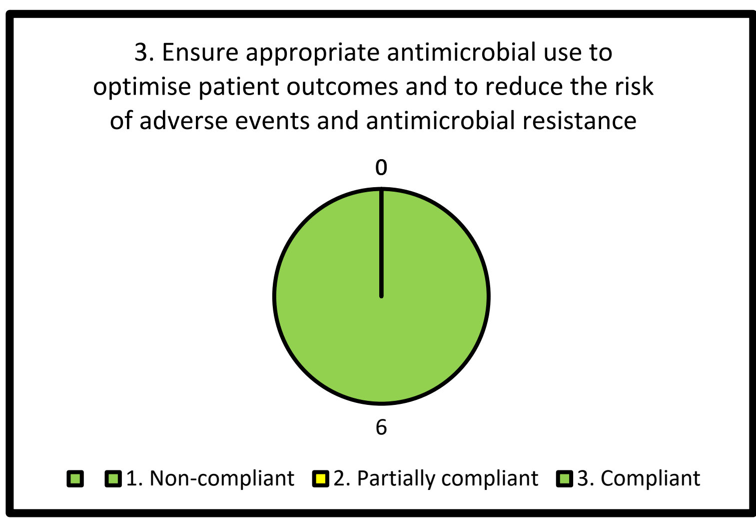


Fig. 24: BAF compliance to Criterion 3.

5.0 Criterion 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

5.1 Conferences and awareness campaigns

Hand Hygiene Campaign May 2023

An overwhelming successful hand hygiene campaign on 5th May 2023 saw the entire IPC team deploy throughout all locations across LCH estate providing awareness to the importance of hand hygiene. The campaign also had a digital footprint where social media was utilised the entire week leading up to 5th May.

IPC Week October 2023

The IPC Team celebrated a different aspect of infection prevention during October 2023, different topics of engagement with staff and the general public included hand hygiene, sepsis, influenza and antimicrobial resistance.

I-Spy Campaign

A range of patient and staff material has been published with the branded approach of I-Spy. Topis include Norovirus, Antibiotic Awareness, MRSA, Influenza and Sepsis. See appendix 3 for example of campaign material designed.

National Cleaning Standards

The trust implemented the National Cleaning Standards and all the star ratings on cleanliness and are displayed at the entrance of each premises.

The IPC Team have developed a number of resources for the I-Spy campaign, which is a nationally recognised project. Resources have been shared outside of the trust, to share important messaging on a number of IPC related topics e.g. norovirus, sepsis

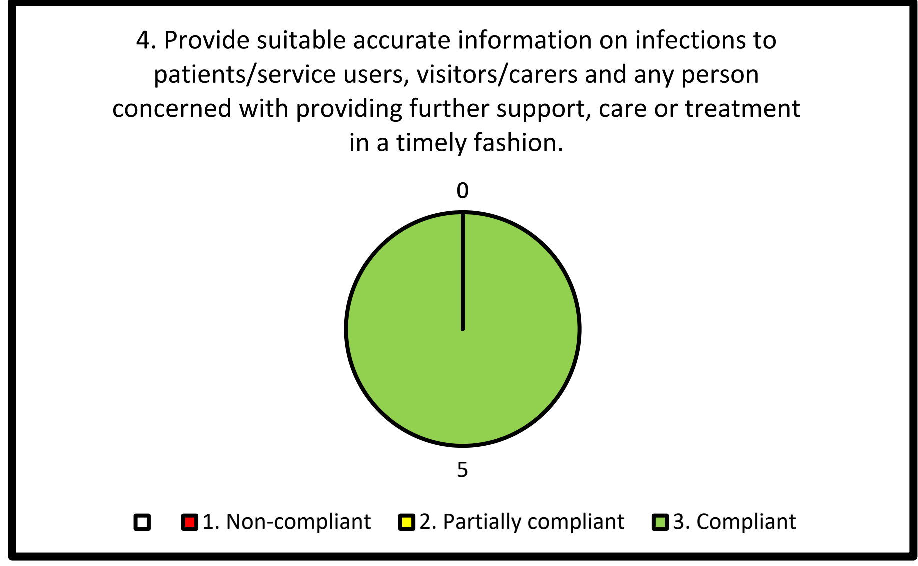


Fig 25: BAF compliance to criterion 4

6.0 Criterion 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.

Outbreak management and surveillance software

LCH IPC Team are alerted either from the laboratory on an electronic system (PPM+) or by the UK Health Security agency (UKHSA)agency for specific infections. The list is reviewed daily by a reactive IPC nurse, which allows appropriate management of infections and potentially infectious patients in real time to reduce the risk to others.

LTHT IPC team have moved to an electronic platform called IC-Net which provides an enhanced surveillance system and the Head of IPC is working with LTHT to consider options around whether this can be utilized by community.

IPC have supported with numerous outbreaks during 2023-24 internally and externally to LCH as part of the cooperation agreement. A log of outbreaks is captured by both gastrointestinal outbreaks and respiratory related outbreaks as well specific infections such as Carbapenemase-producing Enterobacterales (CPEs).

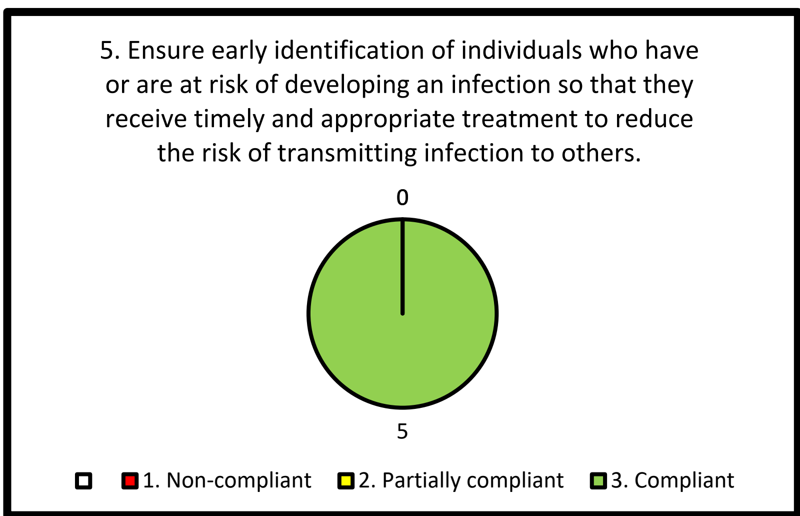


Fig. 26: BAF compliance to Criterion 5.

7.0 Criterion 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

7.1 Statutory and Mandatory Training

The Health and Social Care Act (2008) identifies the importance of effective education and training for all staff members. There is an IPC e-learning package that meets the requirements and is mandatory for all staff at levels 2 and 3.

Training compliance rates were on average 92% at yearend for level 1 and level 2 training via E-Learning for Health.

The IPC Team offer bitesize training in a variety of ways either face to face or virtual covering a range of topics, including measles, sepsis and Carbapenemase-producing Enterobacterales (CPEs).

The IPC currently are supporting NHS England's National IPC Team to develop a community specific e-learning package that will meet the requirements of the IPC Education Framework.

7.2 Student placements

The Infection Prevention and Control Team had 13 learners allocated to the team throughout the year, unfortunately 3 did not attend placement with 2 of the 3 not giving any prior warning they would not be attending, nursing time was spent preparing their placements regardless of the non attendance which followed. First, second- and third-year nursing students, were supported on placement with the majority spending 2 weeks with the team. The following comments have been made by students through the PARE (Practice Assessment Record and Evaluation) evaluation, completed within 2 weeks of conclusion of the placement experience.

There were times when workload levels were high, and I saw how different members of the team supported one and other to achieve deadlines.

I saw a lot of good teamwork within the team, no one is afraid to ask for help about something which shows a good team.

During my two weeks, I had the opportunity to work alongside specialist infection prevention and control nurses who taught me in detail about important aspects of microbiology, best practice in infection control, and the importance of team work and collaboration.

My mentor went above and beyond to supply learning opportunities for me
Although a short placement, if there was areas I required more information and guidance about I was provided with it. All the nurses on this placement were extremely knowledgeable within their area of expertise and were incredibly helpful.

Every member of staff was so supportive and made me feel part of the team from day 1.

IPC Team Development - Education and team building

- Team members attended the Queens Nursing Institute Aspiring Leader Programme.
- Team member completed a Public Health Certificate at Leeds Beckett University.
- A team member returned from a secondment at NHS England Northwest Regional IPC Team.
- Team have had engagement with the Infection Prevention Society (IPS) for continuous professional development and the 'Institution Membership' was purchased, to support education, learning and networking.
- Positions of responsibility: A Senior IPC Nurse is the secretary for the Infection Prevention Society. The Head of IPC is the Coordinator for the Yorkshire Branch Infection Prevention Society. The Head of IPC is a member of the CNO's IPC Shared Decision Making Council representing community care.

Fit Testing

Following the update of the National Infection Prevention & Control Manual (NIPCM) to include Transmission Based Precautions, it recommends filtering face piece (FFP) respirators must be worn when caring for patients with known or suspected airborne infections or when performing aerosol generating procedures.

During the period April 2023-April 2024, we have completed 93 Fit Tests for LCH staff. Fit Testing was provided externally to a GP practice in Leeds in this period and 4 Fit Tests were successfully completed. A further session for the same GP practice is planned out of this time period.

There are currently 96 staff members in LCH with an up-to-date Fit Test (completed within 2 years). Please see graph below which breaks down staff Fit Tested in Business Units:

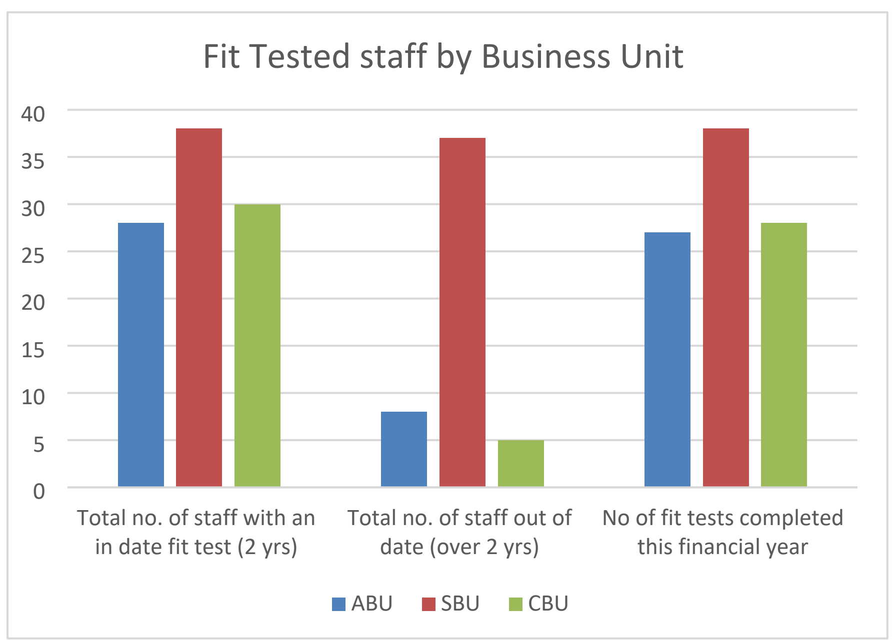


Fig. 27: Staff fit tested per business unit (2023-24)

As outlined in the BAF, LCH have limited assurance on the accuracy of staff fit tested and how this is recorded. A review of the LCH process for Fit Testing going forward is required and how this is recorded to enable clinical team managers to access their level of compliance and to keep a more accurate up to date record, and overall improve assurance in the BAF.

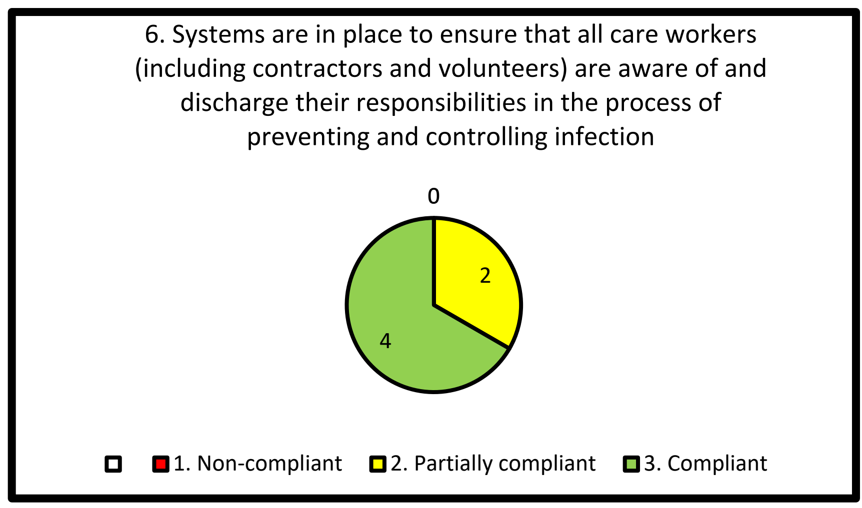


Fig.28: BAF compliance to Criterion 6

Partial Compliance elements:

That all identified staff are fit-tested A record is kept currently however this is not aligned to staff profile as per Health and Safety Executive requirements and that a record is kept: there is a report kept however this is not aligned to staff profile for example on ESR and therefore does provide limited assurance to the board.

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 are a number of clinical interventions such as aseptic technique and catheterisation where clinical staff do not currently undertake any form of regular assessment.

8.0 Criterion 7:

Provide or secure adequate isolation precautions and facilities.

Isolation facilities

LCH inpatient areas such as Wharfdale and Hannah House continues to provide isolation facilities (side rooms) should these be required for patients with specific infections that require isolation as per relevant policy. Patient that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed. The result of this clinical risk assessment should determine patient placement and the required IPC precautions. Clinical care should not be delayed based on infectious status.

Patients can be cohorted together in bays, if there are two or more patients with the same condition for example, a gastrointestinal outbreak or a respiratory infection. All decisions are to be clearly documented in the patients electronic records.

During 2023-24 the IPC Team have supported with numerous outbreaks both internally for LCH and supporting the wider healthcare economy. This included measles, scabies, Mpox, Hepatitus A and Carbapenemase-producing Enterobacterales (CPEs).

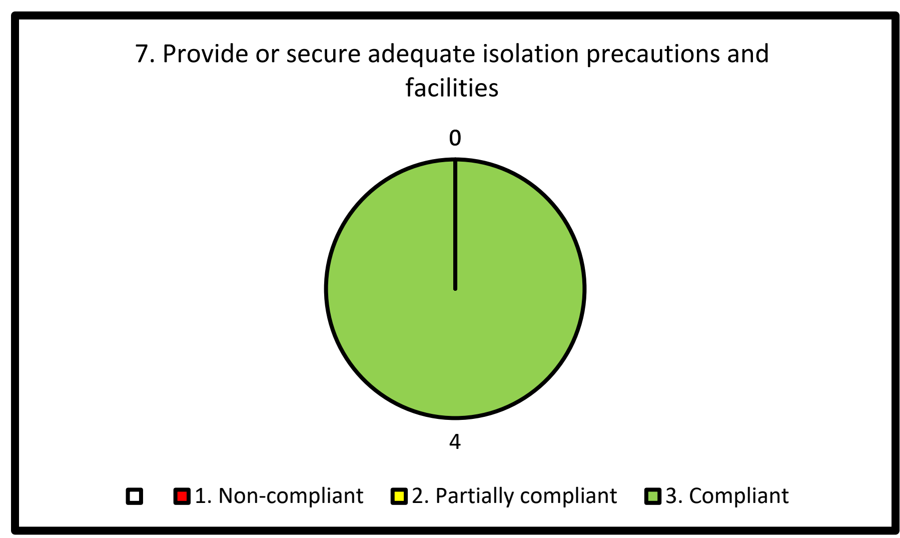


Fig. 29: BAF compliance to Criterion 7.

9.0 Criterion 8:

Provide secure and adequate access to laboratory/diagnostic support as appropriate

LCH has a dedicated contracted microbiology service with Leeds Teaching Hospitals NHS Trust, which provides a 24/7 service with UKAS (United Kingdom Accreditation Service) accreditation. A microbiology consultant is available 7 days a week with specific core contracted hours via Leeds Integrated Care Board (ICB) to provide specific support and advice. The service provides support with IPC Patient Safety Investigations as well as policy and guideline updates. All results for specific organisms such as MRSA, CDI, E.coli, influenza etc are reported via PPM+ which is then accessed by the IPC Team and reiterated to clinicians on measures required on system 1 electronic patient record.

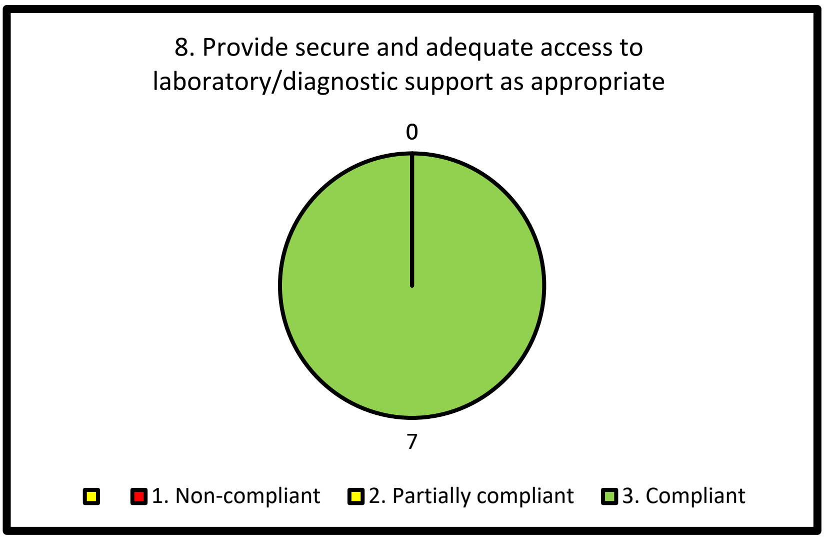


Fig. 30: BAF compliance to Criterion 8.

10.0 Criterion 9:

Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

10.1 Policies and guidelines

The overarching policies are written in line with the Trust Governance policy which outlines requirements for responsibility, audit and monitoring of policies to provide assurance that policies are being adhered to. Both policy and manual are available for staff to view on the Trust intranet as well as the Leeds Healthcare Pathway. The IPC team have a rolling programme of policies which require updating each year. All policies updated this year have incorporated the National IPC Manual.

- Aseptic Non touch Technique (ANTT) Policy

- Clostridium Difficile
- Diagnostic & screening Procedures including safe sampling, handling and transportation of specimen's policy
- Food Safety
- Guidelines for the management of Headlice
- Guidelines for the management of Animals in the community in-patient health care premises
- Guidelines for the management of Scabies
- Guidelines for the management of Toys in the community
- Healthcare waste
- Infection Prevention and Control overarching policy
- Isolation policy and procedures for LCH trust in patient areas
- Linen and Laundry Management Policy
- Local Decontamination of reusable medical equipment
- Management of communicable disease outbreak within the community setting
- Management of Patients with Methicillin Resistant staphylococcus Aureus (MRSA)in the community and social care settings
- Prevention and control measures for specific infections in the community
- Prevention and management of multi-resistant bacteria (Including Carbapenemase producing Enterobacteriaceae (CPE) Glycopeptite Resistant & extended spectrum Beta-lactamase
- Respiratory Virus Policy
- Standard Precautions Policy (includes hand hygiene, PPE & management of spills within the community
- Transmissible Spongiform encephalopathy: Prevention of cross infection incidents policy

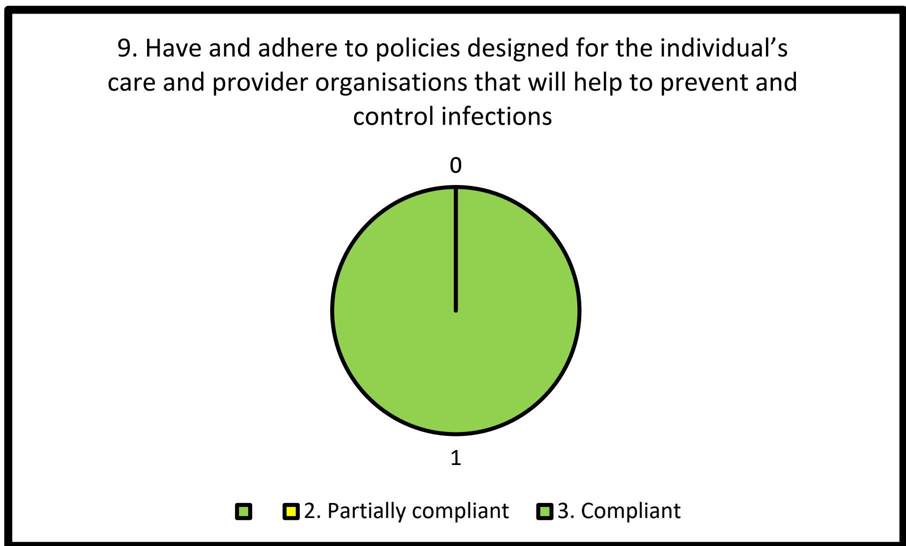


Fig. 31: BAF compliance to Criterion 9.

11.0 Criterion 10:

Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

11.1 Staff health

LCH commissions SWYFT to provide the Occupational Health Service. Staff who have had an occupational exposure are referred promptly to the relevant service for example: GP, occupational health, or accident and emergency. Staff understand immediate actions for example; first aid, following an occupational exposure including reporting the process. A system included in the hand hygiene audits monitors the management around skin health (COSHH Regulations). This includes regular skin checks to identify any occupational dermatitis.

Seasonal Staff Winter Vaccination Campaign – Covid-19 and Influenza 2023/2024

The Code of Practice (2012) for the prevention and control of healthcare associated infections (HCAI) emphasises the need for NHS organisations to ensure that its frontline health care workers are free of and protected from communicable infections (so far as is reasonably practical). Influenza is a highly contagious illness which can be serious, particularly for older people or those with other health conditions. Health and social care workers care for some of the most vulnerable people in our communities and 50% of staff may carry flu and may unknowingly pass flu onto others.

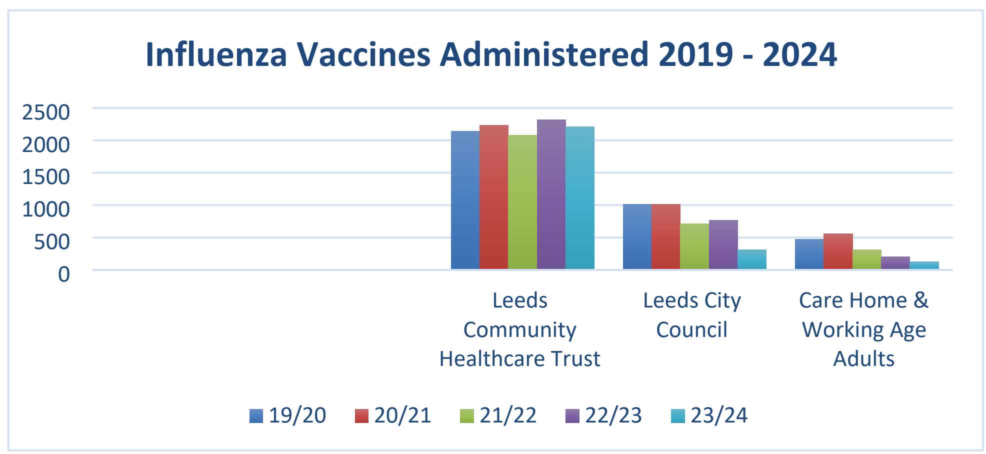


Fig. 32: Influenza Vaccines administered 2019-24.

Health care staff are also at increased risk of transmission of infections. Therefore, it is important that staff help protect themselves (and their families) and the patients that they care for by receiving annual flu vaccinations. Staff vaccination also results in lower rates of influenza-like illness and mortality in healthcare settings and helps to ensure vital business continuity in the health and social care sector (by reducing staff flu related illness).

Staff were invited via email to the newly commissioned vaccination booking system (Vaccination Track – a citywide system in Leeds used for flu and covid bookings to ensure a streamlined process for staff who are booking and the vaccinators who were administrating) to book both vaccinations together, influenza only or covid only. LCH staff received a 7-day reminder email since the launch of the campaign, reminding them to book a vaccination or inform us they have received a vaccination elsewhere or decline the vaccination offer.

The campaign finished in February 2024 and the total number of frontline staff vaccinated for influenza was 58%. As a consequence, the CQUIN target of 95% was not achieved. The percentage of staff vaccinated for Covid-19 was 48%.

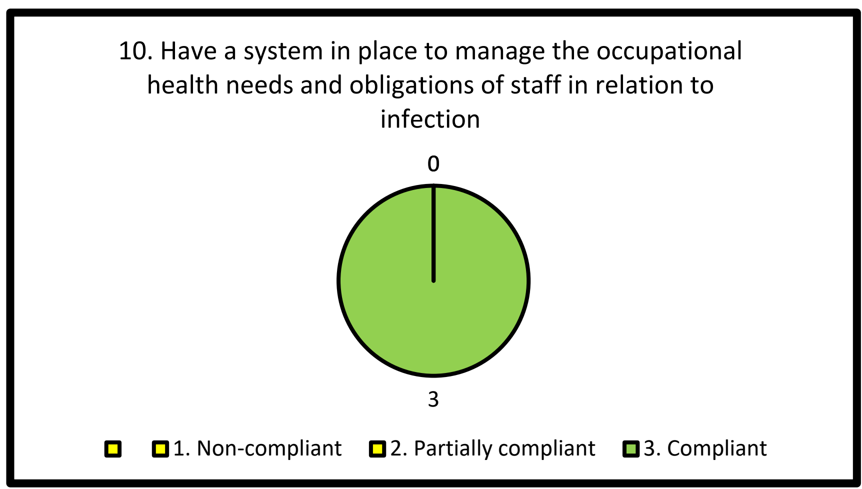


Fig. 33: BAF compliance to Criterion 10.

12.0 IPC team structure and celebrations

- The team has continued to work at an enhanced capacity with an uplift in funding from Leeds City Council in line with the cooperation partnership agreement.

- In March 2024 a staff members secondment came to an end and now they works as a Sepsis and Deterioration Nurse within LCH supporting the key deliverables of the Improvement Group for the Deteriorating patient.

- The IPC Team were shortlisted for the Nursing Times Award for the I-Spy Sepsis programme of work.

13.0 Challenges and forward plan 2024/2025

Forward Plan 2024 - 2025

- Aline fit testing to ESR and promote shared organisational responsibility.
- IPC will continue to be a high priority for the Trust and the team have set out an ambitious but flexible programme of work over 2023-24.
- Building on pandemic preparedness for future potential outbreaks of novel viruses and update emergency planning resilience.
- Embed work around antimicrobial resistance, building on collaborative work with the West Yorkshire ICB incorporating core principles around data, education and sustainability and the impact on climate change.
- Continue to focus our attentions around the collaborative citywide HCAI Improvement Group including MSSA's and GNBSI's.
- Education and development of IPC team and implementation of the core competencies from the Infection Prevention Society (IPS)
- A focus around Quality Improvement to be implemented by IPC in relation to auditing, hand hygiene compliance, fit testing and HCAI Surveillance.
- Continue to build engagement with the ICS for West Yorkshire for IPC.
- Development of the branded approach to awareness raising and education by building on the 'I-Spy' series and share within ICB.

Challenges for 2024-25 will include:

- Achievement of the HCAI objectives with specific emphasis on the gram-negative agenda and CDI.
- Cost improvement and the Quality and Value programme.
- The uncertainty around new and emerging infections.

14.0 Conclusion

It is noted that overall LCH is compliant in the majority of areas of the Health and Social Care Act (2008,22) 10 criterion. Where there are areas of partial compliance there is an action plan in place for 2024/25 and any significant risks have been added to the risk register.

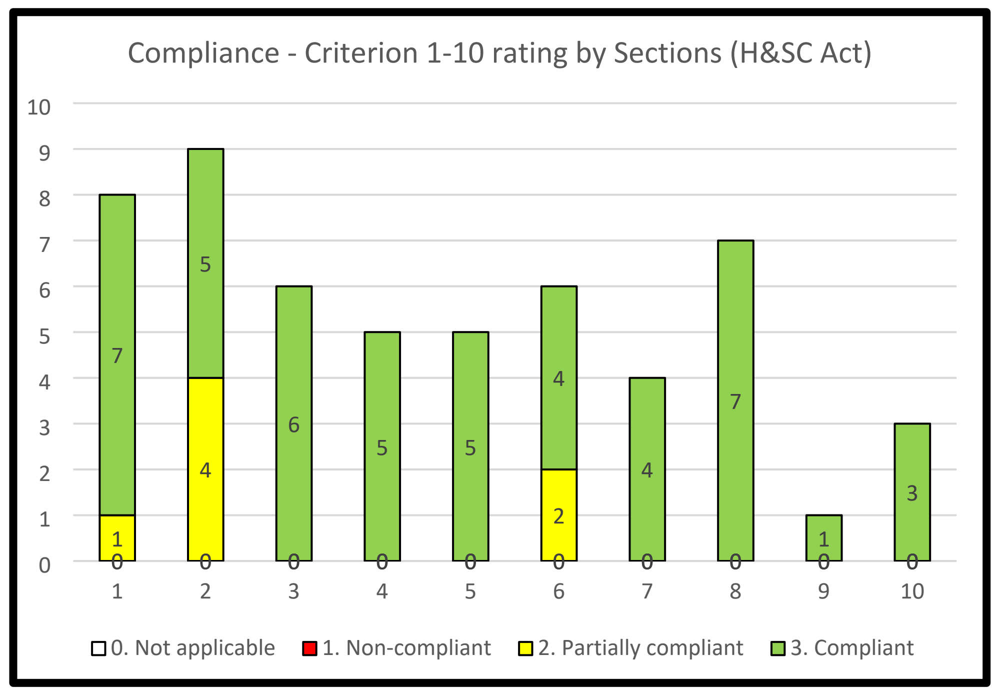


Fig.34 Overall compliance with the Health and Social care Act (2008)

It is evident that 2023-2024 has proven to be a very successful year for the Infection Prevention and Control team within LCH. We have delivered successfully on the fourth fiscal year of the enhanced 'Partnership Cooperation Agreement' with Leeds City Council, which has now seen a permanent uplift in funding.

This report demonstrates the continued commitment of the Trust and evidence successes and service improvement through the leadership of a dedicated and proactive IPC team. It is also testimony to the commitment of all LCH staff dedicated in keeping IPC high on everyone's agenda. The year has continued to be dominated by undulating world of infection and the IPC Team workload increased dramatically as a result. Keeping staff and patients safe was priority during this time, as well as the system wide working through the city of Leeds.

Recommendation
Quality Committee and the trust Board is asked to note the contents of this report including areas of noncompliance for information.

References

- Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

- NHS England » National infection prevention and control

- Health Protection Board Report 2023

Appendix 1.0

1. LCH business unit overview

Children's Business Unit (CBU)

The Infection Prevention and Control Team have continued to foster positive working relationships with the teams across Children's Business Unit within LCH and the wider economy, supporting teams with management of outbreaks, implementation of guidance, and general advice. The IPC team has been involved with the following:

- The Hannah House IPC environmental audit took place in January 2024 with the overall score decreasing from 93.6% to 89.9%, areas of concern involved fabric of the environment, high surface dust, unclean lighting and damaged plaster, paintwork and flooring. Since this audit was completed, the flooring has been repaired in part of the building due to concerns raised by the fire service in relation to the ability to drag a slide mat for evacuation along the floor, however areas of floor which are patched with tape are still in situ.
- The PLACE (Patient-Led Assessments of the Care Environment) Inspection saw improvements in some of the domains, these are detailed in a separate report, this year the inspection involved young people for the first time from the youth board, who made an exceptional contribution to the process.
- Concerns continue at Hannah House in relation to domestic staff cover, for planned and unplanned absence at the site. Currently 2 staff cover a 7day service – no provision is available for domestic staff to be provided in their absence – this has been escalated through Domestic Management, Hannah House Management and into the IPCG. Hannah House have maintained a 5-star rating for the majority of the year, dropping no lower than 4 stars at any point. A calendar of dates has been produced for the audits to be completed monthly with IPC, Hannah House and Domestic services working in collaboration.
- The annual Infection Prevention Audits were completed at all 4 Specialist Inclusive Learning sites, namely Farnley Academy, Pennyfields, Broomfields and John Jamieson. The visits to the SILC sites were completed in collaboration with Health and Safety colleagues from LCH and LCC, independent health and safety representatives for academy site and school team representatives. Unfortunately audit outcomes decreased in 2 of the sites, this was mainly seen in terms of fabric of the building. Some improvements have been seen in 2 of the sites. Pennyfields Academy saw an increase in score following a significant decrease the previous year.
- SILC (Specialist Inclusive Learning Centre) schools auditing revealed trends across the city in terms of areas for improvement across the sites. An executive summary is being worked on to pull these issues together for presentation to the council, with invitation to key stakeholders to also raise their concerns.
- Regular IPC presence in the CBU Quality Meetings to offer a general overview from an IPC point of view, work is ongoing to produce a standardised set of feedback to CMT including audit feedback, vaccination uptake (during winter vaccine campaign) Datix, and planned building work to enable discussion of IPC implications to be shared. The positive working relationship with CBU lead through regular meetings has fed into a number of positive pieces of work, e.g. bespoke winter vaccination session for Community Paediatrician colleagues. The new Clinical Lead due to start in post will continue this.
- The IPC team encouraged staff in the Children business unit to uptake the winter vaccine offer of flu and covid vaccination. Sessions were provided to teams on a

bespoke basis face to face and virtually in team meetings, providing information about how to use vaccine track to book onto sessions, location of clinics, myth busting and answering questions.

Projects

- Children's Community Nursing Team trialled the use of prefilled saline syringes, feedback on use has been positive and IPC nurse is leading a task and finish group to implement use across the organisation. Key Stakeholders including Clinical Staff, Medicines Management, NHS Supply Chain, and Procurement have been involved so far, project is ongoing.
- Collaboration with LCC colleagues on hand hygiene resources targeted at a child audience. Input also provided on Healthy Schools packages, with the implementation of an introduction to vaccination for Key Stage 1 children.
- Hand Hygiene sessions were delivered in 2 Specialist Inclusion Schools, these were enjoyed by both the staff and children and provided an interactive learning opportunity for the children, run in collaboration with SLIC school nurses.
- Measles responsiveness was discussed in preparedness for an outbreak across different sectors of the economy in Leeds. Involvement in management of an exposure at LTHT and in an LCH setting has been managed.
- Pertussis has increased across the country at the latter part of the financial year 23-24 and communication to staff through all staff emails has been devised. The IPC Team continue to support with reports of suspected and confirmed cases in staff and students, and our partners in Occupational Health Services are offering vaccination to relevant staff groups as per Green Book.

Specialist Business Unit (SBU)

The Infection Prevention team continue to collaborate closely with the teams within the specialist business unit, supporting them with any outbreaks, general IPC support and advice.

Usual activities have been maintained including:

- Annual audits of all Police Custody suites across Yorkshire, ensuring compliance with IPC standards and to offer support and guidance on environmental issues. LCH staff work within a police custody suite building and alongside non healthcare staff, which can be a barrier to good IPC practice. This has been highlighted in some areas where cleaning was found to be inadequate and has been addressed by the clinical team managers with support from the IPC team.
- Annual IPC environmental audits have been undertaken in Adel Beck and WYOI. Adel Beck continues to have a good standard of compliance and cleanliness. It is obvious that LCH clinical staff take ownership and pride of IPC within their environment.
- WYOI has shown an increase in IPC standards this year as demonstrated via the annual audit scores which improved from 73% to 86%. Issues, previously, were exacerbated by difficult environmental issues and staffing constraints including no cleaning contracts. Cleaning contracts are now in place, which has released the healthcare staff from these duties. The environment will remain an ongoing challenge, however WYOI staff continue to actively engage with IPC colleagues to address any issues identified and escalate any concerns to the senior prison

management team. The concerns previously identified, remain on the LCH risk register.

- IPC have worked closely with WYOI and Adel Beck to prevent and control outbreaks alongside wider Leeds healthcare economy colleagues. A good relationship has been built with the staff working in these areas and IPC, which will promote and ensure good IPC compliance long term.
- Annual IPC environmental audits have been completed for Leeds Sexual Health at the Merrion centre.
- Bi-yearly dental water tests continue to be conducted by the Dental team and overseen by the IPC and Water Safety Group following installation of the sterile straw system. Yeadon dental had 1 chair out of range result on testing. This was quickly resolved by the dental team. IPC continue to monitor the results & support the Dental team.
- Annual IPC environmental audit completed for CNRU, which, continue to run an outpatient only service, their inpatient unit remains closed.
- IPC previously worked closely with Podiatry following an increase in sharps incidence reported via Datix relating to the non-removal of blades. The previous 2 years had 8 & 9 incidence respectively of blade non-removal. This year there has been a reduction with 2 blades returned. There is already a robust action plan & audit system in place to try & reduce the sharps incidences relating to removal of blades, but further work will continue to monitor the incidents and any common themes.
- SBU staff continue to report the quarterly PPE & HH auditing results via the reporting system. There remain some reporting issues with variable returns in each quarter. Q1 & Q4 saw 2 teams not reporting, whereas Q2, 2 teams didn't report & Q3, 4 teams didn't report. IPC are aware that all teams remain under significant pressure & thank those that did return the reports. The reports are demonstrating a reduction in compliance with bare below the elbow both from the returns and from incidental reporting. These issues continue to be addressed via the IPC team & from the Senior Management teams.
- The Sexual Health management team were supported when issues of non-compliance with BBE were identified within the team. Regular visits were made in support of the senior management team & will continue, to remain a focus of support.
- An annual assurance visit to the Steris decontamination unit was not undertaken this year. A joint visit between IPC, dental & podiatry teams is planned early in 2024.
- A mixture of proactive supportive visits & outbreak visits has taken place with a wide range of services supporting vulnerable groups, facilitating closer working relationships with the wider community and other public health professionals, ensuring the continuity of service provision following change in guidance and the implementation of the new IPC manual.

Projects:

For the annual winter vaccination campaign, multiple specialist teams were offered bespoke vaccination sessions and / or presentations to try & improve staff engagement, access to the vaccinations & to myth bust. Several teams were enthusiastic participants & this appeared to be well received by the teams accepting the offer.

In collaboration with colleagues within SBU and GAMA, the IPC team previously worked on a trial for an alternative skin cleansing product which would maintain patient safety, increase sustainability, and potentially have cost savings for LCH. This product was successfully briefly introduced, however, was withdrawn due to production issues. This will hopefully be revisited this year & planning has commenced.

Adult Business Unit (ABU)

- From the time period of April 2023-April 2024, there have been 9 outbreaks in total reported by the ABU (Neighbourhood teams/Wharfedale Recovery Hub)- 3 of gastro-related causation and 6 confirmed Covid-19 causation. This shows a vast reduction of Covid outbreaks reported from last year which was 36 in total.
- An E coli BSI was identified on Wharfedale Recovery Hub in Q1 2023; following this some learning was identified around catheter management and bespoke training was provided by CUCS.
- Following identification of a reduction in Hand Hygiene compliance in Q1 2023; a roll out of hand hygiene training was provided by the IPC team and a number of Neighbourhood Teams were supported.
- The areas which have been identified as having the lowest completion rate is the **Recovery Hubs** and **Therapy Supported Discharge Service**. Support will be provided to these teams in consistent completion of this audit to provide assurance.
- The IPC team are currently reviewing the current IPC quarterly audit to make it more digitally accessible for remote staff, which will hopefully increase compliance.

Wharfedale Recovery Hub;
The IPC Team have provided the LCH staff at Wharfedale recovery hub with a lot of support during 2023/2024. In January 2024, the ward reported a D&V outbreak which lasted for a considerable amount of time and learning was identified that staff required some support with assessing patients' bowels and identifying signs of infection. Some work was done with staff around clinical assessments and good communication.
There has also been some education provided in the form of a presentation to support staff in using a risk assessed approach when caring for patients with Multi-drug resistant organisms, which the hub has received several patients diagnosed with. Because of the nature of the environment versus the holistic needs of the patients, it can be a decision that needs to be carefully considered and supported by the IPC team with.
In 2024/2025 the IPC team are commencing an Infection transfer documentation audit to identify if there are any gaps in the communication of infection status from referring services/bed bureau. This is to provide assurance against the Health and Social Care Act (2015) that services are providing sufficient information on a patients infection status in order to minimise the risk of infection to the patient and other patients in the care environment.

Appendix 2.0 External work cooperation agreement

Successes

- Remodel of the IPC staffing taking into consideration priorities and team skill mix
- Health Protection (HP) / IPC framework developed to identify future priorities according to the cooperation agreement
- Provided strategic direction through the leadership of the HP Board
- PH leadership in outbreak management and leading prevention programmes
- Local surveillance systems to identify and address incidents and outbreaks. Working closely with UKHSA, co-ordination of IDRR meetings and development of the HP Star dashboard.
- Parasites – Scabies, Bedbugs and Headlice public facing and workforce facing
- Environmental audits (e.g. all internal LCH settings, care homes, Ministry of Justice, WYOI, Adel Beck, contingency hotels)
- Winter respiratory preparedness work and wider outbreak planning
- Care home log and integration into HP Star dashboard
- RESTORE implementation (Evaluation and Celebration event at Gipton Fire Station for care homes who participated in RESTORE2 training programme)
- Delivery of the Winter vaccination programme LCH and LCC.
- Leeds City Council Adult Social Care provided additional funding for delivery of the winter vaccination programme to care home staff.
- 7-day response supported the management of difficult flu outbreaks within care homes, especially over weekends. IPC provided flu packs and support was given to obtain antivirals.
- Hand hygiene – glove awareness, soap opera packs that went to schools.
- Training and educations: SILC schools, care homes, RESTORE2, bespoke
- National Projects – NHS E Stat Mand Training
- Delivery of Hep A vaccinations in partnership with LCH SAIS, NHSE, Leeds ICB
- Measles preparedness – involved in contact tracing for primary care case.
- Communicable Disease Control Nurse – partnership between LCC EH and IPC
- AMR awareness week – Millenium Square, I Spy leaflet, wider comms
- Presentation to WY ICB - AMR
- LCH IPC shortlisted for a Nursing Times Award for the ISpy Sepsis programme – LG presented reasons to win at the NT HQ, award ceremony in Oct 23.
- UKHSA presentation, Infection Prevention Society conference, Sector Led Improvement conference

Care Home Environmental Auditing – Commissioned through the cooperation agreement with LCC.

Over the report period, the IPC Team have coordinated and delivered a structured audit programme for the Leeds Care Home economy. The purpose of this activity is to appraise care home environmental standards and compliance with the criterion standards outlined in the Health and Social Care Act. The activity also fosters a collaborative working relationship with care settings with an overarching aim to improve whole economy compliance standards.

A total of 153 registered care homes/ working age adult (WAA) units have been identified within the Leeds area and these have been subject to a rolling two yearly "face to face" audit activity. The audit process provides an effective means of appraising and assuring IPC standards within the local economy and through quality improvement strategies, collaboratively working with individual homes, to improve environments and infection control practices in line with legal and best practice requirements.

Within the report period a total of 80 care home audits have been completed with 5 care homes requiring follow up reviews to provide supportive input and collaborative quality improvement activity.

The care homes are audited against 10 compliance standards:

- Environment
- Hand hygiene
- Personal protective equipment
- Prevention of blood and body fluid exposure incidents
- Management of waste
- Organisational controls, (policies, risk assessments etc)
- Urinary catheter Management
- Mouthcare
- COVID 19 Management

The IPC Team are committed to continuing the collaborative working philosophy and to further assure and enhance infection prevention standards within the area. Key priorities will include:

- To continue the IPC audit programme with a total of 73 settings requiring auditing. In addition to ensure follow up audits are completed in areas where medium and high risk compliance was noted
- Facilitate enhanced engagement with the Domiciliary Care sector both for educational and potential assurance purposes
- Continue IPC advice, support and guidance to all social care providers, including working age adult services
- Continue to attend relevant meetings, including Care Home System Meeting and Outbreak control meetings
- Provide expert subject matter advice throughout the city
- Monitor, collate and report data in relation to outbreaks of respiratory illness and other agents such as scabies. Separate arrangements are in place to manage outbreak of enteric illness.
- To develop a social care Champions Group and the proposed organisation and delivery of quarterly sessions.
- Disseminate new guidance and evidence as required and utilisation of the Care Home System Working Group bulletin

External Training Provision

The IPC Team have provided enhanced education and training within the wider care economy of Leeds. The initial primary focus of this project was to work with care facilities providing both nursing and residential care, Working Age Adult Care Teams, Third Sector providers, Domiciliary Care Providers, Mental Health Providers, and the local authority Adult Social Care Team.

During 2023/24 a total of 139 face to face training sessions were facilitated by the team. In addition to this were several virtual workshops and bespoke training opportunities. Bespoke IPC training was also delivered to the LCC care teams at Merrion House. These included mandatory update and induction training.

The primary content of the sessions included:

- An update on COVID 19 and the gravitation towards this being managed as an endemic agent
- Understand how infections impact on individual clients and their families and staff, including signposting to available supportive web material
- Reinforcement of the ongoing need to consider other infectious agents, in addition to COVID 19
- Identify the key elements included in Standard Infection Control Precautions and transmission-based precautions
- Demonstrate compliance with basic hand hygiene practice
- Revisit the appropriate use of PPE and correct donning/ doffing procedure
- Understand best practice in relation to management of waste; single use items; laundry
- Management and body fluid exposure
- Development of strategies for staff to positively influence safe practice and become IPC champions within their respective care settings.
- Sessions were also delivered to address specific issues highlighted in audit activity. These have ranged from PPE usage, cleaning etc.

The sessions were delivered in a variety of formats, including Power Point, Virtual and workshop style. Feedback from sessions was comprehensively positive, with free text comments including.

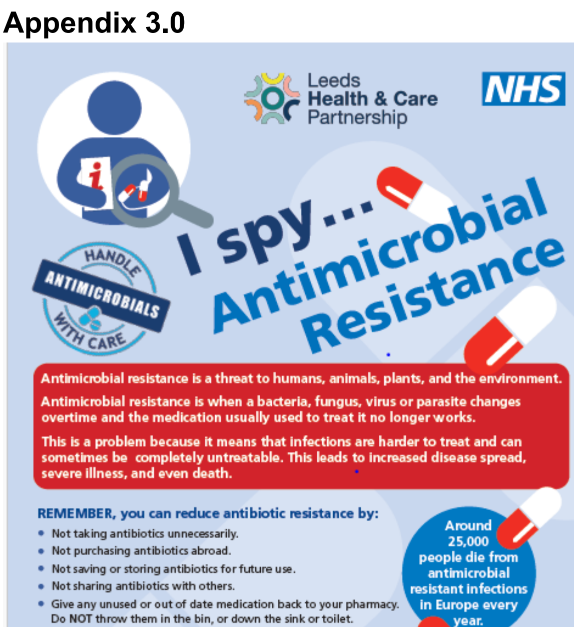
“ Staff enjoyed the refresher from ----, staff love when he comes here and does training as he is very knowledgeable and nothing is ever too much for him”

“------ delivered training excellently and it was very enjoyable”

“------ is always very well received as his demeanour puts staff at ease and encourages participation. He is ready to give practical solutions to issues staff encounter. Staff trust what he says”

Chris Whitty (Chief Medical Officer for England) visited Leeds on Wednesday 17th January to meet with the Director of Public Health Victoria Eaton and colleagues from Leeds City Council (LCC) in preparation for the Chief Medical Officer Annual Health Report 2024, which will be on the topic of Health in Cities.

Appendix 3.0



Leeds Health & Care Partnership

NHS

I spy... Flu

Flu is a virus which is highly infectious and can easily spread from person to person via the droplets caused by coughs and sneezes.

Flu can cause a variety of symptoms and some people can become so unwell that they need hospitalisation.

Symptoms of flu include:

- Sudden high temperature.
- Chills and fever.
- Aching, feeling tired or fatigued.
- Headache.
- Dry cough.
- Sore throat.
- Nausea and vomiting.
- Diarrhoea.
- Loss of appetite.

Flu viruses can live on your hands and other surfaces for up to 24 hours.

Flu is considered a seasonal infection and tends to affect people in the winter.

Taking antibiotics will not help you recover from flu. The best medicine is self-care including:

- Resting and sleeping.
- Staying hydrated.
- Keeping warm.
- Taking paracetamol or ibuprofen to reduce a temperature and help ease pain.

You can reduce the risk of spreading flu by:

- Washing hands frequently.
- Covering your mouth and nose when coughing or sneezing.
- Throw used tissues away as soon as possible.

The best way to help prevent flu is to get a flu vaccine. Contact your GP to see if you are eligible.

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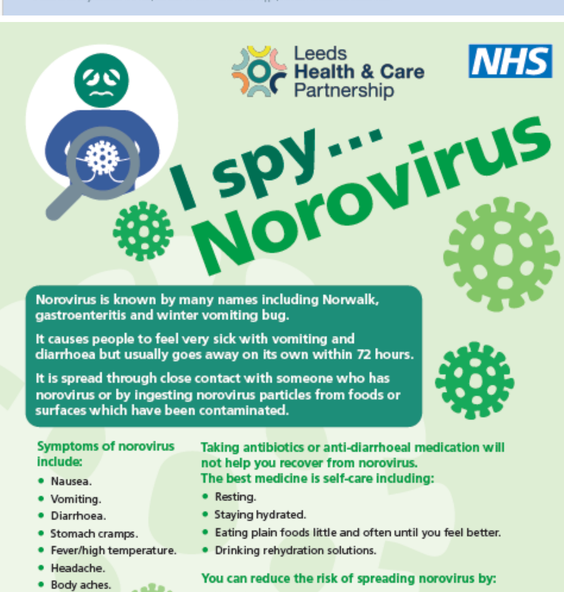

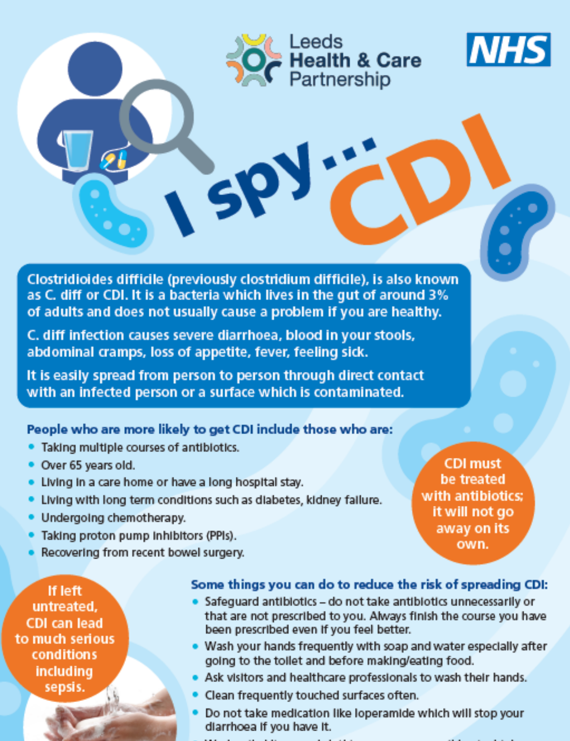

Appendix 4: IPC Board Assurance Framework and annual plan

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. All of our water sytems are now up to date. Some water coolers have been removed from non LCH locations. Working with LYPFT. New Water cooler in place.	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,	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	There is a planned timescale on adopting the new waste streams with a Waste Manager in post within LCH.

segregation, storage, packaging, transport, treatment, and disposal.	waste streams being in place. We have a legal responsibility to ensure compliance with this standard.	
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.

Report compiled by Head of Infection prevention and Control and Deputy DIPC, with contributions by members of the Infection Prevention and Control Team.

Agenda item:	2024-25 (43)

Title of report:	Safeguarding Combined Annual Report

Meeting:	Trust Board Meeting Held In Public
Date:	3 September 2024

Presented by:	Sheila Sorby, Interim Executive Director of Nursing and AHPs					
Prepared by:	Lynne Chambers Head of Safeguarding					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval √	

Executive Summary:	The safeguarding of vulnerable individuals remains a top priority for LCH This report demonstrates our commitment to continuous improvement in safeguarding practices. We are confident that with continued focus, collaboration, and resource allocation, we will further enhance our ability to protect those at risk. This annual safeguarding report provides a comprehensive review of our safeguarding practices, initiatives, and outcomes in 2023/24. Our focus has been on strengthening our policies, enhancing training, and improving our response to safeguarding concerns. In the coming year, our key ambitions in safeguarding include reviewing and enhancing our training and development programs to ensure all staff are equipped with the latest knowledge and skills to identify and respond to emerging risks.

Previously considered by:	Quality Committee July 2024

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	√
	Use our resources wisely and efficiently	
	Enable our workforce to thrive and deliver the best possible care	√
	Collaborating with partners to enable people to live better lives	√
	Embed equity in all that we do	√

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No		Why not/what future plans are there to include this information?	To be determined

Recommendation(s)	LCH Board is recommended to note the contents of this report and approve its publication.

List of Appendices:	None

Safeguarding - combined Annual Report 2024/25

1 Introduction

The Combined Safeguarding Annual Report is to provide LCH Quality Committee and LCH Board with a brief overview of the Safeguarding achievements, challenges and ambitions for 2023/24. The paper was shared with safeguarding committee 13/08/2024 and was approved by quality committee, 29/07/2024.

2 Current position/main body of the report

The safeguarding annual report outlines the key achievements for 2023 and key ambitions for 2024 for all the sub-sections of safeguarding and the wider team, including:

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

3 Impact

The impact of our annual report as a critical document is that it can impact various aspects of our safeguarding service's operations, from strategic planning and compliance to stakeholder engagement and public confidence. It serves as both a reflective tool to assess past performance and a forward-looking guide to drive future success.

4 Quality

The quality of an annual report, especially in a healthcare/safeguarding context, is crucial and as such, reflects the professionalism, transparency, and effectiveness of the team and the organisation. In summary, the quality of our annual report is determined by its ability to effectively communicate the organisation's performance, challenges, and future direction in a clear, transparent, and strategic manner.

5 Resources

Capacity within the team has been an ongoing issue over the past few years, this is due to staff turnover, staff mental well-being and a whole service review for the CLA team. This has now been resolved and with new funding from the ICB, recruitment to 4.5 new posts is ongoing. We were also successful in recruiting a clinical psychologist to the support the team's mental well-being. We have been able to maintain the service over the past year, however the CLA and adult team have been on business continuity, but we maintained the service by staff across the whole of safeguarding being flexible and supporting each other across the whole team.

6 Risk and assurance

In LCH, safeguarding, risk management and assurance are paramount to protecting vulnerable individuals and upholding the highest standards of care. We employ a rigorous risk assessment process to identify potential safeguarding concerns, allowing us to take proactive measures to prevent harm. This includes regular training for staff to recognise signs of abuse and neglect, clear reporting pathways, and robust

procedures for managing incidents. Our assurance framework involves continuous monitoring, internal audits, and external evaluations to verify that safeguarding policies and practices are effective and compliant with legal requirements. These processes ensure that we maintain a safe environment for all individuals under our care and provide confidence to stakeholders that safeguarding is a top priority in our organisation.

7 Equity

LCH actively works to ensure that all individuals, regardless of race, gender, socioeconomic status, or other characteristics, have equal access to opportunities, resources, and support. This commitment is reflected in LCH recruitment practices, where we strive to build a diverse workforce that mirrors the communities we serve. We endeavour to ensure that our staff are equipped to deliver services that respect and meet the unique needs of every individual. Through these efforts, we aim to create an environment where everyone feels valued, respected, and empowered to thrive."

8 Next steps

To conclude this year's report, it is important to reflect on a period marked by significant achievements, notable challenges, and profound growth in our health safeguarding efforts. Our commitment to protecting and promoting the well-being of vulnerable populations has driven numerous initiatives, improvements, and collaborations that underscore our dedication to excellence in safeguarding practices. As we look ahead, the next steps in our safeguarding journey will focus on building upon the foundations laid this year. We will strengthen partnerships with key stakeholders, fostering a collaborative approach to safeguarding that leverages shared expertise and resources. Finally, we will commit to ensuring that our safeguarding efforts are inclusive, accessible, and responsive to the needs of all vulnerable populations. These next steps will be essential in maintaining momentum and achieving our long-term safeguarding goals.

9 Recommendations

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

Safeguarding - combined Annual Report 2024/25

31/07/2024

Safeguarding - combined Annual Report 2024/25

Authors:

Head of Service, Safeguarding Adults, Children, Children Looked After (CLA) and Care Leavers – Lynne Chambers
Safeguarding Adults – Grace Stewart-Hanson (now left the organisation)
Prevent – Sharon Thomas
Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Dementia – Rachel Watkins
Safeguarding Children – Wendy Brown
Specialist Child Protection Medical Services – Dr Anna Gregory
Sudden Unexpected Death in Infancy and Childhood (SUDIC) – Debbie Reilly – Julie Wilson
Children Looked After and Care Leavers – Angela Dillon
Learning Disability – Lisa Smith

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Introduction and Executive Summary
Leeds Community Healthcare NHS Trust (LCH) places high priority on the safety of all children and adults at risk who are or whose parents or carers are in receipt of services. The Safeguarding Team ensure LCH meets its statutory requirements outlined in Working Together 2018, The Care Act 2014 and the Mental Capacity Act 2005. Partnership working in health safeguarding is often referred to as the "golden thread" because it runs through and connects all aspects of safeguarding practice. Effective partnerships are crucial in creating a comprehensive, coordinated approach to safeguarding vulnerable individuals.

The purpose of this suite of reports is to provide LCH Quality Committee and LCH Board with a brief overview of the Safeguarding achievements and challenges in 2023 – 2024 and outline key ambitions for 2024-25.

Team Structure
The Safeguarding Team based at White Rose Park, provides both corporate and operational functions and sits within the Quality and Professional Development directorate delivering safeguarding advice, guidance, support, supervision and training for all LCH employees.

The team consists of Named nurses and Named Professionals, and a Designated Nurse (Children Looked After CLA)

also, Doctors and Nurses, Safeguarding Advisors and Specialist Practitioners with responsibility for:

- Safeguarding Adults
- Mental Capacity, Deprivation of Liberty Safeguards and Dementia
- Prevent
- Safeguarding Children
- Specialist Child Protection Medical Services
- Sudden Unexpected Death in Infancy and Childhood
- Children Looked After and Care Leavers
- Learning Disabilities
- Clinical psychologist

Governance Arrangements
LCH Safeguarding strategy is due for review July 2024, once completed, bi-annual up-dates on the current strategy are submitted twice a year to the Quality Committee who also receive the minutes of our bi-monthly safeguarding committee after each meeting including any escalations. In addition, outcomes from safeguarding committee are shared with the Integrated Care Board (ICB) who, are core members of the group, and this is followed by an assurance meeting with the HoS for safeguarding and the Designated Nurse for adults and Children at the ICB. We also have membership of the Children's and Adults Advisory groups and with Leeds Safeguarding Children Partnership (LSCP) and Leeds Safeguarding Adults Board (LSAB) and are subscribed to the relevant sub-groups.

Safeguarding priorities are set down in an annual work plan which is reviewed bi-monthly and shared via the Safeguarding Committee.

The Safeguarding Team is continually learning, improving, and disseminating best practice. Through our contributions to Leeds Safeguarding Partnership (LSCP) practice audits, the continuous cycle of preparation for Ofsted Joint Targeted Area Inspection (JTAI) and Care Quality Commission (CQC), as well as through collaboration with agencies in the Leeds Safeguarding Children Partnership, Leeds Safeguarding Adults Board and Safer Stronger Communities (previously known as Safer Leeds), we have scrutinised, analysed and identified practice learning points as we strive to ensure the people of Leeds receive the best possible care.

A further layer of safeguarding assurance is provided through a series of yearly audits, section 11 audit for LSCP, self-assessment to the LSAB and a Safeguarding Annual Declaration to the ICB
Key achievements are set out at the head of each report.

Safeguarding Adults

Key achievements 2023-2024:

- Production and successful launch of a Safeguarding newsletter.
- Raising awareness of the use of the Routine Enquiry for domestic abuse template on the electronic record system.
- Raised awareness for the use and value of Professional curiosity.
- Positive partnership working with Leeds Safeguarding Adult Board contributing to the Multi-agency Practice Audit.
- Participation in national and local safeguarding campaigns.
- Continued facilitation and embedding of the Safeguarding supervision training within LCH.
- Positive partnership working alongside the LSAB and partners to embed the self-neglect strategy.
- Successful launch of the Level 3 refresher safeguarding training package.
- Integration of Wharfedale rehabilitation unit.
- Introduction of the new Safeguarding Team backdrop for MS Teams.
- Created links with West Yorkshire Police Safeguarding unit, processes in place for requesting information.
- Created links with probation service.
- Attendance at the non-fatal strangulation working group.

Key ambitions 2024-2025:

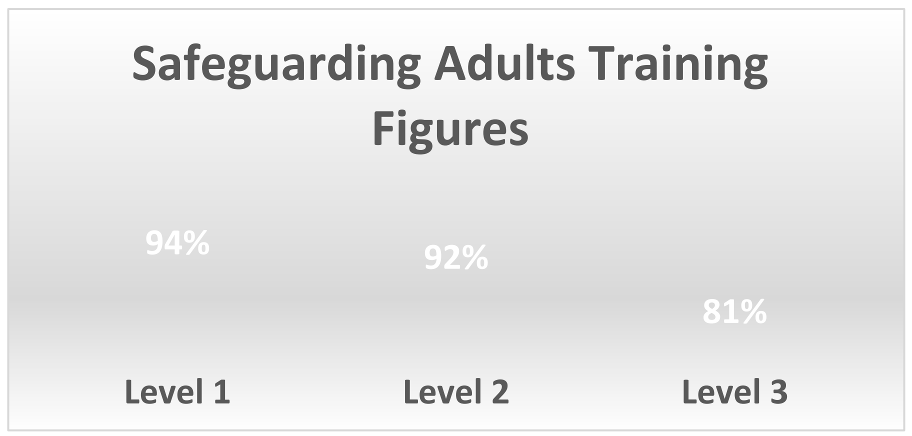
- Working towards the addition of an electronic SA1 safeguarding referral form for S1.
- Raise further awareness of the Exceptional Risk Forum for self-neglect.
- Undertake Audit(s) for example The use of the Routine Enquiry template on the electronic record system.
- Partnership working to review Domestic Violence and Abuse responses across the city via the use of the DASH Risk Assessment in response to recent law changes regarding Non-Fatal Strangulation.
- Continuation of Safeguarding Supervision training for senior adult practitioners across LCH.
- Partnership working to review the communication with the Public Protection Unit.
- Ongoing work to support staff to manage cases of self-neglect.
- Continued partnership working with the Leeds Safeguarding Adult Board and the Leeds Health Economy.
- Participate and increase awareness for staff across the trust via 60-minute updates.

A key priority for LCH is to raise awareness and empower staff to recognise the signs and symptoms of abuse. The aim is for all staff to feel informed and confident to access the team for support and advice. The Safeguarding Adults Team does this by continuing to provide advice, training, and support to staff, in line with our statutory duties. The main form of contact with the safeguarding team is through telephone contact. Calls are received into the team from staff across the Trust. The staff within the safeguarding team respond to these and share a plethora of advice/recommendations. Audit of the calls can provide thematic data which can be used to target. Awareness raising/training or/and support.

We recognise that there are many different platforms for learning and always incorporate different techniques to help facilitate learning, there are also many different aspects of safeguarding.

Training

The team prioritised and worked hard to create and facilitate the introduction of the refresher Level 3 Safeguarding Training as per Adult Safeguarding: Roles and Competencies for Health Care Staff | Royal College of Nursing (rcn.org.uk). The team are continuously reviewing and developing training packages in line with the changing horizon of safeguarding in Leeds and Nationwide. Despite the pressures of staff capacity, Safeguarding is prioritised within LCH, and compliance currently sits (as of March 2024) at 82% with an aim to achieve over 85% by the end of Q4 this year.



Safeguarding Supervision Training
Safeguarding supervision training is not mandatory but deemed crucial to help staff to reflect, process and understand their role in safeguarding patients.

It allows an opportunity to:

- Discuss individual cases.
- Reflect, review, and change practice if needed.
- Identify areas of good practice.
- Identify gaps in learning.

Leeds Community Healthcare recognises the importance of this and continues to facilitate training to clinical managers within the trust as per LCH strategy 2023/26. Safeguarding supervision is also available for any specialist unit for example Continence, Urology, and Colorectal Service (CUCS). To date we have managed to train 74 senior staff members.

Examples of Campaigns facilitated by safeguarding and involving partnership working across Leeds.

16 days of action campaign to end violence against women/white ribbon campaign.

Safeguarding week in Leeds is held in June each year and gives the health economy and partners the opportunity to highlight and raise awareness of Safeguarding by offering additional opportunities for staff learning on current safeguarding issues. Last year sessions were facilitated in person, virtually and by use of social media platforms.

Multi-agency working is a crucial element of safeguarding, and the safeguarding team works in partnership within the health economy and with colleagues in other provider organisations, Adult Social Care, West Yorkshire Police, and voluntary and private sector organisations to safeguard and protect the people of Leeds. Multi-agency working in safeguarding is a key benefit that can dramatically reduce the risk of abuse, by enabling different services to join forces to prevent problems occurring in the first place.

The key principles of multi-agency working are the commitment to hold each other to account, to understand interlinking risks and needs from all perspectives, and to take collective responsibility to help and protect all involved. Multi-agency working is evident with our involvement in the Multi-agency Practice Audit. This is led by the Leeds Safeguarding Adult Board and the current and ongoing theme is **Self-neglect.** This theme links in with our inter-agency Policy and Procedure and is a subject the team continue to be passionate about.

Inter-agency Policy and Procedure
In response to lessons learned from previous and current Safeguarding Adult Reviews (SAR) we continue to raise awareness and focus on self-neglect. Self-neglect is a complex subject which frequently requires a multi-agency response.

The LSAB board members (including LCH) worked with developed a city wide, self-neglect policy LSAB Self neglect policy (v1).pdf (leedssafeguardingadults.org.uk) and a self-neglect strategy Leeds Self-neglect Strategy (leedssafeguardingadults.org.uk) .

The Leeds Safeguarding Adults Board self-neglect strategy is based around four core pillars:

- People
- Prevention
- Partnership
- Practice

These four P's build upon the learning from citizens, practitioners, services, and our Safeguarding Adult Reviews in Leeds and reflect the areas of development that need to be taken forward across the city.

The Exceptional Risk Forum (ERF) continues to take place having been established by the Leeds Safeguarding Adults Board in recognition that sometimes, despite the best efforts of agencies, an exceptional risk to their safety can remain. The LSAB Exceptional Risk Forum can offer agencies with a fresh perspective and multi-agency advice and recommendations as to how that person's risk could be reduced, LSAB (2021).
LSAB Exceptional Risk Forum (leedssafeguardingadults.org.uk) link to guidance, checklist, and referral forms.

LCH staff are encouraged to use the referral checklist as an aide memoire to support them when managing complex cases of self-neglect in the community. This assures and reminds staff of all expected actions prior to referral to ERF and often solves issues before it gets to that critical point. The ERF panel has a core membership of Health, Social Care, Housing and Forward Leeds with the option of co-opting in any other agencies deemed relevant e.g., West Yorkshire Fire Service, Police, Yorkshire Ambulance service etc. LCH are a core member of this group.

The Care and Support Statutory Guidance (March 2020) states that self-neglect is a form of abuse and neglect. It defines self-neglect as: “a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding” (Section 14.17).

This may include people, either with or without mental capacity, who demonstrate:
- Lack of self-care (neglect of personal hygiene, nutrition, hydration and/health, thereby endangering their safety and wellbeing)
- Lack of care of one’s environment (squalor and hoarding)
- Refusal of services that would mitigate the risk of harm.

Leeds Community Healthcare previously gained an overall opinion of High Assurance following an external audit relation to the controls in place to manage and support our patients who self-neglect and continue to work to maintain this assurance.

The Domestic Violence/Abuse agenda continues to be a priority area for Safeguarding and the Trust. The team have continued to work hard to fulfil the requirements to maintain the Domestic Violence Quality Mark previously awarded by Safer Stronger Communities. We continue to build on this achievement with the use of the routine enquiry template embedded within our electronic record system. The use of which will be reviewed by audit this coming year.

LCH continues to be an open and reflective contributor to Domestic Abuse Related Death reviews (DARD) (previously known as - Domestic Homicide Reviews (DHR) and Safeguarding Adults Reviews (SAR) where required. Both processes allow for analysis of findings from investigations carried out by individual agencies involved in the case, to make recommendations for improving future practice where this is necessary.

88% of high-risk victims-survivors experience multiple forms of abuse, including physical and sexual abuse, harassment and stalking and jealous and controlling behaviours. (Safe lives)

88%

7

women a month are killed by a current or former partner in England and Wales (March 2015 Crime Survey for England and Wales)

Domestic Violence/Abuse Champions

Safeguarding champions act as ambassadors for safeguarding in LCH, imparting their enhanced safeguarding knowledge to their teams’, ensuring safeguarding is on the agenda at team meetings, managing a safeguarding information board, and encouraging staff to maintain alertness to safeguarding in all that we do. Safeguarding Adult champions can be any band, and any speciality (including children’s services)

The Safeguarding team continues to engage virtually and face to face with LCH Adult Safeguarding Champions; this is set to reach a wider audience supporting staff to learn by sharing identified cases, receiving bespoke training, and developing their knowledge and understanding of the wider safeguarding strategy and agenda. Champions feedback included that they value the meetings, gain a greater understanding of safeguarding issues, themes, and trends, and feel more confident sharing learning to colleagues in their own teams.

PREVENT

Key achievements 2023-24:
- Monitored and encouraged training uptake.
- Maintained up-to-date information and resources on LCH dedicated webpage for Prevent.
- Provided regular updates to staff via briefings and newsletters.
- Supported LCH to deliver on our Prevent Duty
- Maintained strong multi-agency relationships including contribution to the Channel Panel.
- Continued to raise the Prevent agenda across the organisation.

Key ambitions 2024-25

- Continue to raise the profile of Prevent.
- Maintain up-to-date information and resources on our dedicated Prevent intranet page.
- Support the organisation to be compliant with our Prevent Duty.
- Work alongside other health agencies in Leeds to ensure staff are kept updated and there is a forum for Prevent leads to share concerns and learn from practice.
- Explore the potential of having Prevent champions across the organisation.
- Continue to share the Local Authority Prevent newsletter with LCH staff to support clarity and uniformity messaging in relation to the Prevent agenda.

Prevent is one strand of the Government's counter terrorism strategy known as CONTEST. The Prevent strategy aims to stop people becoming terrorists or supporting terrorism. Prevent addresses all forms of terrorism but prioritises these according to the threat they pose to our national security. Prevent is delivered in partnership by a wide range of organisations including LCH. Together we recognise that the best long-term solution to preventing terrorism is to stop people been drawn into terrorist behaviour in the first place. The objectives of the Government's Prevent strategy are to:

- Tackle the causes of radicalisation and respond to the ideological challenge of terrorism.
- Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support.
- Enable those who have already engaged in terrorism to disengage and rehabilitate.
- Safeguarding vulnerable people who may be at risk of being drawn into terrorism is an essential part of the Prevent Strategy. Terrorism is a real and serious threat to us all because terrorists actively seek to harm us, to damage community relations and to undermine the values we share. Throughout the country there is a requirement for Prevent local action plans, to be in place to support vulnerable individuals underpinned by a robust training package.
- Health has a key role to play. Partnership involvement ensures that those at risk have access to a wide range of support, from mainstream services, through to specialist mentoring or faith guidance and wider diversionary activities.
- A joined-up approach, motivation, and commitment to drive standards forward have resulted in achieving and maintaining our training compliance levels; this is a testimony to staff /services' resilience and commitment.
- The e-learning resource is available for all staff members; meeting the WRAP (Workshop to Raise Awareness of Prevent) training requirement for level three practitioners and counts toward the intercollegiate safeguarding competence / training requirements.
- Regular meetings continue to take place across the health economy, where a shared learning approach and response is being explored. This ensures continuity and reassurance around matters such as advice, consent, confidentiality, and documentation as well as support around each other's organisational practice.
- LCH continues to support a dedicated staff intranet Prevent page, with access links to training, information, resources and contact details for concerns. Resources are regularly shared across the health economy to be used for staff dissemination.
- It is also important to note that prevent, remains a legal duty and all NHS Trusts continue to be contractually obliged to collate and provide performance data; this is reviewed regionally before scrutiny by the National Safeguarding Steering Group.

Local Overview

- The national safeguarding website www.actearly.uk, continues to encourage family and friends to act early, share concerns and seek help if they are worried that a loved one is being radicalised. The website includes case studies, signs to spot, FAQs and details of the national advice line staffed by trained Prevent officers.

- The site also provides toolkits for staff and partners to access a range of support materials, from templates to posters to business cards and tweets. https://www.counterterrorism.police.uk/actearlypartners/
- Throughout the last year, prevent concerns have continued to be addressed; regular monthly Channel Panels have continued via Teams; and a new Hybrid approach has been adopted allowing staff to meet face to face or via MS Teams. The prevent team/police/chair and vice-chair continue to keep in close contact with any concerns across the city adapting practice as the prevent climate continues to shift in complexity and dynamics.
- National support for Channel and Prevent comes through the Channel Duty guidance providing a robust framework for building on much of the good work we know is already being delivered, whilst strengthening the quality and consistency of panels and the practice of panel members across England and Wales. This enables us all to manage the vulnerability of individuals at risk of being drawn into terrorism more effectively. The long awaited Prevent duty guidance has now been refreshed and updated to reflect several recommendations of the Independent Review of Prevent. This includes, updated language and terminology, and a refocus on tackling the ideological causes of terrorism.

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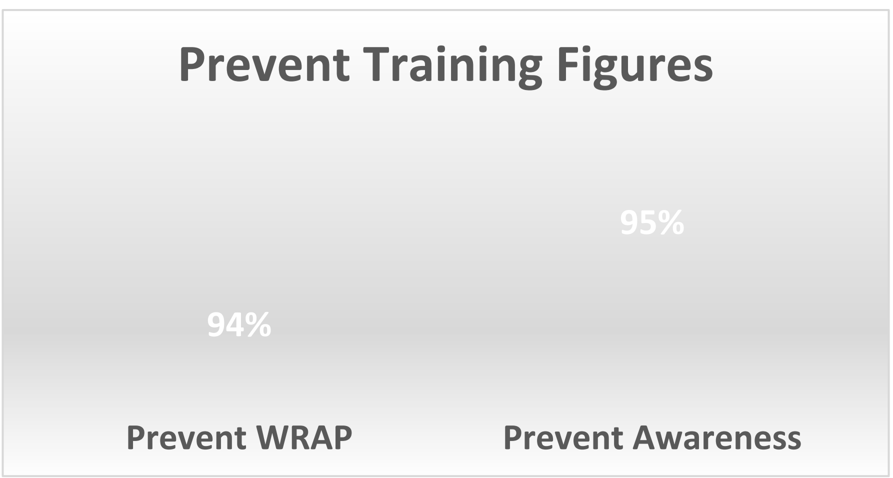

We acknowledge that face-face training generates a conversation and would be the gold-standard in an ideal world. However, within the current climate and risks around extremism, we felt we needed to reach out to all staff, regardless of roles and responsibilities. The e-learning resource is available for all staff members; meeting the WRAP (Workshop to Raise Awareness of Prevent) training requirement for level three practitioners and counts toward the intercollegiate safeguarding competence / training requirements.

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Leeds Prevent Referrals
Referrals into the Prevent local authority and Police team come from many areas, schools, colleges, universities, healthcare professionals, social care members of the public, family members, the police themselves. The Local Authority Prevent team continue to support organisations/schools/educational settings with Prevent training and guidance.

LCH staff remain engaging and vigilant when assessing concerns and are contacting the team for discussions around potential Prevent issues. However, we mustn't become complacent, but ensure we remain professional and always work within our remit of roles and responsibilities and are constantly developing and evolving, to ensure we offer the best experience of channel/prevent for clients/families and people who come through our services.

Leeds local Issues
The demographic of Leeds provides us all with lots of challenges within our practice and daily life, many communities now find themselves within a national if not global financial crisis, touching, not just our deprived areas of Leeds, but working families also, which may lead to an increase in people's susceptibility to being exploited and radicalised. The online space continues to be a focal point for those out to exploit people's vulnerabilities with mis-informed information and ideologies.

The Extreme-right-wing groups in Leeds continue to cause concern feeding off people's anxieties and emotions within the current financial climate, offering mis-guided and ill-informed information and often, what appears help and support to people suffering; however, this always comes with a price and steps into the criminal space.

Vulnerabilities have more opportunity to be preyed upon, and those using the internet for work/school/pleasure maybe taken advantage of, also, there is an increased opportunity for people to self-radicalise in the home.

LCH Response
Safeguarding accessibility remains on full capacity, and we will continue to offer support and advice through a range of media platforms. LCH continues to have representation at Channel and Silver meetings, being an ideal platform for learning, reflection and ensuring that LCH continues to be compliant, effective, and efficient around the Channel Duty.

The PREVENT partners newsletter (from the local authority prevent team) continues to provide partners with a reflective, platform of information around prevent. Highlighting the shared approach to keeping the citizens of Leeds informed and as safe as possible.

Training for staff remains at a constant, which is really reassuring that we have that commitment from staff during these challenging times. Latest quarterly training figures report. **89%** level 3 uptake (B5 staff and above) **91%** level 2 uptake (B4 staff and below). Development of a resources page accessible for all staff is now active, information is available on the safeguarding adult's intranet page, covering a wide range of topics, including, Prevent, domestic violence, cuckooing, modern slavery, with further support available from the safeguarding team.

Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Dementia

Key Achievements 2023/24

- Welcomed new Mental Capacity Lead to the Safeguarding Team.
- Supported health audit of referrals to ASC from agencies across the health economy, where professional concerns relate to issues of self-neglect.
- LPS future ambitions 'delayed beyond the lifetime of this government'.
- Supported rehab unit at Wharfedale Recovery Hub with offer of further training and onsite support.

- Mental Capacity Assessments forms updated in line with correct sequencing of assessment case law.
- Easy Read MCA for Service Users, Families and Carers developed alongside learning disability project manager.
- One minute guide for patients/ citizens with dementia experiencing domestic abuse co-produced and delivered across the health economy.
- LCH staff have now attended the minimum training of dementia awareness enabling them to be a Dementia Friend.
- Facilitated a lunch and learn with the dementia and mental health practitioners for the neighbourhood teams to raise awareness of their roles and referral process.
- Hosted available session to all LCH staff on MCA with guest speaker solicitor Ben Troke.
- Bespoke advocacy session provided by Advonet to increase awareness of advocacy services available across the city.
- Lasting Power of Attorney (LPA) One Minute Guide (OMG) updated for Health and Welfare.
- Updated reporting system for Deprivation of Safeguards (DoLS) supporting the recording and communication of patients under the DoLS system.
- Supported staff in complex Best Interests meeting particularly from dental services.

Key Ambitions 2024-2025

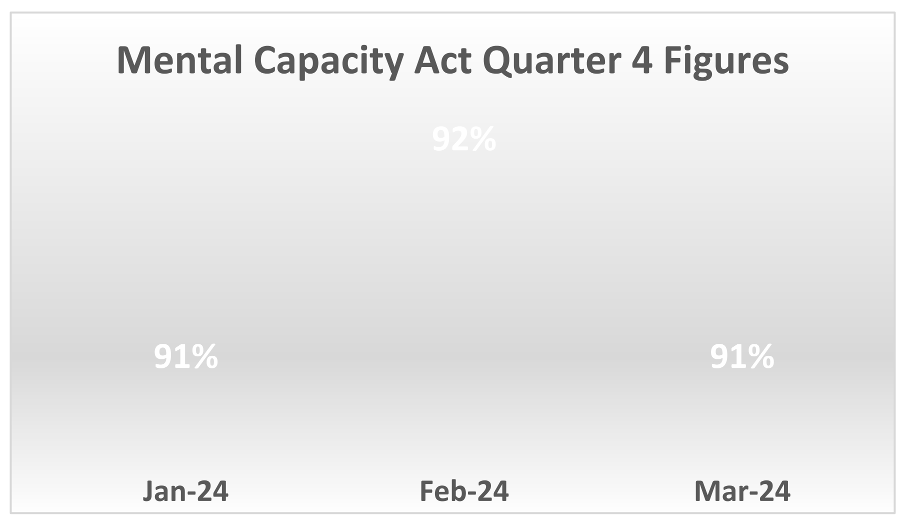
- Support movement towards community of practice following suggested changes from mental capacity local implementation network.
- System updates for MCA on System1.
- Exploring training development platform on Leeds Health and Care Academy with the rest of the health economy with potential to host MCA training resources.
- Mental Capacity Assessment and LD diabetes guidance for practitioners.
- To increase Dementia Training figures, package to be implemented and accessible via e-Learning.
- With Leeds Partnership re-development of the Dementia Pathway for screening and referrals.
- Key MCA/ Dementia topics for lunch and learns alongside 60 min updates imbedded within the safeguarding team.
- Continue to offer staff education/ support sessions for staff who care for family/ friends living with dementia.
- Review of MCA/Dementia Champion forums.

The Named Nurse for MCA/DoLS/Dementia left post in April 2023 and as her replacement the new Named Professional for MCA /DoLS/Dementia did not start post until September 2023. To provide additional support in the interim period our MCA/dementia trainer was contracted to support LCH staff further in this period.

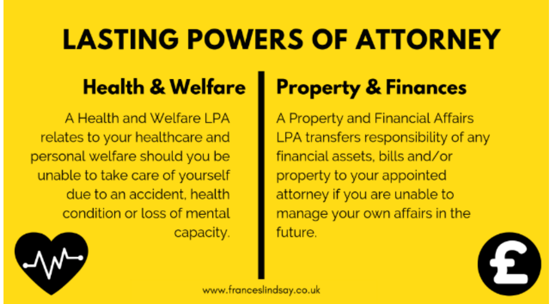
The Named Professional has remained actively involved in the health audit of referrals to Adult Social Care from agencies across the health economy, where professional concerns related to issues of self-neglect. Exploring further analysis of MCA and related safeguarding concerns within the self-neglect remit.

There had previously been focus with the trust managing Wharfedale Recovery hub where it was to become a ‘Responsible Body’ in the context of the MCA amendment bill: Liberty Protection Safeguards (LPS). However as of April 2023 the government stated that such would be delayed “beyond the lifetime of this parliament’.

Figures for MCA statutory training have continued to increase since beginning in post with an internal drive to promote the accessibility via the new acquired e-learning package which was implemented in January 2023. MCA training figures have continued to increase since December 2023 and at end year March they remained at 91%; above the expected requirement for stat/man training compliance.



There remains a drive to support Wharfedale Recovery Hub with MCA on a needs led basis, with training offers continuing to be made available to the service. Time was allocated to the unit to offer support to staff and patients to encourage a person-centred approach to the care and treatment for people living with dementia (PLWD) underpinned by the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Within this bespoke face to face training, role modelling and clinical supervision was made available to all staff on the unit. The 'This is me' document has been integrated into the Wharfedale Units clinical records. There has been a continued focus on updating supporting documents for staff and patients, with the update of Mental Capacity Assessments (MCA1 forms) to reflect the correct sequencing for mental capacity assessments, alongside that there has been an update of the 'Best interests decisions' form (MCA2). Working alongside the learning disability project manager easy read documents have been developed for MCA, as well as updated information on Lasting power of attorney (LPA) for health and welfare decisions.



The Named Professional has continued to support the dental service in 'best interest decisions' especially in cases that remain complex. We have seen the successful completion on a three-way court of protection application with our NHS colleagues at LTHT and LYPFT.; 'This was a considerable piece of work with 20 colleagues from LCH, LTHT and LYPFT who worked remarkably well together to ensure a range of procedures were completed together to ensure patient experience of feeling safe and accessing the care they needed at one time'. A bespoke training session was kindly made available to staff at LCH provided by specialist solicitor Ben Troke addressing areas of the MCA and DoLS. To develop stronger links with our advocacy service within Advonet and ensuring statutory requirements are adhered to when required for IMCA representation, a session was made available for staff to access, outlining the different advocacy roles available from statutory to non-statutory advocacy.

Dementia level 2 initial/ refresher training figures continue to remain below the expected requirement for stat/man training compliance with a yearly average of 68%, however at end year as of March 2024 training figures have increased over the last 3 months to 75%; this is because of a drive to increase attendance numbers by removing the cap of how many staff members could attend the allocated training sessions. It has been often reported that staff have had to cancel attendance due to a lack of capacity and the focus must always be on patient care. To further address the declining figures, we have agreed there needs to be a move to more availability of e-learning, given the success with MCA training. This is to support staff and allow the flexibility of training packages being available to access as and when, fitting around rapidly changing environments in community services. Moving forward the aim is to trial the implementation of e-learning with bespoke virtual trainings sessions on dementia topics being provided as lunch and learn sessions/ 60 min updates.

The Dementia steering group has been stepped down with reconsidering how Dementia is everyone's business. Following this the dementia work plan will now be implemented through each relevant work stream within LCH. We are currently working with our Leeds Dementia Partnership group regarding the redevelopment of the Dementia Screening and Referral Pathway and how that becomes more person centred across the city.

Everyone working in health and social care who make decisions for people who lack capacity has a legal responsibility to know and follow the Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk). LCH has a statutory duty to ensure we comply with the legislations on consent and MCA (2005), to ensure the care and treatment delivered is lawful and best practice. Effectiveness domain which looks for assurances in this area. The safeguarding team support the embedding of MCA (2005) into everyday clinical practices and ensures this can be evidenced for assurance purposes. Routine work that promotes best practice for MCA and dementia includes giving specialist MCA & dementia advice and guidance to staff, including the use of relevant legislations on consent and MCA (2005).

Through changes to the Mental Capacity Local Implementation Network, the Named Professional will continue to be part of the proposed new working group which will aim to focus on supporting a movement towards a community of practice. There will be continued focus on working with our dementia partnership on the development of the dementia screening and referral pathway.
To support a knowledge gap between MCA assessment and diabetes care and support for those with an identified learning disability an available support tool to support assessment will be made available for staff to assess mental capacity in this area. The Named professional will aim to bring dementia training availability in line with current availability of MCA training through our e-learning platform.

Key achievements 2023-2024:

- We explored work undertaken in previous years and completed audits to establish how effective and embedded in practice the previous work has become.
- We shared some audit outcomes with services so that collectively we can celebrate what is working well and where improvements could be made.
- We supported our Children Social Work Colleagues in undertaking multi agency audit.
- Safeguarding have maintained our statutory presence with strategy discussion requests from Children's Social Work Service (CSWS). We ensure accurate data collection regarding these discussions and share information across the health economy where relevant. We continue to work with CSWS and Police colleagues to achieve tripartite strategy discussions whenever possible.
- There has been significant demand on LCH practitioners for attendance at strategy discussion, see chart below depicting a steep trajectory year on year.

- We contributed to the city wide Joint Targeted Area Inspection (JTAI) around Serious Youth Violence (SYV). Working with LCH services and practitioners this was a demanding piece of work, undertaken in a short timeframe. https://www.gov.uk/government/publications/joint-targeted-area-inspections-of-the-multi-agency-response-to-serious-youth-violence/joint-targeted-area-inspections-of-the-multi-agency-response-to-serious-youth-violence

Nigel Thompson, Deputy Director Multiagency Operations at CQC:

"This important collaboration by the joint inspectorates will look closely at how agencies work together to prevent and respond to serious youth violence. These inspections will highlight good practice and identify where improvements can be made, to safeguard children and young people, and protect their communities."

- The safeguarding team continue to support various meetings in relation to preventing and reducing the growing concern around SYV and Gangs.

- We worked with LCH services and partner agencies to establish a united Early Help registration process within our current I.T system. Going forward we hope to enable this to capture and share data.
- We developed an LCH Level 3 children's safeguarding training package to accommodate the wide range of services within LCH. We also maintaining the use of the LSCP Level 3 training for some services as a gold standard of multi-agency working.
- We also developed a Non-Fatal Strangulation presentation highlighting this concerning issue.

- We contributed to and updated the successful launch of the Safeguarding newsletter.

Key ambitions for the children's safeguarding team 2024-2025:

- Continued response to practitioners calling for support/advice in a timely manner.
- Repeat and update audits undertaken where improvements have been identified.
- Review group work around Domestic Violence and Abuse within the trust and contribute to a training package for practitioners.
- Update the trust Quality Mark award, evidence, for Domestic Violence and Abuse.
- Update the Section 11 audit evidence for the trust.
- Continue to attend and contribute to Leeds Safeguarding Children Partnership subgroup meetings.
- Continued facilitation of learning from Child Safeguarding Practice Reviews and other safeguarding issues via 60-minute updates and directly with services where needed.
- Continue to embed learning within the trust

Who are we?	**What do we do?**
Named Nurse for Safeguarding children. (full time) Senior Specialist Safeguarding Nurse. (Part time) Three Specialist Safeguarding Nurses, one part time. One Nurse has a specific focus on the Front Door Safeguarding Hub.	We are a dedicated and experienced team who provide a trust wide service to all staff across LCH who manage safeguarding complexity and risk. We work within the guidance of Working Together to Safeguard Children (2023) to safeguard children, offer compassionate specialist guidance, advice, and direction to practitioners, escalating concerns where needed. We work closely with other parts of the health economy and multi-

	agency partners, participating in a variety of collaborative meetings and subgroups. Our work is underpinned by statutory responsibility, evidenced based practice, reflection, peer review and supervision which assists our learning & supports consistency in our decision making. Our team demonstrates resilience and is committed to supporting LCH and wider colleagues by adopting a positive approach that enables others.

LCH Children's safeguarding team continue to fulfil the daily commitment to LCH practitioners. There work is underpinned by Working Together to Safeguard Children which was updated in Dec 2023.

The team believe that safeguarding is everybody's business. As accountable practitioners we work hard to enable confidence and competency in LCH practitioners, who are valued and supported in all aspects of safeguarding work they do.

In efforts to support and raise awareness of current and ongoing Safeguarding messages the team facilitate briefing sessions, recently these sessions have included Trauma Informed Practice, Professional curiosity, Perplexing Presentation and Was Not Brought. They participate in National and Local Safeguarding Campaigns sharing messages and signposting practitioners to the Safeguarding My LCH page, external training & further information. We will often seek support from external speakers for some 60 min briefing sessions or to support our Champions meetings, such as Police colleagues to talk about the Police Information Portal (PIP) or Claires Law, or private speakers with expertise in identifying safeguarding risks of Hidden/Invisible/Unseen men. At times we have also had speakers with lived experience who offer a perspective that has huge impact.

Supervision is integral to the role and responsibility of the Children's team. We strongly believe it promotes staff resilience. Over 2023/24 we have continued to offer Child Protection (CP) Supervisor Training and we facilitate Child Protection Group supervision. We offer 1:1 supervision and Safeguarding Peer Supervision. In doing this work the safeguarding team are constantly listening to difficult and distressing information so it's important that there emotional wellbeing is recognised and that they are supported by good leadership. The trust has several resources we can access and have utilised. Going forward we will also have regular psychological support.

We audit our Safeguarding Peer Supervision sessions and below are some examples of the feedback given by practitioners.

- ***'I would like a clear model when offering supervision. This form doesn't apply to child protection doctors.'***
- ***'The LCH Safeguarding Team are wonderful'.***
- ***'We have a fantastic team who support with everything.'***
- ***'I find LCH Supervision is very good having had a very different experience previously.'***
- ***'I would like to add that the quick access to the LCH Safeguarding Nurses for advice and guidance is excellent.'***

This is a case example. It demonstrates how the Children's Safeguarding team supports work in practice, across several processes.

Case example

It is a statutory responsibility of all agencies to offer information in the event of an LSCP Rapid Review. The review involves exploration and analysis of information held by agencies regarding a child and family when a child has come to significant harm. This process supports the identification of learning and good practice.

When the Named Nurse for Safeguarding Children was undertaking an LCH record review of this nature, and despite the tragic events surrounding the issue in question it was excellent to establish how

LCH Safeguarding Children team had supported valuable decision making and promoted excellent multi agency working.

From the child's electronic patient record it was apparent that concerns had been raised regarding a man living with a woman due to have their baby. The LCH practitioner felt clear that this was a safeguarding issue however unsure how to manage the concerns raised from the information that had been shared with her. She contacted LCH Children's Safeguarding team and was directed and supported to Make a Claire's Law application, which she did.

Claires Law enables the police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending.

Anyone can make an application about an individual who is or was in an intimate relationship with another person, and where there is a concern that the individual may harm or have harmed another person. (West Yorkshire Police)

Domestic Violence Disclosure Scheme factsheet - GOV.UK (www.gov.uk)

Following the application for Claires Law being submitted, the LCH practitioner went on to liaise with mum's Midwife. The midwife had an appointment with mum and at that appointment, once establishing it was safe to speak to mum, she was able to share why a Claire's Law application had been requested by the allocated LCH Practitioner. Mum accepted that the request had been made to help inform her decision making. It also raised awareness of the practitioners supporting her enabling them to offer more support if needed. Mum shared that she felt safe and understood why practitioners might be concerned. The LCH practitioner also liaised with the Family Outreach Worker, who planned on-going support to mum.

The one call to LCH Safeguarding Children's team resulted in both mum and professionals being in a more informed place to safeguard mum and baby. The scenario demonstrates several practices that support safeguarding children. It demonstrates appropriate information sharing, appropriate use of LCH safeguarding children team, support, and appropriate guidance in seeking a Claire's Law application, appropriate consideration of the needs of an unborn child and potential vulnerabilities of mum. It demonstrates professional curiosity and multi-disciplinary working. It highlights domestic violence and abuse (DV&A) and considers impact of DV&A on the child; it reiterates the importance of information sharing where there is a need to safeguard. For me as Named Nurse this sequence of events overall demonstrates good safeguarding children practice and is something that is part of the daily duties within the children's safeguarding team in collaboration with LCH services.

Children Looked after and Care Leavers

Key achievements 2023-24:

- Review Health Needs Assessments (RHNA) delivery continues to meet Key Performance Indicators (KPI's) and National performance targets, with audit indicating high standard of health assessments. This is despite every service delivering RHNA's being under tremendous capacity pressure.
- Maintaining the delivery of training to those supporting Looked After Children at level three standard as per the Intercollegiate Document 2020.
- Looked after children and care leavers health needs are seen as a priority population in Leeds.

Key ambitions 2024-25

- To gain consensus that Leeds looked after children and care leavers can expect a similar level of healthcare and support offered in other places across WYICB, to ensure we can work effectively to begin to reduce the health inequalities they experience. To have the start of a transition plan to move towards this.
- To have developed and begun to deliver on a cohesive city-wide health plan for CLA care leavers that plans to deliver the CYP plan for Leeds, Leeds corporate parenting strategy 24-

27 and implement recommendations from "Understanding the health needs of children who are looked after in Leeds".

- To improve LCH's ability to provide the Initial Health Needs Assessment to inform the planning at the first childcare review, in line with statutory requirements.
- To work with our young people in care and care leavers to give them a voice and influence in health service provision.
- To ensure statutory training from level one to five, Intercollegiate Document 2020, is accessible for all staff needing this.
- To meet key targets for health for immunisations and SDQ's.
- To explore outcome-based service targets in addition to inputs and activity-based targets.
-

Areas for improvement:

- IHNA delivery continues to be on the Trusts and WYICB risk register as the delivery is not within statutory timelines.
- The impact of CLA capacity continues to be on the Trusts risk register. CLA Specialist Nursing Team Capacity will continue to be critical until team expansion is in place. Plans are in place to support the team until then.
- Identification of health needs and health outcomes for children placed in other authorities and in residential settings.
- SDQ completion for 11–17-year-olds and immunisation take up rates for the 13–17-year-old looked after children.

Future planning 2024-27

- There are discussions taking place between WYICB Leeds commissioners and public health commissioners regarding the future completion of RHNA's for 0–12-year-old looked after children living in Leeds. This could have implications for the Specialist Nurse CLA team case load and capacity needs.
- A service development document and options appraisal for the Looked After Children Specialist Nursing Team was completed March 23. Following this the CYP Population Board commissioned work to map out health service provision and need for the looked after children population in Leeds with a brief to deliver recommendations for improvement. This was completed and presented to the CYP Population Board in January 24. 20 recommendations were made. These have been prioritised and a plan is being developed for implementation.

Annual Report

This is the annual looked after children and care leavers report 2023-24 for Leeds Community Healthcare (LCH), covering the period form 1st June 2023 to 31st May 2024. It forms part of Leeds assurance arrangements in relation to services delivered to Leeds children placed in and out of Leeds and children placed in Leeds by other local authorities. It reflects the priorities set out in the Looked After Health Team Service Level Agreement, "A child of Leeds" Leeds Corporate Parenting Board Strategy 2021- 2024, and The Looked After Children and Care Leavers Health Improvement Plan. The primary objective is to ensure that all looked after children and Leeds care leavers are supported to improve their health outcomes.

Each child and young person will have a unique journey into care, the most common reason for becoming looked after is abuse or neglect (65%). These are major adverse childhood events (ACEs) which can cause trauma. Most children in care will have experienced a minimum of 4 ACE's, this is linked to significant health inequalities.

Leeds Looked After population:

The demographics of looked after children in Leeds has changed significantly over the past 6 years and is predicted to continue to change. As of 31/03/24, 1548 children where in care and looked after by Leeds Local Authority, an increase of 300 over the last 6 years. Additionally, there are 254 children placed in Leeds by other authorities.

1,238 CLA live in Leeds. Leeds City Council also place children and young people in other authorities; 564 live in other authorities with 141 of those being placed in external residential settings. These are

some of our most vulnerable children and young people, the majority meeting the criteria for complex care needs under continuing healthcare funding.

LCH Looked After Children Health offer.

LCH are commissioned to provide one WTE (whole time equivalent) Designated Nurse for looked after children and 0.2 WTE Designated Doctor. The Specialist CLA nursing team consists of one WTE Professional lead nurse and 4.9 Band 6 Specialist nurses. This team have responsibility for all looked after children living in Leeds who are in year 9 school year up until when they reach their 18th birthday or cease to be in care (or 19th if they have an EHCP (Education Health and Care Plan)). They are commissioned to see all children regardless of age who are living in the other WYICB places, for Review Health Needs Assessments (RHNA's) and to monitor/coordinate the delivery of their health plans. Additionally, they have responsibility for oversight of all looked after children placed beyond the WYICB area and should monitor/coordinate health plan delivery. They are also commissioned to provide as service to care leavers. The 0-19 team currently complete RHNA's for all looked after children from birth up until the end of school year 8 who live in Leeds and the Inclusion Nurses complete assessments for CLA attending SILCs (Specialist Inclusive Learning Centres). Integrated Children Additional Needs (ICAN) services are commissioned to carry out all Initial Health Needs Assessments (IHNA's).

Performance v targets

Table one showing performance against targets and key health indicators.

2023-2024

20.30% 37.80% 95.10% 56.60% 75.40% 87.60%
25.00% 28.00% 93.80% 54.70% 73.50% 84.80%
25.60% 31.30% 94.90% 56.50% 75.40% 90.30%
16.00% 21.00% 92.43% 56.40% 76.50% 89.10%

	Q1	Q2	Q3	Q4
IHNA within 20 days of entering care (statutory target)	20.30%	25.00%	25.60%	16.00%
IHNA within 20 days of notification (local KPI)	37.80%	28.00%	31.30%	21.00%
RHNA within statutory timeframe (rolling annual %) KPI target 90%	95.10%	93.80%	94.90%	92.43%
SDQ completion (rolling annual %)	56.60%	54.70%	56.50%	56.40%
Immunisations up to date (rolling annual %) National target 85%	75.40%	73.50%	75.40%	76.50%
Up to date dental check (rolling annual %)	87.60%	84.80%	90.30%	89.10%

- The completion of IHNA's in a timely manner to meet either statutory or local KPI targets continues to be a challenge. Considerable effort has been invested in systems working to improve timely requests for IHNA's, this work is ongoing. WYICB Leeds is to provide cost pressure monies to support extra clinics to reduce the backlog of appointments.

- The completion of RHNA's remains high across Inclusion Nursing, PHIN's and the Specialist Nursing team for CLA. This work has been prioritised by the Specialist Nursing team, and only statutory work has been completed over the past year. This is in line with risk assessment analysis and Business Continuity Plans for the team.

- The Strength and Difficulty Questionnaire (SDQ) is an evidence-based tool used to assess children and young people's emotional and mental health. National guidance is that all looked after children and young people over the age of 4 have SDQ assessments, which should inform the health assessment. Nurses completing RHNAs are required to facilitate the completion of SDQ for all looked after children between the ages of 11 and 16. In quarter one 56.6% were completed, this fell slightly in quarter four to 56.4%.

- LCH has a target of 85% of looked after children's immunisations being up to date, which is in line with the national schedule. 75.5% were fully immunised in Quarter one 2023 and 76.5% in quarter 4, showing little change. When we look at different cohorts, 91.8% of under fours, 83% of 5–12-year-olds and 67.8% of 13 -17-year-olds had up to date immunisations at the end of quarter 4.
- In quarter one 87.6% of children had an up-to-date dental check (a check in the last 12 months) this increased to 89.1% in quarter four. When we look at different cohorts, 98.6% of under fours, 90.4% of 5–12-year-olds and 80% of young people aged 13-18 had an up-to-date dental check at the end of quarter four.
- The percentage of children and young people having met key health indicators are lower for the 13 plus population, which is reflective of the capacity issues the Specialist Nurses CLA have been facing. The commitment to fund extra capacity for this team will ensure this can change in the future.

Quality Assurance.
Two new audits were conducted over the past year, focussing on children placed in other authorities, as this is an area of concern recognised nationally and locally.

- Audit of timely record reviews 23, which highlighted that reviews were not being consistently reviewed.
- In depth complex case, multi-agency audit February 24, which gave clear indication of improvements needed to meet the needs of these children and young people.
- Monthly reports are produced showing performance against Key Performance Indicators.
- Health Needs Assessments (HNA's) completed out of area are audited for quality against national standards.
- HNA's completed by LCH practitioners are audited every 2 months, with all services audited at least Once a year. This allows any issues around slip in standards to be addressed quickly. Individual practitioners are given feedback for exemplary HNA's and when the standard needs to be improved. If there is a broader issue within a service, training updates are offered, and the service is re audited in the coming months.

These reports and audits tend to measure inputs and not outcomes for children and young people. The Multi Agency audit of children with complex needs highlighted that we need to improve outcomes to meet the health needs of this cohort.

Foetal Alcohol Spectrum Disorder (FASD)
Last year's annual report highlighted the higher incidence of FASD in the Looked after children population and the need to develop improved diagnostic and support services in Leeds. Work is currently being undertaken by the SEND Board to examine how the Neuro diversity Pathway can be improved, which includes exploration of provision for FASD.

Unaccompanied Asylum-Seeking Children (UASC's)
Leeds continues to be a welcoming host for unaccompanied asylum-seeking children There has been a significant increase in the numbers coming to Leeds in the last 12 months, in line with Home Office revised guidance. There are no extra monies for health, consequently health care must be sourced from current resources.

Care Leavers
As of 31/3/24, Leeds Children's social care services offer support to 690 care leavers, 38 of whom have a recognised disability, 69 are parents and 205 are former UASC's.
The Care Leaver Hub at Archway, Roundhay Road, Leeds was delayed in opening, but began offering care leaver services from the beginning of March 2023. This Hub offers support to Carer Leavers 18-25. There is a creche for children, cooking and washing facilities and leisure activities where young people can connect with others. There is a recording studio and pool tables and therapeutic quiet rooms which care leavers can utilise. There has been a great deal of discussion about health's offer to this project, which can be revisited considering the proposed increase in capacity to the service.
Discussions are underway to explore a care leaver offer from maternity services, consulting with care leavers to ensure coproduction.

Consideration across Leeds health system is needed to explore what Care Leaver protected status means to health.

SUDIC (Sudden Unexpected Death in Childhood)

Key achievements 2023-24: • Maintained and facilitated the SUDIC process in Leeds to a high standard. • Stabilised the team following periods of long-term absence and staff changes. • Continually reviewed systems and processes to support practice. • Accessed the online, basic training modules developed as a national training programme • Delivered with West Yorkshire Police (WYP) partners a biannual SUDIC training event to support professional development. • Led with WYP partners, the sharing and standardising of regional SUDIC practice via the Child Death Peer Network (this has replaced the SUDIC Strategic Reference Group). • Attended national Child Death professional network meeting to share and learn from practice across the country • Developed a new SystmOne SUDIC template to better support CDOP data collection. • Established a relationship with Child Bereavement UK in relation to the family support they can offer following a SUDIC
Key ambitions 2024-25: • Maintain the high standards of service delivery achieved in previous years and continue to develop practice. • With WYP partners, continue to deliver biannual professional development events to support practice development. • Continue to develop and expand the regional Child Death Peer Network • Team members will access regular psychological support to assist with maintenance of mental wellbeing. • Identify additional medical cover to support maintain SUDIC service delivery throughout the year. • Develop and embed partnership working with CBUK to ensure families are supported and guided through the bereavement stress and trauma which accompany the sudden or unexpected death of a child.

This report provides a summary of the activity of the Leeds Community Healthcare NHS Trust (LCH) Sudden Unexpected Death in Childhood (SUDIC) Rapid Response Team for the period April 2023 – March 2024.

'The death of a child is a devastating loss that profoundly affects all those involved. The process of systematically reviewing the deaths of children is grounded in respect for the rights of children and their families, with the intention of learning what happened and why, and preventing future child deaths'.
Working together to safeguard children - GOV.UK (www.gov.uk) chapter 6.

Working Together to Safeguard Children (2023) sets out the framework within which the statutory child death review partners (i.e. the Local Authority and the Integrated Care Board) arrange to review the deaths of children. The immediate response to an unexpected child death, the Joint Agency Response (JAR) is facilitated by a multi-agency partnership under the aegis of Leeds Local Safeguarding Children Partnership (LSCP). The LCH SUDIC Team is responsible for facilitating the statutory JAR, also known as the SUDIC Process, when the death of a child, (under the age of 18 years) normally resident in Leeds occurs that:

• is or could be due to external causes
• is sudden and there is no immediately apparent cause (including sudden unexpected death in infancy or childhood)
• occurs where the initial circumstances raise any suspicions that the death may not have been natural
• occurs in the case of a stillbirth where no healthcare professional was in attendance

Following the Royal College of Paediatric Child Health, Sudden and Unexpected Death in Infancy and Childhood: multi-agency guidelines for care and investigation (2016*)* the LCH SUDIC team work together with the relevant agencies to respond to child deaths in a thorough, sensitive and supportive manner.

The objectives are to:

• *establish, as far as is possible, the cause of the child's death*
• *identify any modifiable contributory factors*
• *ensure the provision of ongoing appropriate support to the family*
• *learn lessons to reduce the risk of future child deaths and promote the health, safety and wellbeing of other children*
• *ensure that all statutory obligations are met*

LCH SUDIC team consists of medical, nursing and administrative staff who are responsible for the co-ordination of the SUDIC process for the city. The team is also supported by LCH Child Safeguarding colleagues when required. Reports on the circumstance of the child's death are provided by the team to His Majesty's Coroner and Leeds LSCP Child Death Overview Panel (CDOP). SUDIC activity is reported into the LCH Child Death Review Group and LCH Performance Monitoring who further report to the West Yorkshire Integrated Care Board (ICB).

SUDIC Activity: Between April 2022 to March 2023 there were 31 deaths of children normally resident in Leeds which met the SUDIC criteria. Some comparative data is set out in the tables below:

Table 1

	Under 1yr	Under 5s	5-12	Teenage	Number
2021/22	5	2	2	3	12
2022/23	10	7	5	9	31
2023/24	6	5	2	4	17
Total	21	14	9	16	60

Table 2

	Male	Female	Number
2021-22	8	4	12
2022-23	19	12	31
2023-24	10	7	17
Total	37	23	60

Thankfully, the number or sudden or unexplained deaths of children in Leeds remains a small subset of the child population; with children under 1year tending to be the most vulnerable and boys being more susceptible than girls. No single cause of death predominates, but road traffic collisions and unsafe sleeping arrangements are recurrent themes.

The number of SUDIC cases in 2022-23 (31) is anomalous, though anecdotally in keeping with the experience of other areas regionally and nationally. Speculative attributions have been made to increased deaths from infection e.g. invasive group A streptococcus, following emergence from Covid-19 "lockdown" periods, but scientific data or research is yet unavailable to account for that tragic surge.

The SUDIC process has been completed for 9 children who died during 2023-24. Post-mortem reports, Final Meetings or Child Death Overview Panel (CDOP) meetings remain outstanding for the other 8 children.

SUDIC team visits to the scene and the child's family
Integral to the Joint Agency Response are the visits made by the SUDIC team to the scene of the child's final collapse and/or death (if it occurred out of hospital) and to the family to obtain as much detail from them as possible. The visit to the family is also an opportunity to assess for any immediate support needs of the family and to explain our roles in finding out, if possible, more about why their child died.

Where appropriate, home or scene of death visits were carried out by the team for all the children who died during 2023-24. Ideally these occur within 24-48 hours of the child's death; this is not always achievable due to the work pattern of the SUDIC team (Monday – Friday, 08:30 – 17:00), the need to be guided by any police investigative parameters and the wishes of the child's parents.

The response timeframe for the visits carried out is set out below:

SUDIC Visits to Family 2023-24				
24-48 hours	**48-72 hours**	**over 72 hours**	**No visit**	**Total**
5	5	3	4	**31**

Initial SUDIC Meetings & 28 Day Reports
The initial meeting seeks to establish the circumstances of and, if possible, the reasons for the child's death, consider the immediate needs of all family members, and contribute to the identification of any learning about how best to safeguard and promote children's welfare in the future.

Initial multi-agency meetings were held for all 17 of the Leeds childhood unexpected deaths occurring during 2023-24. This is consistent with performance over the preceding two years.

During 2023-24, 28 Day Reports to HM Coroner have been provided by the SUDIC Consultant for 17 of the deceased children.

SUDIC Final Case Discussion Meetings & Final Reports
Final meetings have been held for 10 of the 17 children who died during the 2023-24 period and reports have been provided to HM Coroner and the Child Death Overview Panel (CDOP).
The SUDIC Team are awaiting the Post-mortem Reports for 7 of the children who died during 2023-23. Final Case Discussion meetings will be convened once the PM Reports are available.

Governance
The SUDIC Team are members of the Leeds Safeguarding Children Partnership Child Death Overview Panel (CDOP) which is a statutory group.

The responsibility of CDOP is to review information in relation to the deaths of all Leeds children. The CDOP review seeks to establish whether any modifiable factors were identified in relation to the child's death and to make recommendations accordingly. Following review, a summary of information is submitted to the National Children's Mortality Database by the CDOP Administrator.

The LCH SUDIC Team is responsible for providing the SUDIC reports for each child to the Leeds CDOP and ensuring that any relevant recommendations made by the panel are fed back to LCH Child Death Review Group.

LCH Child Death Review Group
The SUDIC Team are members of the LCH Child Death Review Group.
All SUDIC deaths are reported into the LCH Child Death Review Group along with the expected deaths of children under the care of LCH services.

The deaths are reviewed with the aim of ensuring that a critical appraisal of LCH input is carried out and where necessary, action is taken, and lessons learned. CDOP recommendations relevant to LCH services are communicated through this group.

Information from this group is reported to the LCH Mortality Review Group which provides assurance to the LCH Trust Board.

Process & Performance: The work of the SUDIC Team is reported into LCH Performance systems and to the ICB monthly. Actions related to SUDIC processes are captured within the Safeguarding Teamwork plan which is governed within the Safeguarding Committee.

Tailored psychological support to the team has been procured externally, however this will be provided internally 2024-25 onwards. This is a much needed and appreciated support to the team.

SUDIC Process Awareness Raising: An online "Child Death Review Processes in Leeds" learning package has been offered via the Leeds LSCP training programme. This gives practitioners across the multi-agency partnership an opportunity to gain some basic understanding of the SUDIC process. Biannually, a one-day training event facilitated by West Yorkshire Police and the, SUDIC Paediatricians is delivered to ensure local and regional processes are well understood by all those involved, particularly in those areas where there may be significant turnover of staff, e.g. Emergency Departments.

Family Engagement: This has remained a key priority. A leaflet is given to grieving families which sets out brief details of the SUDIC process in accessible language, contact details for the team, information on how to give feedback and how we use and look after personal information. Families are also given leaflets detailing a range of bereavement support groups including the Community Bereavement Service offered by Martin House Hospice.

During 2023-24, discussions took place with third sector colleagues in Child Bereavement UK (CBUK) resulting in the establishment of a relationship which will enhance the support families receive, ensuring there is someone available to guide the family through the whole process, from the initial shock of bereavement through to the coroner's hearing and beyond should they wish it.

The post, which covers West Yorkshire, has been funded by CBUK and another charity acting in support of bereaved families, Elliot's Footprint. Throughout 2024-25 we will continue to build on this relationship to enhance service delivery to the families of Leeds experiencing the sudden or unexpected death of a child.

Review of links with partners: The SUDIC Team has maintained links with the national Child Death Peer Network, formed from teams across England. The virtual meetings give participants an opportunity to share practice, discuss common issues and creates the potential to influence local and national practice.

The Leeds SUDIC team, alongside West Yorkshire Police leads on the development and delivery of our regional training programme and regional peer network.

Partnership working and actions related to identified modifiable factors: Where necessary SUDIC cases are taken forward by the Named Nurse for Safeguarding Children for consideration by the LSCP as a Child Safeguarding Practice Review (CSPR).

The SUDIC team also draw early attention to any modifiable factors CDOP members may need to action as there can be considerable delay between a child's death and case discussion at CDOP.

Conclusion: 2023-24 has seen the SUDIC team stabilise and coalesce into a strong interdependent unit; this has enabled us to reflect on the team's success whilst continuing to develop practice internally; across the multi-agency Child Death Review Partnership; and to look at developing new partnerships to continually enhance the service offer made to grieving families.

The SUDIC Team would be unable to carry out their work without the support of colleagues within LCH and across a wide variety of partner agencies; we are grateful for their professional and caring support of bereaved families as well as their co-operation with, and their contributions to this important work.

Learning Disabilities

Key achievements 2023-24:

- Development of the LD workplan through recruiting a project manager
- Development of the LD Hub- internal intranet page for staff to access information and guidance relating to LD.
- Ask Listen Do
- Development of the accessible complaints form & close working with the 'Ask Listen Do' champion to help make the complaints process more accessible and user friendly for people with LD.

- Development & roll out of Easy Read COPD “keeping me well” booklet.
- Development of the “what makes good care” flow chart.
- Reasonable adjustments made to mortality process.
- End of Life mapping of accessible documents
- Increasing accessible information across the Trust
- Commenced implementation of The Oliver McGowan Mandatory Training in Learning Disability and Autism

- Awareness raising sessions.

Key ambitions 2024-2025:

- To support the implementation and identification of the Reasonable adjustment flag.
- To review how we can identify people with a Learning Disability, for services that do not use system 1
- Participate in all benchmarking Networking events and support improvement specifically as a specialist organisation.
- To Support the roll out across the city of phase 2 of The Oliver McGowan Mandatory Training in Learning Disability and Autism
- To continue the development of easy read material
- To analyse the data for those with a learning disability and review what is required.
- To analyse the data from incidents, complaints, and concerns to identify themes for learning, and areas where improvements are required.
- To Audit the use of sensory boxes in services and whether this improves outcomes and experiences.
- To Audit the mortality process for those with a Learning disability, to gather areas of good practice and any learning.

This is the first annual report completed to highlight how the organisation is improving care for those with a learning disability (LD). The Named Nurse for Learning disability is now part of the Safeguarding team. This aligns with other Learning disability Leads and / or teams across west Yorkshire giving assurance through safeguarding structures that care and improvements are made.

The Named Nurse for Learning Disability has a role that is key in supporting the organisation to deliver the trust goals to the people who have the highest inequalities in accessing health care. Ongoing development of this role is vital, and the organisation has supported the named nurse to complete the PG cert in learning Disability and /or Autism, and then continuation to become an Advanced Clinical Practitioner. To ensure improvements in care continued a project manager was appointed on secondment for 15 months.

Improvements are made through participating and compliance with the learning disability improvement standards for NHS trusts and learning from the lives and deaths of people with a learning disability and autistic people (LeDeR). Both are national quality improvement initiatives.

The learning disability improvement standards for NHS trusts were developed by people with a learning disability, their families to state what is expected from the NHS. The four standards concern:

- respecting and protecting rights.
- inclusion and engagement
- workforce
- learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism or both)

The organisation has participated in the NHS Benchmarking which gathers baseline information from providers on their compliance with the standards, the views of staff and people who use NHS services.

The LeDeR programme was set up as a service improvement programme to look at why people are dying and what can be changed both locally and nationally to improve the health of people with a learning disability and reduce health inequality.
LeDeR works to:

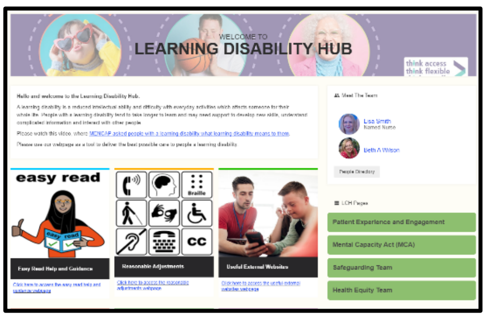
- Prevent people with a learning disability and autistic people from early deaths.
- Reduce health inequalities for people with a learning disability and autistic people.
- Improve care for people with a learning disability and autistic people.

A detailed project plan has been produced through the appointment of a project manager for Learning disability. This has ensured focus, review and highlighted success in a consistent manner giving assurance that we are improving care for those with a learning disability across our organisation and working in partnership across the city and region.
LCH continues to work across the city and across the west Yorkshire region. The Named Nurse for LD is an active member of both citywide and regional groups.

Key Achievements: 23-24

Development of the LD workplan through recruiting a project manager
The LD workplan is an incredibly detailed document based around the Learning Disability Improvement Standards and learning form LeDeR. This is a newly created tool, which captures all activity and progress made because of outcomes and findings from benchmarking. This ensures a focused approach to quality improvement capturing success and outcomes.

Development of the LD Hub- internal intranet page for staff to access information and guidance relating to LD.
Development of LD Hub is a useful online platform where staff can access up-to-date and relevant information, guidance, easy read documents, and links to useful resources. This will improve the quality of care for people with an LD by equipping clinical and support staff with information, advice, templates, leaflets, and documents that can help them provide better care to people with LD in their everyday practice. To date, the LD Hub and pages contained within it have amassed over 1100 views.



Ask Listen Do (ALD) is about making it easier for people to give feedback, raise a concern or complain about their health care. This improves lives, the services people receive, and it helps to keep people safe. A presentation was produced to increase awareness, which included a video for the engagement team to ensure they understand the principles of Ask Listen Do. A Patient Engagement Team (PET) officer will be the champion for ALD and the PET will now lead this initiative. This has ensured all members of the engagement team improved their skills and knowledge on the initiative.

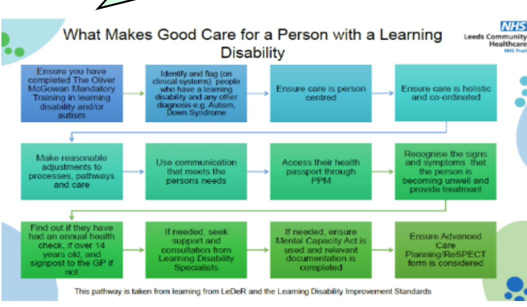
The complaints form was reviewed, and an adapted process was identified including an accessible form for people with LD This will be reviewed by the Learning Disability Project Manager and evaluated. It will ensure that patients with LD and those who may have limited comprehension or difficulty understanding complex language, find it easier to engage with the complaints process, understand this and know what to expect. It also empowers the staff and patient experience officers who are handling the calls to support people with reasonable adjustments.

Development & roll out of Easy Read COPD "keeping me well" booklet.

The COPD easy read document which has been rolled out for use within community respiratory and nursing services is a way of helping people with an LD or their carers to be more proactive in their care, understand their early warning signs and know when to escalate/ seek further advice, care and treatment. This is a fantastic way of ensuring people are equipped with information in an accessible format which is easy for them to understand.

The person this was made for said, **"Normally I would pass letters to my wife, but I like the pictures on it, and I can understand it better than the normal leaflet. It's better and I like the big writing".**

Development of the "what makes good care" flow chart. A flowchart was developed as a direct result of LeDeR outcomes and findings from the LD standards benchmarking. This is to support staff when working with people with a learning disability. It is currently on the LD Hub and is uploaded as a separate document so staff can download and print it. The process can be followed when working in all services and has headings that can be used when reviewing care under the mortality process. It highlights key areas for staff to consider that if followed will support the person with a learning disability to access health care, feel listened to and offered any support they need to achieve the best outcomes possible.



Reasonable adjustments made to the mortality process.
Following a review of the trust's mortality process it was noted that if a person with a learning disability and/or Autism dies after 24 hours of being admitted to hospital we do not review care. Changes have been made to the process and for the next year, when someone dies, the teams should review every death of a person with a learning disability and/or Autism, even if they died in hospital to ensure learning is identified. The Learning Disability Lead will then review for themes and consider any areas where improvements can be made.

End of Life mapping for accessible documents
Working across the city work has commenced to review end of life care documentation. This has included mapping what is available for all people and then ensuring easy read versions are available or in process. This document will then be available for all staff to use and ensure person centred accessible information is available.

Increasing accessible information across the Trust
The Project manager has increased accessible information across the trust. A branded easy read template was developed and is being used to create accessible information for services across LCH. We have 6 live documents and 28 are in production. Documents are completed in conjunction with staff and are taken to groups for people with a learning disability, to ensure the documents are fit for purpose. Any feedback is acknowledged, and amendments are made accordingly. People have expressed their appreciation, about being asked for their opinion.

The Oliver McGowan Mandatory Training in Learning Disability and Autism
The E learning element of The Oliver McGowan Mandatory Training in Learning Disability and Autism was mandated across the trust for all staff, compliance and feedback is very positive. The organisation continues to be involved in how the city will implement the Face-to-Face element of the training.

Awareness raising
Presenting at events both within LCH, the city and the region ensure staff who support people with a learning disability are aware of the support available to them, it can include peoples experience, culture, how care should be, access to care and sharing of improvements. This year has included

attending the matrons conference, west Yorkshire school events, clinical forums within the organisations, preceptorship events and the launch of LD champions and newsletter. The topics covered can include the offer of consultation and accessible information, the improvements made, the health needs of people with a learning disability, health passport and annual health checks.

Feedback from a preceptorship event:
'It is such a refreshing change not having a PowerPoint and having the opportunity to have an open and honest discussion.'
'Never really had any training around LD prior to this session. Will feel more confident now when I care for a patient with LD.'
'The statistics mentioned around poor health outcomes for people with LD was sad and shocking. Knowing this will help me think about the bigger picture when dealing with patients'
who have LD.

Benchmarking
The organisation participates in many areas of Benchmarking but specifically two associated with people with a learning disability. The learning disability Providers was a new Benchmarking exercise for LCH.
Mental Health, Learning Disability and Autism (MHLDA) indicators
The project benchmarks data in many areas of care, it includes data, staff survey and a survey of those accessing our services with a Learning Disability
Learning Disabilities Providers
This project benchmarks data for all specialist providers of learning disability and autism services. LCH provide specialist support to children with a moderate and severe learning disability.
Through participating in these projects areas of improvement are added to the Learning disability action plan.
This year, we achieved full return on the staff survey (150 responses in total). This was met with congratulations at a benchmarking event, and we were asked how we achieved this. The benchmarking project managers said they would love to write a story on what we have achieved to share with people participating in the programme and nationally.

Clinical Consultation
Clinical consultations are available to all staff across the organisation. Over the past year, this has included advice via email, M S Teams, attendance at meetings / clinical appointments and joint visits when required. The Named Nurse for LD supported a young male and their family with other members of the team during an acute situation which required high level of skill, knowledge, leadership, and expertise over a 6-week period requiring flexibility of the role. Consultations over the year have resulted in staff having increased knowledge, quicker access to specialist services, ensuring legal processes are followed and care is safe, effective, and responsive.

"We both wanted to thank you for your commitment, care and professionalism".

'We brought cases to discuss where there have been concerns regarding Learning Difficulties, Learning Disabilities, Neurodevelopmental Difficulties, Cognitive impairment, or cases that have felt stuck to reflect and consider next steps. We have been able to use the consultation model to inform our clinical practice, develop our practice and increase awareness of services available to the teams we support. This has been valued by the team attending the consultation, the staff we support through case catch up in the youth offending services and the young people that are involved with the Youth Justice Service.'

Specialist Child Protection Medical Services (SCPMS) June 2024

Key achievements 2023-24:

- The staffing has been better and for the last 6 months I have been a 'floating' consultant to cover some of the leave. There have still been a few gaps but better than it was. This has been improved by one colleague doing weekly CP sessions.
- Continued to improve our interaction around strategy discussions and Child Protection.
- Continued to engage in regional peer review and Named Doctor regional meetings
- Maintain strong links with the LCH Children Looked After and Safeguarding team
- Continued to develop the working relationships with acute paediatricians in LTHT
- Increasing engagement in strategy meetings and case conferences where child abuse or neglect is suspected – many by remote access e.g. teams.
- Involvement with the Risk and Vulnerability Subgroup of Leeds Safeguarding Children Partnership regarding child victims of Female Genital Mutilation. We also provide an FGM assessment to several other authorities.
- Attendance at Multi-agency Safeguarding Operational Group (MASOG) by Named doctor to look at operational processes for community paediatrics, police and social care
- Majority of team members now trained on ALSG Child Protection Recognition and Response course
- Named doctor is increasing networking between the Named and Designated doctors for other areas and across Leeds.
- Named Doctor joined a national named doctor group set up during lockdown. This continues to run but less frequently- attended irregularly
- Named Doctor– continued to deliver training to a range of professionals – social worker, education, police and health including GPs, also front door team.
- RCPCH key standards for CP medicals audited- we did extremely well and only have a few areas to improve, mainly leaflets for families etc, feedback from social care etc. see attached with report.
- It was recognised that security around child protection, adoption and fostering clinics was not in place. There is now a security guard in place daily to cover these clinics. There have been some challenges with this, but it has led to staff and the dept feeling safer in this high-risk environment.

Key ambitions 2024-25

- Have a full complement of doctors including enough to ensure there is cover for annual and study leave.
- Ensure we have extra Peer review sessions as the increased numbers of cases has led to us being delayed with our sessions, at one point up to 4 months behind, this has improved recently to 2 months. We do ~6 cases per hour, need 71 hrs per year, currently 58 hrs. having some extra longer sessions to catch up and stay on top of this.
- Re-establish our psychology support as the previous psychologist left.
- Apply for SARC service again. - Commissioning process starting in next months.
- Undertake our first CPRR course- planned for October.
- Named Doctor involved in developing new Safeguarding training for paediatric trainees through the region due to significant change from current provision.
- Address the gaps from our RCPCH audit along with the LGI team, shared leaflets etc.

Who are we?	What are we proud of?
10 community paediatricians, band 5 nurses, 1 play therapist and a health care support worker, 2.8 admin staff and 1 clinical services manager Part of ICAN (Integrated Children with Additional Needs) services. commissioned by Leeds CCG	Providing a daily **senior doctor led** clinic to see children (0-18) referred for all forms of child abuse **Trained and skilled administrative staff** to take referrals from 09:00-17:00 on weekdays **Compassionate, highly skilled nursing staff** to chaperone and support families & medical staff in clinic Clinical work underpinned by **peer review and supervision** to challenge practice & offer support **Dedicated team**, who show great strength and resilience to rise to the many changes this year Continuing to provide **medical training** in child protection **information sharing** and working together to safeguard children **Monthly governance programme** for continuing professional development and links with the regional peer review programme.

What we did in 2023-2024

- The team saw 446 children between April 2023-March 2024. This is an increase on the number of children we saw in the previous year for referrals (previous year 444 referrals). We continue to see cases that would have been seen by LGI but were redirected to us on the new SOP.
- 69% physical abuse; 13 % neglect; 4% anogenital examination for medical issues or Female Genital Mutilation, 13% siblings of index children. Clearly many of the children would have neglect alongside the physical abuse. We noted the neglect cases have significantly increased in the last few years, see chart below, likely due to the impact of austerity and Covid. We also saw 35 children for follow up, this is a significant increase and is due to the unmet health needs of the children and needing to review them.
- We aim to provide child protection medical reports to Social Care in 4 working days. Performance has improved over the last year, approx. 60% (previously 28%) reports sent within 4 days to social care. The main delay is with the Drs providing the reports to be typed up or checking theirs or a trainee's report.
- Clinical governance sessions have been well attended face to face. Sessions to discuss departmental safety for staff led to a change in staffing. A journal review looking at hyperpigmentation post injury and the research. Multiagency discussion with police and legal re reports. We had a session on report writing which generated a useful discussion. We undertook a notes audit looking at the proformas.
- Held 51 peer review meetings last year.

Conclusion:
This year we welcomed our LCH Learning Disability lead nurse into the team. We also had some staff movement and are about to welcome a new Named Nurse for Adult Safeguarding and a Specialist safeguarding Adults Nurse. Following a service review the CLA team will be appointing more staff to the team in addition to current staff, to enable them to meet the increasing service need and meet statutory requirements.

The increase in all safeguarding needs across the country is driven by various factors, reflecting societal changes, heightened awareness, and the complex challenges facing vulnerable populations. There is growing recognition of the vulnerabilities within various populations and the importance of protecting those at risk. We work hard to understand the factors contributing to this rise enabling the implementation of strategic responses, to better address safeguarding challenges and ensure the safety and well-being of individuals in need. Enhanced training, improved reporting mechanisms, multi-agency collaboration, community-based support, policy, advocacy, and the use of technology are critical components of an effective safeguarding strategy.

Key themes emerging from this report point to the priorities for the team:

- The setting and maintaining of quality standards across all safeguarding.
- Fast effective responses to emerging safeguarding themes.
- Continuous development of training packages in line with emerging safeguarding themes
- The essential development and maintenance of internal and multi-agency relationships and networks to ensure high quality service delivery with safeguarding of vulnerable children and adults remaining at the core of all we do.
- Resilience across the whole (and wider) team
- Flexibility and adaptability of all staff in support of each other

2024-25 will see the Safeguarding Team:

- Continue to support the self-neglect agenda and raise awareness of non-fatal strangulation
- Continue to support the PREVENT agenda and work alongside other health agencies in Leeds to ensure staff are kept updated and there is a forum for Prevent leads to share concerns and learn from practice.
- Explore a training development platform on Leeds Health and Care Academy with the rest of the health economy with potential to host MCA training resources.
- With the welcome additions to the CLA workforce, plan to developed and deliver on a cohesive city-wide health plan for CLA and care leavers, that plan to deliver the CYP plan for Leeds. Leeds corporate parenting strategy 24-27 and implement recommendations from "Understanding the health needs of children who are looked after in Leeds".

- Develop and embed partnership working with CBUK to ensure families are supported and guided through the bereavement stress and trauma which accompany the sudden or unexpected death of a child.
- Support the roll out across the city of phase 2 of The Oliver McGowan Mandatory Training in Learning Disability and Autism
- Work towards a full complement of doctors including enough to ensure there is cover for annual and study leave.

To conclude this year's report, it is important to reflect on a period marked by significant achievements, notable challenges, and profound growth in our health safeguarding efforts. Our commitment to protecting and promoting the well-being of vulnerable populations has driven numerous initiatives, improvements, and collaborations that underscore our dedication to excellence in safeguarding practices.

Leeds Community Healthcare NHS Trust

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	Report to:	Trust Board 3rd Sep 2024
Date of Meeting:	24th July 2024	Date of next meeting:	25th Sep 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. The Chair briefly left the meeting for the Short term beds item due to a potential conflict of interest.	
Alert	**Action**

Advise

- Quality & Value – Committee received an update, with £12m of savings now identified, £8m of which was recurrent. The Q&V Internal Audit had completed, report due shortly. Concerns around capacity of the programme team and well-being of staff generally still present. The Committee felt assured regarding the process. It was reassured that EQIAs would be completed where change was proposed, and service changes would move through the Q&V Board to Business and Quality Committee for info/approval. Service redesign was a 26-week programme so none had reached conclusion as yet.
- Third Sector strategy – updates received re: current and future (2024-27) strategy. Challenge lay in sharing records between organisations, Loop solution being implemented to address this. More detail to be added re: financial accountability linked to the Q&V programme before presentation to the Trust Board.
- Procurement Strategy update – work still ongoing. Progress being made regarding internal audit's limited assurance report. To come to Committee in Sep.
- Internal Audit Report – Health and Safety (limited opinion). Significant work was underway to drive improvements in line with the action plan.

Assurance

- Service focus – Infant Mental Health Service. This service was recognised across the system as delivering excellent care, a small team with a big impact. Potential digital opportunities would be worked through with the Q&V programme.

Leeds Community Healthcare NHS Trust

Committee Escalation and Assurance Report

- Leeds Sexual Health Mobilisation update – successfully went live on 1 July. An improvement in run-rate had been observed in June, and there was confidence in achieving the plan.
- Safe Staffing report – safe staffing had been maintained across both inpatient units over the last 6 months.

Risks Discussed and New Risks Identified

- Waiting times – a review into the MindMate SPA referrals backlog was underway and would be brought back to Committee in Sep.

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	16 (extreme)	Reasonable	This was deemed as reasonable assurance on this occasion, but the Committee was mindful of the ongoing position regarding waiting lists. An update would be welcomed at the Sep meeting.
Risk 3 Failure to invest in digital solutions. If the Trust fails to implement the agreed digital strategy, then, 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.	12 (high)	Reasonable	N/A
Risk 4 Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation and adverse media attention.	9 (high)	Reasonable	N/A

Committee Escalation and Assurance Report

Risk 5 Failure to deliver financial sustainability: There is a risk that the Trust will not be financially sustainable which will jeopardise delivery of all our strategic goals and priorities.	16 (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 does not have suitable and sufficient staff capacity, capability and leadership capacity and expertise, within an engaged and inclusive workforce then the impact will be a reduction in quality of care and staff wellbeing and a possible misalignment with the objectives of the Q&V programme.	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:	13/08/24

Agenda item:	2024-25 (45)

Title of report:	Charitable Funds Committee June 2024: Committee's Chair assurance report

Meeting:	Trust Board Meeting Held in Public
Date:	3 September 2024

Presented by:	Sheila Sorby, Interim Executive Director of Nursing and Allied Health Professionals					
Prepared by:	Steph Lawrence Executive Director of Nursing and Allied Health Professionals					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	

Executive Summary:	This paper identifies the key issues for the Board from the Charitable Funds Committee held on 18 June 2024.

Previously considered by:	N/A

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	√
	Use our resources wisely and efficiently	√
	Enable our workforce to thrive and deliver the best possible care	√
	Collaborating with partners to enable people to live better lives	√
	Embed equity in all that we do	√

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	N/A
	No		Why not/what future plans are there to include this information?	N/A

Recommendation(s)	For noting

List of Appendices:	N/A

Executive summary (Purpose and main points)

This paper identifies the key issues for the Board from the Charitable Funds Committee held on 18 June 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 Charitable Funds Officer outlined activity since the last Committee meeting. Preparations were underway for the Trust's show that would be held in the Summer to raise funds for the Charity.
The Charitable Funds Officer explained that she had contacted local businesses for support in terms of sponsorship and raffle prizes, and this had opened up doors for future engagement. There was an opportunity for companies to advertise in the programme which would be sold at the event. Approximately fifty tickets had been sold to date. Further comms had been planned for the coming weeks.

The Pennies from Heaven initiative had been launched Trust wide in April 2024 and approximately seventy staff had signed up so far. The Charitable Funds Officer said the name had changed to Microhive and she had a meeting planned with the Trust's Graphic Designer to look at promotional material.

The Charitable Funds Officer had enrolled on a fully funded Level Three Diploma in Fundraising Apprenticeship which would commence in July 2024.
The Executive Director of Nursing explained that the Trust Board had agreed to extend the Charitable Funds Officer's post for a further 13 months to 31 August 2025, to cover the duration of the course.
The Committee Chair and Trust Chair informed the Committee that they were holding discussions around a longer term plan for the Charitable Funds Officer role and agreed to keep the Committee updated.
The Charitable Funds Officer outlined recent bids:

- Garfield Weston – the application had been submitted; it would take approximately four months for a decision.
- The Fore – this bid was declined. The Charitable Funds Officer said that she had received helpful feedback about her application which she would share with Committee members for information.
- Lottery Awards for All – the application needed to focus on a specific project rather than core costs – the Charitable Funds Steering Group were looking at where the bid could be focussed.
- NHS Charities Together would be releasing further grants towards the end of 2024, specifically around staff health and wellbeing, greener communities and innovation.
- The Charitable Funds Officer had met with the Grants Manager at NHS Charities Together and she was keen to support smaller community charities.

Finance Report

The Committee received a report which presented the primary financial statements for the charitable funds as of March 2024 and the income and expenditure for the charitable fund's accounts covering the period from April 2023 to March 2024.

Review of Terms of Reference

The Charitable Funds Steering Group Terms of Reference had been shared with Committee members. The Charitable Funds Officer explained that she had updated the document since the Steering Group had been re-established and highlighted one specific change - *'decision making would only be quorate if the Deputy Director of Finance is present'* had been changed to include '*or nominated person'*. There was a brief discussion around who should be accountable for approving bids under £5000. The Executive Director of Finance and the Charitable Funds Officer agreed to meet to discuss outside of this meeting. The Charitable Funds Officer agreed to amend the Terms of Reference accordingly and share with the Committee.

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

Committee Escalation and Assurance Report

Name of Committee:	Audit Committee	Report to:	Trust Board 3rd September 2024
Date of Meeting:	12th July 2024	Date of next meeting:	11th October 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**
• N/A	
Advise	
• Information Governance and Data Protection Officer (DPO) Update – The Trust had achieved 'Standards Exceeded' in the Data Security and Protection Toolkit. The number of data breaches was low with very few meeting the threshold for external reporting. A deep dive was planned for the Leeds Mental Wellbeing Service where the most breaches had occurred. Data regarding Subject Access Requests that had not met the response timeframe would be included in the next report. It was agreed that the Committee would receive a cyber update on a quarterly basis rather than bi-annually going forward.	
Assurance	
• Internal Audit – The 2023/24 Internal Plan had been completed subject to agreed amendments during the year. Head of Internal Opinion – significant assurance overall. New process for tracking, reviewing and validating closed recommendations for 2024/25 – more info to come in Oct. A risk oversight group was in the early stages of being established, and would monitor progress against all recommendations. • Counter Fraud – quarterly update and 2023/24 Annual Reports received and the 'green' overall compliance rating was noted. • External Audit – Audit work for 2023/24 was complete with no matters requiring a change to the financial statements adopted by the Board on 19 June 2024. The value for money audit work had also been completed with no risks or areas of significant weakness identified. • Register of Gifts and Hospitality 2023/24 received, no issues of note. • Board Assurance Framework Process Update – The Committee reviewed the process for reviewing the 2023/24 BAF and the redesign of the 2024/25 BAF. It was agreed that more scrutiny of the BAF was required to determine whether the breadth and depth of assurance provided by the papers	

NHS Leeds Community Healthcare NHS Trust

Committee Escalation and Assurance Report

received by the various Committees provided sufficient levels of assurance and whether the BAF accurately reflected the strategic risks that the Trust currently faced.

Risks Discussed and New Risks Identified

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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 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

Author:	Helen Robinson/Khalil Rehman
Role:	Company Secretary/Committee Chair
Date:	08/8/2024

Agenda item:	2024-25 (48)

Title of report:	Guardian for Safe Working Hours- Quarter 1 update

Meeting:	Trust Board meeting
Date:	3 September 2024

Presented by:	Nagashree Nallapeta, Guardian of Safe Working Hours					
Prepared by:	Nagashree Nallapeta, Guardian of Safe Working Hours					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	**Main issues for consideration** • CAMHS ST historic rota compliance and payment issues update • Work in progress to address the impact of on-call work on community paediatric training needs

Previously considered by:	Nil

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	
	Enable our workforce to thrive and deliver the best possible care	✓
	Collaborating with partners to enable people to live better lives	
	Embed equity in all that we do	

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	✓	Why not/what future plans are there to include this information?	

Recommendation(s)	• Support GSWH with the work in relation to community paediatric training opportunities. • To note that there is a risk for the Trust of potential grievance case that could be raised by Junior doctors affected by CAMHS historic rota issue.

List of Appendices:	Nil

Guardian for Safe Working Hours report

- ## 1 Introduction

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.

Purpose of Guardian of Safe Working Hours 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.

- ## 2 Current position/main body of the report

There are 22 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
Foundation year	2	FY2	Honorary contract
CAMHS	6	ST	LCH contract
	0	ST	Honorary contract
	2	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 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.

- **Quality**

Exception reports
No exception reports were filed during this quarter.
Fines
No fines levied by the GSWH during this quarter.

- **Resources**

Rota gaps and CAMHS ST rota
The CAMHS ST non resident on call rota consists of a 1:5 rota, and gaps (currently 3 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.

GSWH was unable to obtain the gaps in the rota and cover arrangement data for the last 3 months.

- **Risk and assurance**

Feedback from Junior doctors
Junior Doctors Forum (JDF) was held on MS teams on 04/07/2024.

There was a good turn out of Junior doctors and discussions around preliminary feedback from Junior doctors survey were discussed. There are plans made to improve and ensure continued engagement of junior doctors and to tackle the challenges of working in a community trust where all doctors are not working at the same base. It was felt that having training sessions, availability of food for lunch time meetings and engagement with TLT would be beneficial.

At the recent National BMA annual representative meeting held in Belfast in June 2024, BMA members voted to rename 'junior doctors' as 'resident doctors'. This motion has been formally approved by BMA. All references to junior doctors in the association will be changed to 'resident' from September. There will be official adaptation of the change NHS England and national workforce.

CAMHS Historic ST rota issue

This issue has now reached conclusion that has been put forward to affected Junior doctors. GSWH fines related to this issue is extremely complex and challenging due to the lack of data around how many doctors were affected, for what length of time and retrospective nature of the issue. Some of the affected Junior doctors are considering further actions through formal grievance case route, as offered by the Trust. GSWH has requested and is awaiting information regarding any actions/ plans that the affected Junior doctors would like the Trust to consider as a part of the solution that can be offered.

Community paediatric Training issue

Junior doctors in community paediatrics cover on-call work at Leeds Children's Hospital as a part of their job. Sub-speciality training (Nationally approved training post with specific requirements for specialist training) have raised concerns that they are not receiving the required training due to not having enough training time as recommended by the Royal college guidelines. GSWH held a meeting (24/04/24) to discuss the issue with the key stakeholders (GSWH, College tutor, rota lead at Leeds Children's hospital and LCH's DMD, College tutor, LNC Junior doctors

representative). Useful ideas and suggestions were put forward to LTHT Rota management team. Next meeting to discuss progress and plan is to be held soon.

4 Next steps

GSWH will continue to work with Key people to improve community paediatric training. The next meeting will be in September 2024.

With regards to CAMHS historic rota issue, GSWH is awaiting further information and advice from NHS Employers and BMA legal team with regards to potential fines.

GSWH plans to implement the changes of the terminology from Junior doctors to Resident doctors from September for all Junior doctor related work and meetings.

GSWH is working with Medical Education team and BMA to implements ideas the have been suggested through Junior doctors forum survey for better engagement and improve the usefulness of the meeting.

5 Recommendations

The Board is recommended to:

- Support GSWH with the work in relation to community paediatric training opportunities.
- To note that there is a risk for the Trust of potential grievance case that could be raised by Junior doctors affected by CAMHS historic rota issue.

Name of author Nagashree Nallapeta
Title Guardian for Safe Working Hours
Date paper written 13/08/2024

Agenda item:	2024-25 (49)

Title of report:	Freedom To Speak Up Guardian Annual Report September 2024

Meeting:	Trust Board Meeting Held In Public
Date:	3 September 2024

Presented by:	John Walsh Freedom to Speak Up Guardian					
Prepared by:	John Walsh Freedom to Speak Up Guardian					
Purpose: (Please tick ONE box only)	Assurance √		Discussion		Approval	

Executive Summary:	This report covers the period of 4th August 2023 to 3rd September 2024. It offers a record of the work of speaking up at Leeds Community Healthcare NHS Trust (LCH) and wider work across the health and care system. There were one hundred and seventy concerns overall. Forty-one concerns were raised formally by LCH staff members concerning LCH or LCH services through the Freedom To Speak Up Guardian (FTSUG). A hundred and twenty-five concerns were informally discussed or resolved via the FTSUG. The Speaking Up Champions had three direct concerns. The Staff Survey results for 2023 – 24 are very positive. 76.6% of staff said they had confidence to raise concerns. This is an increase on the previous year (in 2022-3 it was 72.8%) and is one of the highest scores for this question in the region. Helen Thomson is the new Non-Executive Director for Speaking Up. Helen and the FTSUG have met to think through how we will work together. The Freedom To Speak Up Guardian service has: • Worked across the trust with key partners to continue to share and embed the work. • Worked with the Quality and Value programme.

	• Offered to all staff who approach the FTSUG a programme of pastoral support whether they wish to raise a concern or not at the time. • Sought to ensure we learn from concerns and align with all national work, learning and guidelines.

Previously considered by:	N/A

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	
	Enable our workforce to thrive and deliver the best possible care	
	Collaborating with partners to enable people to live better lives	
	Embed equity in all that we do	

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No		Why not/what future plans are there to include this information?	

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

List of Appendices:	N/A

1 Introduction

1.1 This paper provides an overview of the work of the Freedom To Speak Up Guardian (FTSUG), basic activity data and recommendations on the role and its development from August 4th 2023 to September 3rd 2024.

2 Background

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

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

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

3 Current position

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

3.2 Work with the Race Equality Network Speaking Up Champions continues. Work with the Disability, Neurodiversity and Long-Term Condition Network and the LGBTQI+ Network is ongoing. Career development work is offered to any staff member from an ethnic minority community who contacts the FTSUG. This is a plan around their career development linking the staff to support mechanisms in the wider organisation such as mentoring, coaching, interview support and leadership courses. This career development offer now extends to staff who have a health condition. The FTSUG attends the New Starters Forum with the Chief Executive and Director of Workforce to hear and support those new to the trust. The FTSUG also attends the Clinical Students Forum and Preceptorship. New work along with LCH Safeguarding, HR and Security colleagues has started on the NHS Sexual Safety Charter, a Sexual Safety policy and actions to support staff who suffer sexual harassment.

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

3.4 The FTSUG has been involved in the Quality and Value work in the trust. This has included working with teams and leaders delivering this programme and attending the one and three- day workshops.

3.5 Work following the board paper in February 2024 has started. This includes a new clinical quarterly meeting with the Executive Directors of Nursing, Operations and the Medical director. This is to focus on clinical issues arising from concerns. There is a similar plan emerging with the FTSUG, the Director of Workforce and the Head of HR to look at themes from workforce concerns. These will look at themes from informal and formal concerns and can be escalated where necessary to the board. Work on how best to capture stories of speaking up has started in joint work with the Comms Team. A reflection paper on negative reported impact from speaking up has been written by the FTSUG and three other FTSUG's to help us think through how we work in this area.

3.6 The FTSUG's from LCH and Leeds City Council were asked to present to the Leeds Health and Wellbeing Board. This has led to work supporting the Third Sector look at speaking up work. There has been a first meeting with the Third Sector and work is ongoing. The support to Leeds City Council (LCC) and its Freedom To Speak Up work continues.

3.7 Helen Thomson is the new Non-Executive Director for Speaking Up. Helen and the FTSUG have met to think through how we will work together

3.8 Work supporting a regional NHS organisation helping them create the model we use across their trust continues. We have recently started working with another NHS regional organisation to support their practice.

3.9 Presenting on the LCH speaking up work has taken place since last August at conferences and sessions including the national NHS People Promise in Action
Conference, the LCH Clinical Conference, the national Mental Health and Wellbeing in the Health and Social Care Workforce Digital Conference and the national Duty of Candour conference.

4 Activity data

4.1 The table below shows the volume and type of activity with which the FTSUG has been engaged between August 4th 2023, and September 3rd 2024. The table also indicates the nature of the issues raised with the FTSUG.

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

Business Unit	Numbers of concerns formally raised	Issues
Adult Business Unit	9	Culture, leadership, patient care, behaviours
Children and Families Business Unit	4	Culture, leadership, communication
Corporate Services	7	Redeployment, religious and cultural awareness, consultation on staff issues.
Specialist Business Unit	9	Culture, leadership, recruitment issues, behaviours, work flexibility, redeployment.

4.3 Forty-one concerns were raised formally by LCH staff members concerning LCH and LCH services through the FTSUG. One concern regarded another NHS organisation, and the person concerned was signposted to that organisation.

One hundred and twenty-five concerns were informally discussed or resolved through the FTSUG.

The Speaking Up Champions had three issues raised with them.

This brings the overall concerns raised to one hundred and seventy in the period this report covers. The champions have the same number of contacts as 2022-23. The figures for formal and informal concerns have risen considerably. In 2022-23 it was sixteen formal and sixty-one informal concerns. This year it has been forty-one formal and a hundred and twenty-five informal. There is some connection to national figures where there has been nationally a 27.6 increase in speaking up concerns in the 2023-4 period (with one quarter of yearly reporting being the highest since data collection began in 2016/7).

4.4 There were twenty-one informal concerns with the FTSUG are from Black, Asian and minority ethnic communities and of these seven were related to issues of race. There were twenty formal concerns raised by staff from Black, Asian and minority ethnic communities and three involved race and two religion and culture. In comparison with the previous year this shows a rise of fifteen concerns and the same number mentioning race. There is a significant rise in informal work from five concerns with three about race in 2022-23 to twenty-one informal concerns with seven about race in 2023-24. There were seventy-two informal concerns and fifteen formal concerns explicitly concerning physical, neurological and mental health issues. In 2022-23 there were seventeen informal and seven formal concerns regarding health conditions.

5 Themes

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

5.1 We see a significant increase in the number of staff using the FTSU mechanism in the last period. Staff report being supported and heard. This is supported by the recent staff survey.

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

5.3. Leadership, culture, and behaviours in teams are ongoing key factors that have featured historically in speaking up concerns. Health and wellbeing, ways of working, changes in services and process are areas mentioned in recent concerns. Race, disability, inclusion, religion and health issues are featuring in the concerns.

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

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

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6 Assurances and Future Work

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

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

6.2 The following are ongoing and future work and plans.

- To focus on the Quality and Value work in the trust
- To work with the FTSUG at Leeds City Council and Leeds Health and Wellbeing Board on supporting speaking up in our systems in Leeds
- To support the new clinical and workforce meetings to build on the existing triangulation work in the trust
- To continue to focus on staff with protected characteristics in the trust to see how speaking up can support these staff when needed.

7 Conclusions

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

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

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

8 Recommendations

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

Agenda item:	2024-25 (50)

Title of report:	Safe Staffing Report.

Meeting:	Trust Board.
Date:	6th September 2024.

Presented by:	Sheila Sorby Interim Director of Nursing and AHP's.					
Prepared by:	Steph Lawrence Executive Director of Nursing and AHP's.					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	

Executive Summary:	The paper describes the background to the expectations of boards in relation to safe staffing, outlining where the Trust is meeting the requirements and highlighting if there is further work to be undertaken. The report sets out progress in relation to maintaining safe staffing over the last six months. It covers the mandated in-patient areas only and for LCH these are Hannah House and Wharfedale Recovery Hub. Safe staffing has been maintained across both inpatient units for the time period.

Previously considered by:	Quality Committee July 2024

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	
	Enable our workforce to thrive and deliver the best possible care	√
	Collaborating with partners to enable people to live better lives	
	Embed equity in all that we do	

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	√	Why not/what future plans are there to include this information?	This is not a paper that would require equity data.

Recommendation(s)	• Receive the report. • Agree the level of assurance provided.

List of Appendices:	

Safe Staffing Report

1 Introduction

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

This report will just report on the two in-patient areas which is what is mandated by the NQB for the last 6 months 1 January to 30 June 2024.

2 Background

We continue to use a set of principles to monitor safe staffing in our in-patient beds.

3 Children's Business Unit (CBU)

Hannah House is the inpatient unit in the CBU. There are currently 2 vacancies in the team only and there has been minimal use of bank staffing during this period. The bank hours utilised in the last 6 month are outlined below. Safe staffing levels have been maintained at all times.

Band 2 = 8 hours (x 1 shift)
Band 3 = 46 hours (x 4 11.5hr shifts)
Band 6 = 6.5 hours (x 1 shift)

Total Bank = 60.5 hours.

There have been no complaints or incidents recorded with safe staffing as a factor.

One night was cancelled in total during the 6 month period due to not having safe levels of staffing and this night has been re-booked for the child in question.

4 Adult Business Unit (ABU)

Wharfedale Recovery Hub is the inpatient unit in ABU. There is currently just one part time vacancy in the unit and safe staffing levels have been maintained at all times during the reporting period. The nursing and support staff at Wharfedale have now reached a level of stability. Retention is excellent with very little movement in the workforce.

There has been no use of bank staff and no incidents or complaints in relation to staffing concerns

5 Conclusion

This paper provides assurance to Quality Committee and Board in relation to safe staffing levels and that these have been maintained in the inpatient units during the last 6 months.

6 Recommendations

Quality Committee and Board are asked to receive this report and agree the level of assurance provided.

Steph Lawrence
Executive Director of Nursing and AHP's. (now retired).
1st July 2024.

Agenda item:	2024-25 (51)

Title of report:	Professional registration: Nursing and Allied Health Professions.

Meeting:	Trust Board.
Date:	3 September 2024.

Presented by:	Sheila Sorby Interim Director of Nursing and AHP's.					
Prepared by:	Steph Lawrence Executive Director of Nursing and AHP's.					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	

Executive Summary:	This report provides an update on professions regulated by Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) as a statutory requirement within the organisation considering compliance and any fitness to practice concerns. Staff that are required to be registered with statutory regulators NMC and HCPC are appropriately registered. The organisation is aware of referrals to regulators and the processes to manage these situations as detailed in the professional registration policy are being followed.

Previously considered by:	N/A.

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	
	Enable our workforce to thrive and deliver the best possible care	√
	Collaborating with partners to enable people to live better lives	
	Embed equity in all that we do	

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	√	Why not/what future plans are there to include this information?	Not been required before for this annual assurance paper.

Recommendation(s)	Note the positive position of nursing and AHP registration.

List of Appendices:	N/A

Professional Registration of Nurses and AHP's.

1 Introduction

1.1 This paper is the annual assurance to board that the statutory requirement for nurses practicing as a nurse to be on the Nursing and Midwifery (NMC) register and for an Allied Health Professional (AHP) using a protected title to be on the Health and Care Professions council (HCPC) register is meet by relevant staff in the organisation.

2 Background

2.1 As noted in previous papers, nurses and nursing associates are regulated by the NMC and the AHPs are regulated by HCPC. There is a requirement on individual professionals to be cognisant of and accountable for their individual requirements and actions to maintain their registration and this is reflected in the Professional Registration policy. Staff are supported in this through regular notifications from the relevant regulatory body and notifications from the Electronic Staff Register (ESR) in the months prior to their registration expiring.

2.2 Nurses and nursing associates revalidate every 3 years and re-register every year on an individual basis. AHPs registration is done every 2 years for the whole professional group.

3 Current position

3.1 LCH employ 1,145 staff in the staff group "nursing and midwifery" on ESR indicating that they require NMC registration for that post. ESR shows that 1,121 are on the NMC register with current registration.

3.2 Four (4) have an expired or missing registration date on ESR. On checking the NMC register, one (1) has current registration. The service has been advised to update ESR. The other three (3) are currently lapsed due to long term sickness or on maternity leave – managers are aware of this and the staff know that registration requires reinstating before they return to work. In addition, there are 2 (two) staff who are currently temporarily suspended from the register due to disciplinary and police investigations. These are ongoing investigations within the Trust and appropriate processes are in place to ensure the staff are not practising clinically. The remaining 18 staff show in ESR as being in the nursing and midwifery group requiring registration but on checking their posts do not require this.

3.3 LCH employ 580 staff in the staff group "Allied Health Professional" meaning they require registration with HCPC, 563 staff have current registration with the HCPC. Of the remaining 17 staff, 5 (five) are social workers and have current registration with Social Work England and 12 are in roles that do not require current registration.

3.4 Between August 2023 and July 2024, the trust has made five (5) referrals to the NMC and no referrals to HCPC. Of the 5 (five) referrals to the NMC, one was a nurse working on bank who no longer works for us, the case with the NMC has subsequently been closed. Two are staff that have subsequently left their roles within LCH, the cases with NMC are ongoing but there are currently no restrictions on their practice. The final 2 (two) cases have been referred in the last 2 months and have both been temporarily suspended from the NMC register. There are also concurrent police investigations for both of these cases as well. The appropriate internal processes are being followed.

3.5 There have been no referrals from the public for any LCH nurses or AHP's during the last year. The public cases from last year have been concluded with the NMC and HCPC with no sanctions on the staff involved and they continue to work within LCH.

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4. Conclusion

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

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

5.0 Recommendations

5.1 The Board is recommended to note the above position

Steph Lawrence
Executive Director of Nursing and AHP's (now retired).
31/7/2024.

Agenda item:	2024-25 (52)

Title of report:	**Significant Risks and Risk Assurance Report**

Meeting:	Trust Board
Date:	3 September 2024

Presented by:	Selina Douglas, Chief Executive Officer					
Prepared by:	Anne Ellis, Risk Manager					
Purpose: **(Please tick ONE box only)**	Assurance	✓	Discussion		Approval	

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. There are two risks on the Trust risk register that have a score of 15 or more (extreme). There are a total of ten risks scoring 12 (very high).

Previously considered by:	Trust Leadership Team 21 August 2024

Link to strategic goals: **(Please tick any applicable)**	Work with communities to deliver personalised care	✓
	Use our resources wisely and efficiently	✓
	Enable our workforce to thrive and deliver the best possible care	✓
	Collaborating with partners to enable people to live better lives	✓
	Embed equity in all that we do	✓

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	✓	Why not/what future plans are there to include this information?	N/A

Recommendation(s)	• Note the changes to the significant risks since the last risk report was presented to the Board; and • Consider whether the Board is assured that planned mitigating actions will reduce the risks.

List of Appendices:	No appendices

Significant Risks and Risk Assurance Report

1. Introduction

1.1 The risk register report provides the Board with an overview of the Trust's material risks currently scoring 15 or above after the application of controls and mitigation measures. It describes and analyses all risk movement, the risk profile, themes and risk activity since the last risk register report was received by the Board (June 2024).

1.2 The Board's role in scrutinising risk is to maintain a focus on those risks scoring 15 or above (extreme risks) and to be aware of risks currently scoring 12 (high risks).

1.3 The report seeks to reassure the Board that there is a robust process in place in the Trust for managing risk. Themes identified from the risk register have been aligned with BAF strategic risks to advise the Board of potential weaknesses in the control of strategic risks, where further action may be warranted.

2. Risk register movement

2.1 The table below summarises the movement of risk since the last risk register report.

	Current	Previous (June)
Total Open Risks	60	51
Risks Scoring 15 or above	2	4
New Risks	13	9
Closed Risks	4	3
Risk Score Increasing	3	2
Risk Score Decreasing	7	10
Risk Score Static > 3 months	18	26

2.2 The following changes have taken place to risks scoring 15 (extreme) or above since the last risk register report.

Risk	Current Score	Previous Score	Status	Latest Update
1048 Mind Mate Single Point of Access (SPA) increasing backlog of referrals (system wide risk)	15	15	Static 7 months	The risk continues to be 15; phase 2 of the ICB review has been brought forward and urgent decisions need to be made on the redesign of the SPA to ensure it is fit for purpose with the capacity it has.
1187 Insufficient IT Resilience leading to	16	12	Increased	Network Upgrade issues resulting from the Firewall replacement

Risk	Current Score	Previous Score	Status	Latest Update
the risk of extended outages of the infrastructure				16/07/24 has highlighted the fragility of the resilience levels in place and has resulted in an increase in the current score. External IT Resilience review completed, and final report presented to LCH on 10/07/24, developing options paper.
Three risks have been de-escalated below 15 since June 2024.				
1171 Patient safety concerns in Yeadon Neighbourhood Team	12	15	Reduced	The Quality and Value work in neighbourhood teams to review the service specification and how care is delivered is designed to reduce the risk further.
1179 Impact/Management of Neurodevelopmental Assessment Waiting List	12	15	Reduced	The risk score has reduced to 12 following a reassessment of the likelihood from almost certain to likely. The Quality and Value work in CYPMHS is designed to reduce this risk further.
877 Risk of reduced quality of patient care in neighbourhood teams (NT) due to an imbalance of capacity and demand	12	15	Reduced	The risk score has reduced to 12 following a reassessment of the likelihood from almost certain to likely. The Quality and Value work in neighbourhood teams is designed to reduce the risk further.

3. Summary of risks scoring 12 (high)

3.1 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by the Board is not limited 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. The Quality and Business Committees have oversight of risks categorised as ‘high’ (risks scored at 8 – 12).

3.2 The table below details risks currently scoring 12 (high risks)

ID	Description	Rating (current)	Rating (previous)	Status
877	Risk of reduced quality of patient care in neighbourhood teams (NT) due to an imbalance of capacity and demand	12	15	Reduced
1042	Provision of equipment from Leeds Community Equipment Services (LCES)	12	6	Increased
1139	General risk of non-concordance with the overarching organisational process for medical devices	12	12	Static
1169	Hoist, couch and slide sheet risk of non-compliance	12	12	Static
1171	Patient safety concerns in Yeadon Neighbourhood Team	12	15	Reduced
1179	Impact/Management of Neurodevelopmental Assessment Waiting List	12	15	Reduced
1198	Impact of ADHD medication waiting list	12	12	Static
1199	The impact and management of the CYPMHS Therapies waiting list	12	12	Static
1226	Quality and Value - financial balance not achieved	12	N/A	New
1230	Non-compliance with NHSE EPRR Annual Assurance process	12	N/A	New

Four of the risks scoring 12 have not changed since the last report (static), these risks have been reviewed and the target dates to reduce the risks are not yet due.

4. Risk profile – all risks

4.1 The total number of risks on the risk register is currently 60. Of these there are 26 open clinical risks and 34 open operational risks. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	0	1	0	0	1
4 - Major	0	3	2	1	0	6
3 - Moderate	2	7	22	9	0	40
2 - Minor	0	3	8	1	1	13
1 - Negligible	0	0	0	0	0	0
Total	2	13	33	11	1	60

5. Risks by theme and correlation with BAF strategic risks

5.1 For this report the high risks (scoring 8 and above) on the risk register have been themed where possible according to the nature of the hazard and the effect of

the risk and then linked to the strategic risks on the Board Assurance Framework. This themed approach gives a holistic view of the risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance on the management of risk.

5.2 Themes within the current risk register are as follows:

Theme One: Demand for Services	
The strongest theme across the whole risk register is demand for services exceeding capacity, due to an increase in service demand and high numbers of referrals Specifically, fourteen risks relate to an increase in referrals and service demand[1]	The BAF strategic risks directly linked to demand for services are: BAF Risk 2 Failure to manage demand for services BAF Risk 8 Failure to have suitable and sufficient staff resource (including leadership) BAF Risk 9 Failure to prevent harm and reduce inequalities experienced by our patients.
Theme Two: Patient Safety	
The second strongest risk theme is patient safety due to staff working outside their role, lack of incident management, workload pressures, capacity to complete clinical supervision, clinically essential training, and safe operation of medical devices [2].	The BAF strategic risks directly linked to patient safety are: BAF Risk 1 Failure to deliver quality of care and improvements BAF Risk 2 Failure to manage demand for services BAF Risk 4 Failure to be compliant with legislation and regulatory requirements
Theme Three: Compliance with Standards/Legislation	
There is also a risk theme relating to compliance with standards/ legislation[3] This includes: the limited completion of health needs assessments, compliance with information governance, and waste management across the Trust.	The BAF strategic risk directly linked to compliance with standards / legislation is: BAF Risk 4 Failure to be compliant with legislation and regulatory requirements
Theme Four: Quality and Value Programme	
Four risks relate to the Quality and Value programme and concern the impact on staff and patients and the risk that financial balance is not achieved.[4]	The BAF strategic risks directly linked to the Quality and Value programme are: BAF Risk 1 Failure to deliver quality of care and improvements BAF Risk 5 Failure to deliver financial sustainability BAF Risk 6 Failure to have sufficient resource for transformation programmes

[1] Risks: 772, 913, 954, 957, 984, 994, 1015, 1043, 1048, 1112, 1179, 1198, 1199, 1211
[2] Risks: 877, 981, 1070, 1109, 1139, 1168, 1171, 1187
[3] Risks: 902, 1089, 1206, 1230
[4] 1226, 1227, 1228, 1229

6. Impact

6.1 Risk and assurance

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.

7. Next steps

Risks will continue to be managed in accordance with the risk management policy and procedure and the Board will receive an update report at the meeting to be held on 4th October 2024.

8. Recommendations

The Board is recommended to:

- Note the changes to the significant risks since the last risk report was presented to the Board; and
- Consider whether the Board is assured that planned mitigating actions will reduce the risks.

Author: Anne Ellis, Risk Manager
Date written: 8 August 2024

Agenda item:	2024-25 (53i)

Title of report:	**CEO and Chair's Action** (Associate NED as member of Nominations and Remuneration Committee)

Meeting:	Trust Board Meeting Held in Public
Date:	3 September 2024

Presented by:	Selina Douglas, Chief Executive					
Prepared by:	Helen Robinson, Company Secretary					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	√

Executive Summary:	Under Leeds Community Healthcare's Standing Orders, Board committees and other groups undertake work on behalf of the Board. At times it may be necessary for urgent matters that the Board, Board Committees and other groups would normally consider at meetings to be dealt with between meetings. These matters would then be formally reported at subsequent meetings for ratification. For the purposes of this document, the procedure relating to such actions is referred to as 'CEO and Chair's action'. An action to amend the Terms of Reference for the Nominations and Remuneration Committee to include the Associate Non-Executive Director as a member of the Committee for the purposes of quoracy has been recently taken by the CEO and Chair outside of the Board's usual meeting schedule. The action was approved by the CEO and Chair in June 2024, in consultation with two non-executive directors: Khalil Rehman and Richard Gladman.

Previously considered by:	N/A

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	
	Enable our workforce to thrive and deliver the best possible care	
	Collaborating with partners to enable people to live better lives	
	Embed equity in all that we do	

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No		Why not/what future plans are there to include this information?	N/A

Recommendation(s)	• To ratify the decision to approve the amendment to the Nominations and Remuneration Committee's Terms of Reference.

List of Appendices:	Appendix 1 – Nominations and Remuneration Committee's Terms of Reference v9 June 2024 DRAFT

Committee Terms of Reference	

Nominations and Remuneration Committee

Document History:

Version:	9
Date reviewed:	27 June 2024
Last version received by:	Nominations and Remuneration Committee (version 8, May 2023)
Approved by:	Leeds Community Healthcare NHS Trust Board
Date approved:	7 June 2024
Name of author:	Director of Workforce Company Secretary
Date issued:	Version 8: 7 June 2024
Review date:	March 2025
Target audience:	Leeds Community Healthcare NHS Trust Board Nominations and Remuneration Committee

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Proposed changes made to this version
Amendment to paragraph 3.1: Addition of an associate non-executive director as a full member of the Committee.

Nominations and Remuneration Committee

Terms of Reference

1. Introduction

1.1 The Nominations and Remuneration Committee is constituted as a standing committee of the Trust's Board. Its constitution and terms of reference is as set out below.

1.2 The Nominations and Remuneration Committee is authorised by the Trust's Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Nominations and Remuneration Committee.

1.3 The role of the Nominations and Remuneration Committee is to nominate executive directors, including the Chief Executive, for appointment and advise and make recommendations to the Board about remuneration and terms of service for the Chief Executive, executive directors, directors and any senior managers not covered by *Agenda for Change* terms and conditions of service. The Committee also discharges a function in relation to the oversight of employee relations cases of high risk to the Trust. The Chief Executive and / or the Director(s) of Workforce will determine which cases are high risk.

1.4 The Nominations and Remuneration Committee is authorised by the Board of Directors to instruct professional advisers and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise as necessary for or expedient to the exercise of its functions.

1.5 The Nominations and Remuneration Committee is authorised to obtain such information as is necessary and expedient to the fulfilment of its functions.

2 Constitution

2.1 The Board hereby resolves to establish a committee of the Board to be known as the Nominations and Remuneration Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2.2 The Committee will provide assurance to the Trust Board on all areas within its remit based on the evidence received by the Committee using standard classification, i.e.

- **Substantial assurance** based on a conclusion that there is a robust system of internal control and governance in place which will deliver the Trust's corporate objectives (clinical, quality or business) and that controls and management actions are consistently applied

- **Reasonable assurance** based on a conclusion that there is a generally sound system of internal control and governance to deliver the clinical, quality or business objectives and that controls and management actions are generally being applied. Some weakness in the design and/or application of controls and management actions put the achievement of particular objectives at risk. Improvements are required to enhance the controls to mitigate these risks.
- **Limited assurance** based on a conclusion that the design and/or application of controls and management actions are insufficient and the weaknesses put the achievement of clinical, quality or business objectives at risk. Significant improvements are required to improve the adequacy and effectiveness of the controls to mitigate these risks.
- **No assurance** based on a conclusion that there is a fundamental breakdown in or absence of controls and management actions which could result (or have resulted) in failure to achieve the clinical, quality or business objectives. Immediate action is required to improve the controls to mitigate these risks.

3 Membership and attendees

3.1 The Committee will comprise:

- The Board's Chair (who will act as Chair of the Committee)
- Either two non-executive directors (one of whom will act as deputy Chair), or one non-executive director and one associate non-executive director.

3.2 The Committee will be supported by:

- The Director of Workforce
- The Company Secretary

3.3 These officers will service the Committee and provide specialist advice and information for the Committee to make their decisions.

3.4 Other directors or senior managers may be invited to attend (at the discretion of the Chair) as appropriate.

3.5 The composition of the Committee, along with information on attendance will be reported in the annual report.

4 Meetings and quorum

4.1 Committee members are expected to attend all meetings. Apologies must be received by the Chair in advance of the meetings.

4.2 The Committee may invite officers of the Trust to attend. Further attendees may be invited to contribute to key business as required. These officers and additional attendees will not have voting rights.

4.3 The Chief Executive and any other manager acting in an advisory capacity should not be present for discussions about their own remuneration or terms of service, but may attend meetings to support other items.

4.4 In circumstances where an item of business relates to the terms and conditions of employment of a member of the senior management team, the Chief Executive will attend the committee meeting for this item. The Chief Executive will present the paper outlining the proposal, respond to questions and comments about the recommendation but (as a non-member) will not participate in the approval of the recommendation.

4.5 If any Committee member has a pecuniary interest in any matter and is present at the meeting at which the matter is under discussion, he or she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the Committee's consideration has been completed.

4.6 The Chair will preside at all meetings. In extraordinary circumstances where the Chair cannot attend, the Chair will nominate one of the other non–executive Directors (NEDs) to act as Deputy Chair.

4.7 A quorum shall be two members of the Committee. If the Committee is not quorate the meeting will normally be postponed. Exceptionally at the Chair's discretion, a virtual meeting may take place to deal with urgent business. Otherwise, matters would be deferred until the next quorate meeting.

4.8 Meetings shall be held regularly in line with the annual workplan with an expectation of four meetings a year. Additional meetings may be called at the Chair's discretion.

4.9 The Chair of the Nominations and Remuneration Committee and one of the other members, in consultation together, may also act on urgent matters arising between meetings of the Committee in accordance with the Scheme of delegation and the Procedure for emergency powers and urgent decisions (Chief Executive and Chair's actions and Committee urgent matters). Any such action will be reported to the next meeting and be recorded in the minutes of that meeting.

4.10 If, subsequent to any decision of the Committee, there are material changes to the circumstances surrounding the decision that would have implications for the decision should the changed circumstances had been known at the time of the original decision, then these details are to be communicated in full to all members of the Committee, and, as necessary an additional meeting of the Committee should be convened.

4.11 Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

5 Role and duties of the Committee

5.1 The role of the Committee is to:

Nominations:

- Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes.
- Give full consideration to and make plans for succession planning for the Chief Executive and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular, on the Board in future.
- Identify and nominate for appointment candidates to fill posts within the Committee's remit as and when they arise.
- Before an appointment is made, evaluate the balance of skills, knowledge and experience on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates, the Committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.
- Consider any matter relating to the continuation in office of any Board executive director at any time including the suspension or termination of service of an individual as an employee of the Trust.
- Consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of the Committee's responsibilities.

Remuneration and employment matters:

- Advise and make recommendations to the Board about appropriate remuneration and terms of service for the Chief Executive, executive directors and other senior managers not covered by the *Agenda for Change* terms and conditions of service.
- Make recommendations on any residual local pay arrangements not covered by national arrangements.
- Monitor, review and report to the Board on relevant processes of remuneration that are not covered by the *Agenda for Change* pay, terms and conditions or by the consultant contract, the salaried dental contract or the staff and associate specialist contract pay, terms and conditions that may require consideration by exception to meet the business needs of the Trust.
- Ratify and agree any awards at the discretion of the Trust as the employer.
- Advise and make recommendations on termination of employment and or severance payments as detailed in the Trust's standing financial instructions and employment policies.
- Monitor and review (on behalf of the Board) and report to the Board on any exceptional and/or significant employee relations cases of high risk to the Trust including those relating to: employment cases of high cost or of reputational significance.

5.2 When reviewing proposals that have a financial implication for the Trust, the Committee should give due consideration to the Trust's Investment Policy's Scheme of Delegation for Investment Decisions (authorised approval levels).

5.3 The duties can be categorised as follows:

Determining basic salaries

On an annual basis, to ensure that the appropriate salary is applied for the Chief Executive and executive directors, directors and other senior managers not covered by *Agenda for Change* terms and conditions of service.

Contractual arrangements

To make recommendations on contractual arrangements in respect of the Chief Executive, executive directors, directors and other senior managers taking into account relevant national and local policy and guidance.

Development pay for executive directors

To make recommendations regarding development pay for newly appointed executive directors and directors ensuring a robust business case is in place and appropriate approval of the NHS Improvement is sought where necessary.

Performance rewards scheme

To review applications for the performance rewards scheme.

Local contracts

To make recommendations on pay awards for any staff who remain on local contracts.

Exit schemes and extra contractual payments

To have strategic oversight of exit schemes and seek NHS Improvement approval where appropriate. To agree extra contractual payments, taking account of national guidance and ensuring that there are robust supporting business cases.

Severance payments

To consider and recommend to the NHS Improvement for approval any severance payment for the Chief Executive and directors; and for other staff any contractual severance payment of £100,000 or more; and any non-contractual severance payment. Treasury approval must be sought in those circumstances.

Employment policies

To review workforce policies which impact on remuneration and terms of service. To consider and approve if appropriate any variation to a policy where there are financial or financially related matters related to pay.

Other remuneration issues

To make decisions on remuneration issues where a variation in pay, terms and conditions is required in regard to *Agenda for Change* pay, terms and conditions or the Medical and Dental pay, terms and conditions, such as Clinical Excellence Awards, in order to meet the business needs of the Trust.

Employment issues

To receive reports on significant employee relations issues on an exceptional basis, review these on behalf of the Board and report to the Board (in private session) as appropriate. Those cases that will be considered by the Committee will be assessed on the grounds of value for money, reputational risk, impact or precedent or as deemed otherwise to be novel or contentious. The case may relate to current or immediately past employees.

6. Monitoring effectiveness

6.1 Through receipt of assurance reports, the Board will monitor the effectiveness of the Committee. The Committee will produce an annual workplan, an annual self-assessment and an annual report to be submitted to the Audit Committee. This will carry a record of the frequency of attendance by members, quoracy and the frequency of meetings will be maintained. Any areas of concern will be highlighted by the Chair of the Audit Committee to the Board.

7. Authority

7.1 The Committee is authorised by the Board to advise them to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

7.2 The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of those with relevant experience and expertise as necessary in furtherance of its duties.

8. Reporting to the Board

8.1 The Committee will report in writing to the Board through the Committee's Chair's assurance report (produced after each Committee meeting). The report records key issues, actions and decisions and the level of assurance provided to the Board by the Committee's consideration of the relevant item. Minutes of the Committee's meetings will be available for Board members on request.

8.2 The Audit Committee will monitor the effectiveness of the Committee through receipt of an annual report in accordance with best practice.

9. Administrative arrangements

9.1 The Committee will receive appropriate administrative support. Duties will include:

- preparing and circulating the agenda and papers with the Chair
- maintaining accurate records of attendance, main discussion points and decisions taken and issue necessary action logs within five working days of the meeting
- drafting minutes for circulation to the Chair within five working days of the meeting
- maintaining a database of any documents discussed and / or approved and recall them to the Committee when due and filing and maintaining records of the work of the Committee

10. Review of terms of reference

10.1 The purpose, function, responsibilities and duties of this Committee will be reviewed on an annual basis. Any amendments will be put before the Trust's Board for approval.

Agenda item:	2024-25 (55)

Title of report:	Health and Safety Annual Plan

Meeting:	Trust Board Meeting Held in Public
Date:	3 September 2024

Presented by:	Andrea Osborne, Executive Director of Finance and Resources; Jenny Allen, Director of Workforce					
Prepared by:	Cara McQuire, Deputy Head of Safety					
Purpose: (Please tick ONE box only)	Assurance	x	Discussion		Approval	

Executive Summary:	The report provides details of the current compliance with health and safety legislation and policies and the effectiveness of the Trust's health and safety management system. The report informs the Board of the developments that are being made to strengthening elements of the health and safety management system to ensure continuous improvement of health and safety performance. The Health and Safety Group reviewed and agreed the Health and Safety Annual Plan (priorities) 2024/2025 at its meeting in April 2024. Whilst considerable progress was made on the 2023/24 plan, there have been some delays and details of these, and the revised action plan of priorities is contained within this report.

Previously considered by:	Business Committee 29 May 2024

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	x
	Enable our workforce to thrive and deliver the best possible care	x
	Collaborating with partners to enable people to live better lives	
	Embed equity in all that we do	

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	x	Why not/what future plans are there to include this information?	This report does not contain a large amount of data. Staff H&S incidents are small in number when themed.

Recommendation(s)	The Board should confirm that the report including the annual plan 2024/25 provides sufficient assurance of the Trust's management of health and safety.

List of Appendices:	Appendix One: Health and Safety Annual Plan 2024/25

1. Introduction

Looking after the health and wellbeing of staff is far more than supporting staff to develop healthy lifestyles: there is a legal duty to protect as detailed in the NHS Constitution, the Health and Safety at Work etc Act 1974, and the NHS Workplace Health and Safety Standards.

This report provides the Committee with a summary of the principal activities and outcomes relating to the promotion and management of health and safety within Leeds Community Healthcare NHS Trust, since the last report was received.

It provides a review of the management arrangements, legal compliance, accident performance data and health and safety activities and contains an action plan for further planned activities which are required to strengthen the health and safety management system to fulfil the Trust's health and safety obligations.

Workplace health and safety is about sensibly managing risks to protect staff, visitors and the Trust. Good health and safety management is characterised by strong leadership involving managers, workers, suppliers, contractors, and patients.

The Health and Safety at Work etc Act 1974 is the primary piece of legislation covering occupational health and safety in Great Britain.

2. Background

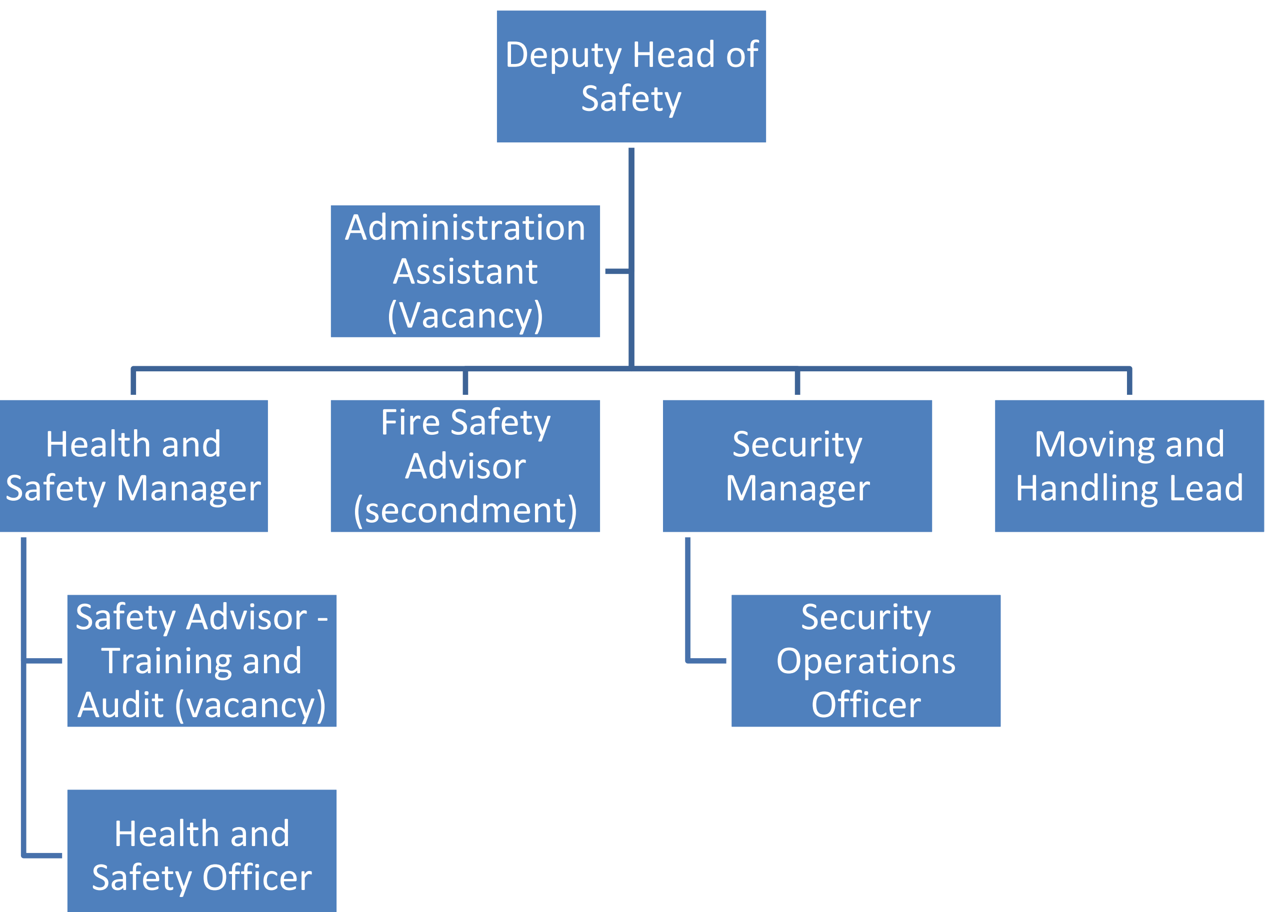
The Trust's aim is to provide and maintain a safe and healthy environment. This can only be achieved through effective leadership by senior management, participation of all staff and open and responsive communication channels.

The Trust is required to monitor and review its arrangements for managing occupational health and safety, to ensure legal compliance and demonstrate that continuous improvements are being made to protect the workforce, visitors and third parties who may be affected by its work activities (Health and Safety at Work etc Act 1974).

3. The Safety Team

The Management of Health and Safety at Work Regulations 1999 requires the Trust to appoint one or more competent persons with sufficient training, experience and knowledge to advise and support the Trust to meet its legal requirements.

The current Safety Team structure which includes the regulatory competent persons is detailed in the following organisational chart:



After successful interview, the Safety Advisor has taken up a six-month secondment opportunity as the Trust's Fire Safety Advisor. He will be attending a Fire training course in July 2024 that covers fire safety within a healthcare setting.

4. Health and Safety Action Plan 2023/24

The Safety Team had an ambitious health and safety action plan for 2023/24, which was progressed but not completed due to:

- Team members' unforeseen absences
- The unavailability of other services from other services/departments whose input and cooperation were required to fulfil some of the actions
- The high and increasing amount of reactive workload that has been generated and requests for guidance and/or assistance by employees
- Input into projects that were not identified when the action plan was drawn-up
- Delays in publishing regulatory requirements nationally (Protect Duty)

Outstanding actions have been carried forward into the 2024/5 action plan (appendix A); this has been reviewed and agreed by the Health and Safety Group. The outstanding actions include ensuring first aid compliance across the Trust, health and safety training for managers, reviews of fire evacuation plans, ensuring the Trust are compliant with the Protect Duty and the development of moving and handling training.

5. Health and Safety Policy

LCH is legally required to have a written health and safety policy that is relevant, current, and meets all legal regulations to help keep staff safe and prevent accidents from happening.

The policy contains three main areas:

- **The statement of general policy on health and safety at work** sets out our commitment to managing health and safety effectively and what we want to achieve.
- **The responsibility section** sets out who is responsible for specific actions
- **The arrangements section** contains the detail of what we are to do in practice to achieve the aims set out in the statement of health and safety policy. This arrangements section could include risk assessment, training, consultation, evacuation.

The policy statement was reviewed by the Health and Safety Group in April 2024, and was endorsed by the newly appointed Chief Executive.

6. Health and Safety Policies and Procedures

An internal review of the current health and safety policies has identified that a number of these are legacy documents that would be better placed as procedures and guidance.

Over the forthcoming year, an impact assessment for the withdrawal of some health and safety policies will be undertaken, ensuring that important information and instructions remains available, but the overall number of policies are reduced.

7. Risk Assessments

The completion and review of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999.

The First Aid need analysis for each occupied building continues. These assessments are used to inform the first aid requirements, including how many first aiders are required, and what level of training is needed.

The newly appointed Moving and Handling Lead has been tasked with identifying the generic manual handling tasks across the services and ensuring that suitable and sufficient manual handling risk assessments have been documented.

The Safety Team is currently supporting the Emergency Planning Manager to ensure that building risk assessments are in place that inform the Trust's emergency response actions plans.

8. Health and Safety Performance

Performance information is based on reactive and proactive performance monitoring (also known as leading and lagging indicators). Reactive monitoring reviews incidents and events that have occurred whilst proactive monitoring identifies what is in place to prevent injury and ill health.

8.1 Reactive Safety Performance

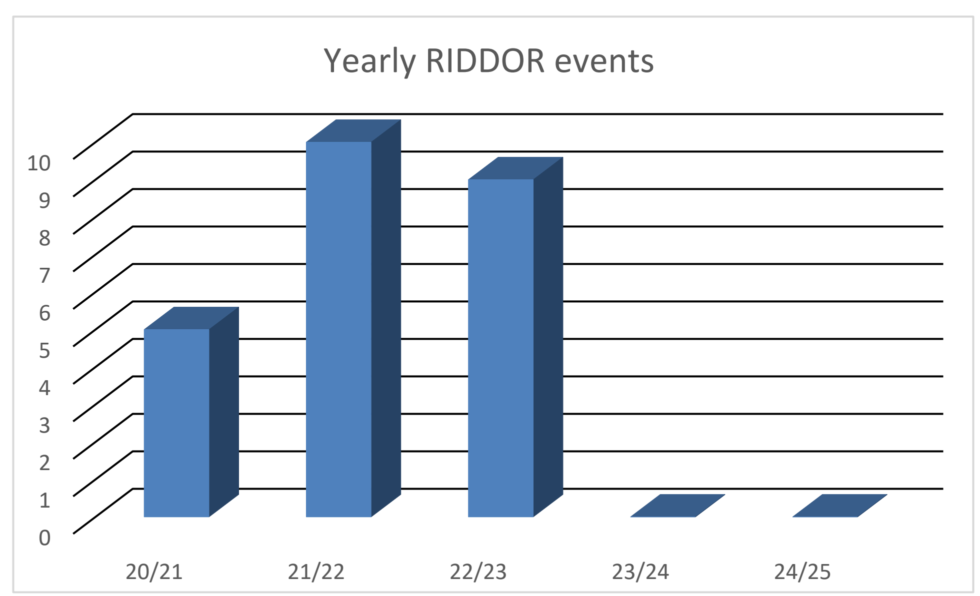
Staff Accidents and Incidents

LCH's incident reporting system is Datix and it is used to report and record accidents. Incident reports are forwarded to the Safety Team to review the contents of the report and determine the severity of the incident.

The Safety Team is the Trust's statutory reporter of accidents that are required to be reported to the Health and Safety Executive (HSE) under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The number of reportable incidents made to the HSE for employees are as follows:

- There were five RIDDOR incident reports made in 2020 - 2021
- There were ten RIDDOR incident reports made in 2021 – 2022
- There were nine RIDDOR incident reports made in 2022 – 2023
- No RIDDOR incidents reports were made in 2023 – 2024
- No RIDDOR incident reports have been made 2024 – 2025 (to date)



There were no new initiatives introduced in 2023/24 that could account for the reduction in reportable accidents or ill health, and it is not known what has caused these results, and whether this is under-reporting or good management.

Communications were produced during the year to explain to staff what RIDDOR incidents were and the importance and procedure for reporting them.

There have been seven significant health and safety incidents that did not fall into the category of RIDDOR because the accidents were not classed as work related.

- A staff member who received a moderate head injury when a waste bin lid with a metal locking device fell onto their head as they attempted to look into the bin; this resulted in over two weeks sickness absence.
- A staff member aggravated a pre-existing injury when they undertook what should have been a two-person respite visit on their own and attempted to hoist a child from their bed to initiate a feed; this resulted in 11 days sickness absence.
- Whilst a staff member was sitting on an office chair, it collapsed underneath her, potentially due to the chair's age and condition.
- A staff member received a minor chemical burn through latex gloves whilst using phenol (a hazardous substance used within podiatry)
- A staff member had a finger trapped by a falling door when attempting to change a awkwardly placed filter in a clinical room.
- A contractor drilled through an electrical cable whist replacing doors (capital works) He was not injured but the incident did trip the electricity and required immediate repair to make the situation safe.
- A member of bank staff was carrying equipment down the stairs as the lift was out of order. She missed her footing and fell down the stairs, resulting in an over 7 days absence from normal duties.

Security Incidents:

The service provides a range of retrospective investigative support to every part of the Trust.

During 2023/24 the Security Service assisted staff with an average of 23 cases of violence and aggression per quarter, including threats of violence against staff, a successful conviction of large scale theft of Trust property, drug users and drug dealers in Trust property (grounds and toilets).

External Security liaison and investigation

The Security Service has engaged with Police (usually by providing CCTV evidence) in a wide range of enquiries on an almost daily basis. The range of crimes includes, for example; burglaries, thefts, assaults, vehicle taking, criminal damage, drug dealing and others.

Additionally the service has participated in the investigation of several external serious crime, (unrelated to LCH activities).

Fire Incidents

There has been one fire incident where a burning smell was noticed coming from the laptop charger where it was connected to the laptop's charging port. Smoke was also

seen emerging from the charging port. The charger was disconnected and unplugged from the computer.

There have been two unplanned evacuations due to the fire alarm sounding. In both cases, a fire engine arrived at the site:

- The first incident took place at Halton Clinic on 4 December 2023, when the contractor failed to disconnect the alarm prior to its weekly check.
- The second incident occurred 22 February 2024 when a staff member forgot to inform the alarm monitoring company EMCS to disconnect the fire alarm before testing the call-points.

Claims against the Trust

A claim has been made against the Trust for a person who required surgery on their finger after trapping it in the hinge side of the door at a health centre in February 2023. This was reported to the Health and Safety Executive, urgent actions were taken to mitigate the risk of this type of incident recurring. There has been no further action requested by the Health and Safety Executive.

Incident Reporting and Investigations

Independent investigations into significant or potentially significant events are undertaken by members of the Safety Team to ensure that root causes are identified, and lessons for improvements can be shared.

During May 2024, a programme of work will commence to improve the reporting categories within Datix that relate to health and safety, fire and security incidents, ensuring that staff are able to report and categorise incidents efficiently.

8.2 Proactive Safety Performance

Health and Safety, Security and Fire Inspections

The Trust's health, safety, fire and security inspections focus on hazards in the work environment; they are a check on workplaces and work activities to ensure that they are healthy and safe. Inspections can help prevent incident, injuries, and illnesses by addressing identified hazards. In the case of security, inspections consider threats and identify vulnerabilities, these are then addressed to reduce potential consequences.

Health and Safety Inspections

Health and Safety building inspections are carried out on an annual basis. These inspections have been completed for all LCH occupied premises and findings have been added to the Assure software system to ensure that any corrective actions are tracked to closure.

The main areas of concern highlighted by health and safety inspections are:

- Fire Safety, including poor housekeeping practices, potential sources of ignition such as untested portable electrical equipment, and fire doors being propped open
- Poor electrical safety practices including trailing wires, and ‘daisy-chaining’ extension leads.
- Lack of manual handling risk assessments
- Staff not reporting building defects
- Some staff remain unaware of the need to complete Display Screen Equipment assessments.

Fire Safety Risk Assessments

All fire risk assessments have been carried out and recorded on the Assure software. The fire risk assessment programme will now revert to a three yearly schedule supplemented by regular inspections to ensure standards are retained.

Some risk assessment actions remain outstanding and some have yet to be assigned. The newly appointed Fire Safety Advisor is reviewing and will be working closely with other departments to ensure that responsibility is assigned and suitable measures are put into place. Any high risk findings have been prioritised and are now resolved.

The main areas of concern that have been identified during fire inspections were:

- Storage of equipment, with storerooms being overcrowded and items left near sources of ignition
- Compartmentation within the buildings to prevent the spread of fire
- Poorly fitting fire doors, with gaps allowing smoke to penetrate

Estates are continuing to address the outstanding findings.

Threats and Vulnerability Assessments (Buildings)

The Security Manager continues to review the security arrangements of all occupied buildings, and has worked with services to identify improvements, particularly in areas of buildings where there is a high likelihood of violence and aggression due to the nature of the service provided.

Security Guards provided by Profile Security who are working with ICAN services are now required to be DBS checked and undertake some of LCH’s statutory training so that they can support the clinical services with enhanced understanding of safeguarding.

There is to be a continued focus on CCTV, with the view to creating a centralised control room where images can be accessed remotely rather than by visiting each site. This will be beneficial as many sites have CCTV provision that is not ergonomically suitable, and it will reduce the travel and time costs of those who need to review images.

The networking of CCTV into a central control room will also assist in the event of an emergency lockdown/evacuation situation.

Safety Team Audits

First Aid needs analysis assessments were completed for LCH's occupied buildings during 2023/24. These identified a number of issues, including a shortage of named first aiders mainly due to hybrid working. Many of the Front of House staff have undertaken first aid courses, but there are still insufficient numbers of staff who are named first aiders. The Safety Team will continue to encourage more staff to enrol on first aid courses. The Health and Safety Group will continue to monitor the situation.

During 2024/25 the Safety Team will focus on the Lifting Operations and Lifting Equipment Regulations, reviewing the Trust's use and maintenance of equipment that is used to lift patients.

Health, Safety, Fire and Security Training

The Management of Health and Safety at Work Regulations require employers to provide adequate health and safety training at different points in their employment (e.g. at recruitment, on being given new or different responsibilities, when new work equipment, technologies or systems of work are introduced). This training must be repeated periodically, where appropriate.

Health and Safety Training

The Safety Team is finalising the Health and Safety Manager Training package which will inform managers of the contents of the Health and Safety Policy alongside their roles and responsibilities in relation to health and safety and roll out of the mandatory course is imminent.

Security Training

During the reporting period a risk assessment was designed for assessing staff risks of lone working, Safety Champions were trained in how to complete and record the assessment. This identified high risk categories, requiring lone worker protection.

The Security Team continues to provide:

- Closed Circuit Television (CCTV) review training
- Telephone Conflict Resolution Courses
- Enhanced physical conflict avoidance and resolution for staff working in young offenders' establishments and Police custody suites.

It is anticipated that a new mandatory training package will need to be provided to ensure that the Trust meets its legal requirements for the forthcoming Prevent Duty.

Preparation is underway for the roll-out of ACT (Action Counter Terrorism) training Trust wide with access for all staff.

Fire Safety Training

Fire Safety training is hosted virtually via MS Teams to remove the need for staff to travel to receive the training and to maximise the Fire Safety Advisor's time.

A new Fire Safety Training needs analysis procedure is in development, that details the content and frequency staff require training dependant on the risks that they are exposed to (activities and working environment).

9 Physical Security Operations

The service routinely carries out physical security and crime prevention activities including:

- Operational control and deployment of locking / unlocking activities carried out by security contractors.
- Deployment of human security resources as required to meet perceived need and to counter specific threats.
- The conduct of physical security surveys and Threat / Risk / Vulnerability assessments.
- Provision of professional advice and recommendations regarding the security of new projects and refurbishments.

Examples of physical security activities in 2023-2024 include:

- The deployment of permanent security guards to one health centre to meet identified risks including extremely aggressive behaviour towards staff by families. Due to the nature of the service and the requirements of the static guards the LCH Security Team has overseen the introduction of specific STATMAN training / E-DBS vetting for guards.
- The development of security protections at WROP including the use of electronic access-control tagging of LCH ID cards, the introduction of 'zoned' colour coded visitor / contractor ID badges and the design of 'panic' and 'Lockdown' procedures and alarms.

10 Manual Handling

The newly appointed Moving and Handling Lead joined the Safety Team in April 2024. He will be reviewing the current manual handling arrangements across the Trust to establish compliance against the Manual Handling Operations Regulations. The Health and Safety Executive was very keen for the Trust to progress this work when the last inspection took place.

11 The Health and Safety Group

The Health and Safety Group, currently chaired by the Director of Workforce, provides a structured approach to communication and consultation. It meets five times a year and provides a forum where Business Unit representatives, Staff-side, the Safety Team, Human Resources, Facilities and Estates can work together to resolve health and safety issues. Issues which require escalation are raised at the Business Committee.

12 Conclusion

The Trust has made progress during 2023/24 in areas that were previously identified as being weak. These include security (violence and aggression, lone working), and fire risk assessments. Unforeseen staff absences have delayed progress with some aspects of health and safety improvements, however the team prioritised any areas of high risk to ensure the Trust remained safe. The action plan for 2024/25 will support further maturity of the Trust's health and safety management system and improve its safety culture.

13 Recommendations

The Board should confirm that the report including the annual plan 2024/25 provides sufficient assurance of the Trust's management of health and safety.

Appendix One

Health and Safety Annual Plan 2024/25

The table below details the key actions for 2024/25; these will improve compliance with legal requirements.

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
Health and Safety					
1.1	**Provision of suitable and sufficient information, instruction and training.** Delivery of the new Health and Safety Training for Managers. Driver: to increase the Trust's health and safety maturity.	Finalise the mandatory training sessions for managers Ensure that all members of the Safety Team can all deliver the contents to the same standard Commence training programme	May 2024 (completed) July 2024 (completed) September 2024	Training slides, trainer manual and supporting manager's handbook are being updated to ensure they provide sufficient information. CRISSP (critical incident staff support pathway) information is being added to ensure staff can access assistance should accidents or incidents cause distress. First training course to be delivered 23 September (ABU).	Cara McQuire, Deputy Head of Safety
1.2	**Accident and Incident Reporting (Reporting of Injuries, diseases and dangerous**	Work with the Governance Systems Manager to ensure that health and safety, fire and	September 2024	First meetings for Datix formatting to commence in May 2024	Cara McQuire, Deputy

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
	occurrences regulations) The Datix incident reporting module needs to align with the Health and Safety incident reporting and investigation procedure Driver: to improve the speed and quality of safety incident analysis.	security categorisations are suitable and can assist in trending and analysis of performance.			Head of Safety
1.3	Ensure the Trust is compliant with the **First Aid at work** regulations. Driver: recent gap analysis conducted. Risk has been assessed and is to be added to risk register.	Resolve gaps in first aid provision across the Trust due to there being few static people in buildings by encouraging additional staff to undertake first aid training courses.	December 2024		Rebecca Mazur, Health and Safety Manager
1.4	Ensure the Trust has suitable processes in place for all Trust's lifting equipment to be legally compliant with the **Lifting Operations**	Undertake an audit of LOLER compliance across fixed and unfixed lifting equipment (patient hoists etc).	June 2024 (commenced)	This has commenced however progress with this action is delayed due to the audit/trainer position being vacant.	Rebecca Mazur, Health and Safety Manager

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
	and Lifting Equipment Regulations (LOLER) Driver: Risk register 1139, service and repair of medical devices.	Work with the Medical Device Safety Officer to complete a gap analysis and action plan for improvement to ensure all relevant departments understand their roles and responsibilities, and that Trust is meeting its legal requirements in relation to the equipment that is used throughout the Trust.	October 2024		
Fire Safety					
2.1	**Fire Evacuation Plans** review of all evacuation plans Driver: Risk register risk 1178: adequate and consistent fire evacuation arrangements in shared premises Driver: Risk 1242 fire evacuation	Support the Emergency Planning Manager, and work with the wider specialisms (Security, Facilities and Estates) to ensure that significant Fire risks for each occupied building are incorporated into the new Emergency Prevention, Preparedness and Response (EPPR) risk assessments	July 2024	The role of the fire marshal is being established across the trust for all staff because of hybrid working.	Charles Okonma, Fire Safety Advisor

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
	arrangements in LCH owned premises.	Once the EPPR risk assessments are in place, the evacuation procedures for each site need to be reviewed (potential new format).	Dependant on above timescale being achieved		
2.2	**Fire training needs analysis -** Document a Trust Needs Analysis for all groups of staff relating to fire training Driver: Risk register risk 1178: adequate and consistent fire evacuation arrangements in shared premises.	Fire training is already provided within the Trust; however the training provision requires a review to ensure that all staff are receiving an appropriate level of training, including fire marshals, safe evacuation of patients	September 2024		Charles Okonma, Fire Safety Advisor
2.3	**Emergency Evacuation of Staff and Patients** Driver: Quality and Value programme. Train the trainer approach is more cost effective than	Complete the evac+chair plus train the trainer course. Work with the new Moving and Handling Lead to develop evac chair training for clinicians – this will need to include	September 2024	Evac Chair train the trainer course is booked for September 2024.	Charles Okonma, Fire Safety Advisor

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
	commissioning individual courses.	a review and training of the patient and staff needs assessment relating to evacuation /Personal emergency evacuation plans			
3. Security					
3.1	**Emergency Prevention Preparedness and Response (EPRR)** Driver: EPRR national audit has identified additional requirements of all trusts for immediate response to emergency incidents.	Support the Emergency Planning Manager, and work with the wider specialisms (Fire, Facilities and Estates) to ensure that significant security threats, risks and vulnerabilities for each occupied building are incorporated into EPPR risk assessments Once the EPPR risk assessments are in place, assist with the development of the evacuation and invacuation plans as appropriate.	July 2024 Dependant on development of the above	Threats, Risks and Vulnerability Assessments are in progress across the Trust's owned and leased premises.	Andrew Stephenson, Security Manager
3.2	**Compliance with the new Prevent Duty**	Lead the response to the introduction of the new '**Prevent Duty'** counter	TBC depending on regulatory		Andrew Stephenson,

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
	counter terrorism legislation Driver: This legislation, and the changes it brings, will enhance the protection of the United Kingdom's publicly accessible places from terrorist attacks and ensure that businesses and organisations are prepared to deal with The Government's response document to the Protect Duty public consultation was published on 2 May 2023.	terrorism legislation; ensure adequate structures, training, policy and procedures are in place in time to meet the legislative compliance deadlines. incidents.	requirements (not yet published)		Security Manager
3.3	**Action Counters Terrorism (ACT)** Driver: as above	Manage and lead the roll-out of ACT (action counters terrorism) training making it available to all staff across the Trust.	TBC (depending on availability)	The roll out of ACT trust-wide is planned, designed and will begin with a communication campaign in September 2024.	Andrew Stephenson, Security Manager
3.4	Centralisation of **CCTV** across the owned estate (network the system securely so that all CCTV images can	Drive the centralisation of CCTV project enabling greater efficiency, effectiveness and speed by remotely reviewing	Ongoing	A central CCTV office has been identified and is being made fit for purpose.	Andrew Stephenson, Security Manager

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
	be viewed from a single, central site) Driver: Risk register 1099 Improper management of CCTV systems, creating information governance risk.	CCTV images from remote locations in one central point.			
3.5	**Supporting the development of a Mandatory Security Management Standard to be introduced in 2025** Driver: Mandatory Security Management Standard to be introduced in 2025	Monitor and actively participate in the national project work being done by NHS England, NAHS and NPAG to develop the new Mandatory Security Management Standard to be introduced in 2025 which will impose very specific duties and responsibilities on the Trust. In doing so position the Trust to be ready to adopt the standard on time and to the required level	Ongoing		Andrew Stephenson, Security Manager
4. Manual Handling					
4.1	Develop a **manual handing training needs analysis** for all	Review the moving and handling training that is currently on offer and what is being developed	March 2025		Matt Freeman, Moving and

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
	roles/services across the Trust. Driver: Recommendations made by Health and Safety Executive to have robust and integrated manual handling training provision.	(city wide training) to ascertain how it meets (if it does) the needs of the services. Identify gaps in training provision. Work with Organisational Development to find/agree solutions.			Handling Lead
4.2	**Manual Handling Operations Regulations 1992 (as amended)** **Ensure that there are suitable and sufficient Manual Handling Risk Assessments and associated procedures** - staff are aware of the risks, and the necessary precautions/control measures have been documented. Driver: As above	Identify all the generic manual handling tasks across the Trust to ascertain legal compliance Undertake a gap analysis to ascertain if all generic manual handling tasks have been formally risk assessed (input onto Assure) and have an associated procedure that informs staff of the correct lifting techniques and how to use specific equipment **Develop** an action plan (based on risk) to address the gaps in risk	November 2024 November 2024 January 2025		Matt Freeman, Moving and Handling Lead

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
		assessments and procedures			

Agenda item:	2024-25 (56i)

Title of report:	Board Assurance Framework – process update

Meeting:	Trust Board Meeting Held in Public
Date:	3 September 2024

Presented by:	Selina Douglas Chief Executive					
Prepared by:	Company Secretary					
Purpose: (Please tick ONE box only)	Assurance √		Discussion		Approval	

Executive Summary:	This paper describes to the Board how the various elements of the Board Assurance Framework (BAF) process have been carried out during the last 12 months, and in particular the processes in relation to the 2024/25 redesign of the BAF.

Previously considered by:	Audit Committee 12 July 2024

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	√
	Use our resources wisely and efficiently	√
	Enable our workforce to thrive and deliver the best possible care	√
	Collaborating with partners to enable people to live better lives	√
	Embed equity in all that we do	√

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	N/A
	No		Why not/what future plans are there to include this information?	N/A

Recommendation(s)	For Noting

List of Appendices:	Appendix A Strategic Risk 7 (assigned to Audit Committee)

Executive summary (Purpose and main points)

This paper describes to the Audit Committee how the various elements of the Board Assurance Framework (BAF) process have been carried out during the last 12 months, and in particular the processes in relation to the 2024/25 redesign of the BAF.

The Audit Committee is asked to evaluate the effectiveness of the Board Assurance Framework process as described in the risk management policy and procedure, in order to provide assurance to the Board.

The Audit Committee has been assigned BAF 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.'

As part of the BAF review process, the Audit Committee should review the adequacy of the sources of assurance for this strategic risk.

Recommendations

The Board should:

- Evaluate the effectiveness of the Board Assurance Framework (BAF) process.

- Review the adequacy of the sources of assurance for the strategic risk assigned to it: BAF Risk 7 **'**Failure to maintain business continuity, including response to cyber security' (see appendix A). Assigned to Audit Committee.

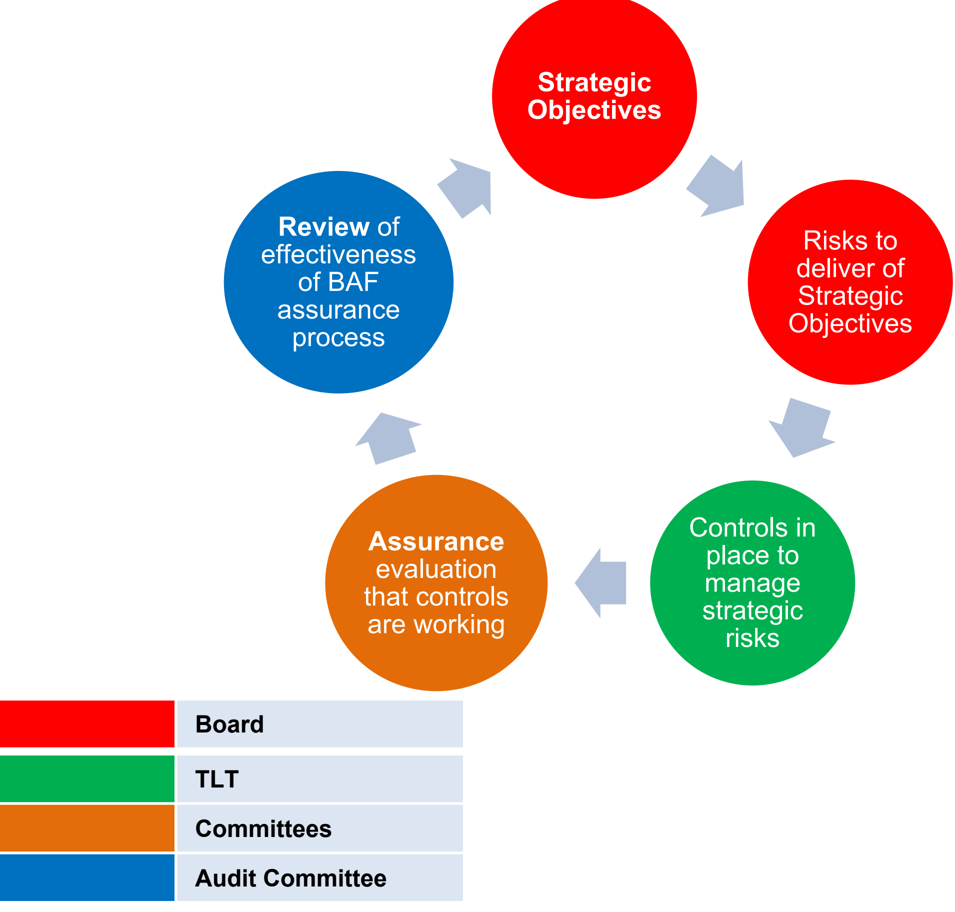
1 Introduction

At any point in time the Board needs to be aware of the current state of progress about its strategic objectives. Whilst there will always be elements of uncertainty, the Board needs to be assured (positively or negatively) as to what is feasible and practicable regarding the delivery of its core objectives. The BAF is a significant tool in helping the Board hold itself to account, understand the implementation of strategy and the risks that might impede delivery of its strategy and brings together:

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

The Audit Committee Handbook identified the BAF as *"the key source of evidence that links strategic objectives to risks and assurances, and the main tool that the Board should use in discharging its overall responsibility for internal control".*

A unique role is allocated to the Board, Trust Leadership team (TLT), and the governance committees. This is described within the diagram and narrative below.



- The role of the Board is to agree the strategic objectives and identify the risks to delivering on these. Identified strategic risks are recorded on the Board Assurance Framework (BAF).
- The role of TLT is to determine how great the risk is (likelihood and consequence) and to control the risks
- The role of the committees who are assigned strategic risks is to continually check that the controls are working by agreeing the sources of assurance needed, reviewing the evidence (within the sources of assurance) and inform the Board whether those risks are being effectively controlled
- The role of Audit Committee is to check that the assurance process is working

This paper describes how the various elements of the BAF process have been carried out during the last twelve months, and in particular the processes in relation to the 2024/25 redesign of the BAF.
The Audit Committee is asked to evaluate the effectiveness of the Board Assurance Framework process in order to provide assurance to the Board.

2 Trust Leadership Team Interim Review

During March 2024 the Directors reviewed the 2023/24 BAF strategic risks for which they were responsible. There was one proposed change to the score for Strategic Risk 5: Failure to deliver financial and performance targets with the score increasing from 12 to 16 due to the increased likelihood of overspending in April 2024. Additional controls and sources of assurance were added, and gaps to controls or sources of assurance identified and actions recorded.
As a result, an up to date version of the BAF was in place from 1 April 2024, pending a full review of the strategic risks aligned to the 2024/25 strategic framework in April 2024.

3 Board agreement on the strategic objectives

The Board considered and approved the draft 2024/25 strategic framework including the proposed strategic objectives and draft annual priorities at its meeting on 28 March 2024.

4 Trust Leadership Team (TLT) full review of strategic risks for 2024/25

During April, following Board approval of the strategic objectives for 2024/25 and the commencement of the new Chief Executive, the TLT then undertook a comprehensive review which resulted in the confirmation of the strategic risks for 2024/25, with some risks consolidated, a new risk introduced, and the rewording of other risks. Director risk owners and risk scores were agreed, the controls and sources of assurance were reviewed, and the strategic risks were assigned to Committees or the Board for oversight.

5 Committees review

At it's April 2024 meeting the Audit Committee was updated on the process for the completed March interim review and the plan for the revised 2024/25 BAF, and then in May 2024 the Business and Quality Committees were advised of the details of the strategic risks that had been assigned to them.

During July 2024 the Business, Audit and Quality Committees will each conduct a review of the sources of assurance for the strategic risks assigned to each committee as part of their review of agenda composition. For Audit Committee this relates to BAF Risk 7 'Failure to maintain business continuity, including response to cyber security' – see Appendix A.

6 BAF Activity Reports

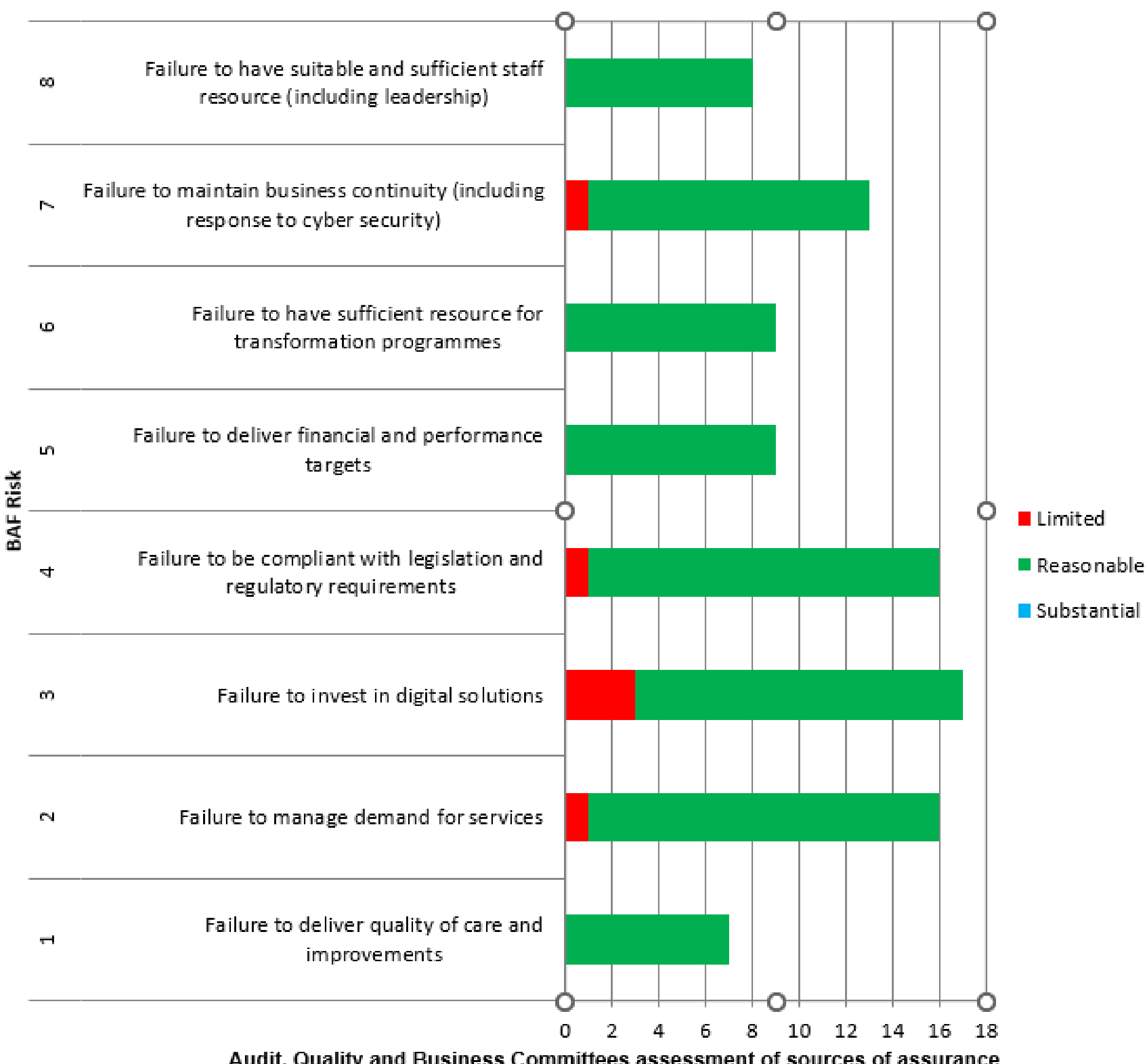
The Quality and Business Committees (November 2023 and March 2024) received and reviewed papers that demonstrated the extent to which each strategic risk had been considered by each committee since adopting the revised Committee Chair's assurance report template in July 2020.

The Business and Quality Committees will next receive BAF activity reports in November 2024 and review their work plans, and where there are insufficient sources of assurance presented at committee meetings for any strategic risks this can be remedied.

7 Review of effectiveness of BAF assurance process

The Quality, Business and Audit Committees continue to evaluate the sources of assurance that have been received at each committee meeting from each agenda item and agree on the level of assurance these provide. The Committee Chairs' assurance reports that are presented at each Board meeting indicate the level of assurance against each relevant strategic risk.

Chart 1 below shows the strategic risks that have been assessed by those committees during their meetings between April 2023 and March 2024 and the levels of assurance provided.



During this period there were a small number of risks for which the committees received insufficient or no relevant sources of assurance at their meetings to be able to evaluate whether the strategic risk was being managed:

Risk 2 Failure to manage demand for services (Business Committee)

Risk 3 Failure to invest in digital solutions (Audit Committee) – this risk was subsequently removed from the Committee in December 2023 due to a consistent lack of relevant assurance from its workplan items but would continue to be overseen by the Quality and Business Committees.

Risk 4 Failure to be compliant with legislation and regulatory requirements (Business Committee)

Risk 7 Failure to maintain business continuity (including response to cyber security) (Audit Committee)

The committees work plans have been mapped against the strategic risks in the revised BAF and where there are insufficient sources of assurance presented at committee meetings, this will be remedied.

8 Quarterly Reviews

As part of the revised BAF for 2024/25, an additional quarterly review process has been established, whereby the Trust Leadership Team will carry out a full review of all strategic risks and update scores, controls/ sources of assurance and any gaps identified, and any changes to links to the Trust's Corporate Risk Register. The output of these quarterly reviews will then be presented to the Trust Board in October, December and March with the full updated BAF shared with Board on each occasion.

9 Internal audit assurance on the BAF strategic risks

The internal audit programme for 2024/25 has now been aligned with the strategic risks to provide useful sources of independent assurance to Committees and the Board. The table below demonstrates how each internal audit connects with a strategic risk.

BAF reference	Audit title
All Strategic Goals and Risks, plus fundamental to HoIA Opinion	Board Assurance Framework and Risk Management Framework
SR1,8&9	Raising Concerns and the Freedom to Speak-Up
SR1,2,4,6,7,8,9&10	Patient Safety Incident Response Framework
All Strategic Goals and Risks	Quality and Value Framework
SR1,4,8,9&10	Mortality Rates/Learning from Deaths
SR1,4,8&9	Safeguarding
SR1,2,4,8,9&10	Health Equity
All Strategic Goals and Risks	Budgetary Control
SR1,5,6&7	Key Financial Systems
All Strategic Goals and Risks	Procurement
SR1,2,4,8,9&10	Children and Young People's Services
SR1,3,4,6,7&8	Emergency Preparedness, Resilience and Response (EPRR)
SR1,4,8&9	Appraisals
SR1,4,6&8	Recruitment: Pre-employment checks
SR3,4&7	Data Security and Protection Toolkit
All Strategic Goals and Risks	Cyber Security
N/A	Audit Management

10 Recommendations

The Audit Committee should:

- Evaluate the effectiveness of the Board Assurance Framework (BAF) process
- Review the adequacy of the sources of assurance for the strategic risk assigned to it (Appendix A).

<table>
<tr><th rowspan="2">Strategic Goals</th><th>1. Work with communities to deliver personalised care</th><th>2. Use our resources wisely and efficiently both in the short and longer term</th><th>3. Enable our workforce to thrive and deliver the best possible care</th><th>4. Collaborating with partners to enable people to live better lives</th></tr>
<tr><th colspan="4">5. To embed equity in all that we do</th></tr>
<tr><td rowspan="6">Strategic Risks</td><td>Risk 1 Failure to deliver quality of care and improvements: If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm. Quality Committee (Exec Director of Nursing and AHPs)</td><td>Risk 5 Failure to deliver financial sustainability: There is a risk that the Trust will not be financially sustainable which will jeopardise delivery of all our strategic goals and priorities. Business Committee (Executive Director of Finance and Resources)</td><td>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, within an engaged and inclusive workforce then the impact will be a reduction in quality of care and staff wellbeing and a possible misalignment with the objectives of the Q&V programme
Business Committee (Director(s) of Workforce)</td><td>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. Trust Board (Chief Executive)</td></tr>
<tr><td>Risk 2 Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage. Quality Committee and Business Committee (Exec Director of Operations)</td><td>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. Business Committee (Exec Director of Operations)</td><td></td><td></td></tr>
<tr><td colspan="2">Risk 3 Failure to implement the digital strategy. If the Trust fails to implement the agreed digital strategy, then, services could be inefficient, software may be vulnerable, and the impact will be delays in caring for patients and less than optimum quality of care. Quality and Business Committees (Exec Director of Finance and Resources, Exec Medical Director)</td><td></td><td></td></tr>
<tr><td></td><td colspan="2">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. Business and Audit Committees (Exec Director of Operations and Executive Director of Finance and Resources)</td><td></td></tr>
<tr><td colspan="4">Risk 4 Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation, and adverse media attention. Quality and Business Committees, and Trust Board. (Trust Leadership Team)</td></tr>
<tr><td colspan="4">Risk 9 Failure to prevent harm and reduce inequalities experienced by our patients. If the trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently causing harm, delivering unfair care and exacerbating inequalities in health outcomes within some cohorts of patients. Quality Committee / Trust Board (Medical Director)</td></tr>
</table>

Strategic 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.

Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

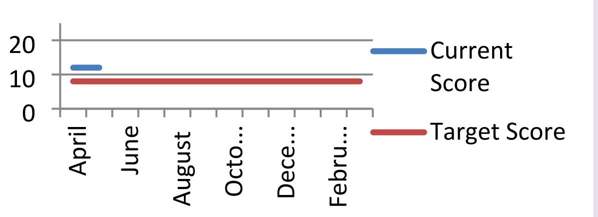
Risk Appetite: Cautious (moderate) appetite for risks relating to its reputation, the Trust's appetite is to ***avoid* risk *(*zero appetite*)*** of financial loss and **minimal (low)** to **cautious (moderate)** appetite to risk that could compromise the delivery of high quality, safe services.

Lead Director/risk owner: Executive Director of Operations and Executive Director of Finance and Resources

Committee with oversight: Business and Audit Committees

Date last reviewed: April 2024

Risk Rating
(consequence x likelihood)
Current score:
4 x 3 = 12
Target score (end of 2024/25):
4 x 2 = 8



Rationale for current risk score:
Risk score assessed against the Number of High Severity Alerts received in the last quarter, the number of CSOC Cyber notifications indicating potential threats detected on the LCH infrastructure, the results from the most recent Phishing campaigns and penetration test (no of highs).

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Ability to test Business Continuity plans with clinical services to test for prolonged service loss.
Deployment of the revised Cyber Incident Response Plan.

Controls *(what are we currently doing about the risk?)*:

- ICS wide command structure (OPEL)
- Critical services prioritisation
- ICS mutual aid support systems
- Information Governance Approval Group
- Trust command structure (Gold, Silver, Bronze)
- Business Continuity Plans (and IT disaster recovery plans)
- On-call rota and on-call escalation procedure
- Technical controls: Software patching regime, smooth walls and firewalls, NHS Digital Advance Threat Protection Service
- 6-monthly penetration test - testing network perimeter defences
- Annual data security statutory/mandatory training for all staff
- CareCert Weekly plus High Severity Alert Notifications for up-to-date alerts from NHS Digital to highlight risks
- BAE Systems cyber response service contract in place until September 2024 (recovery from attack) plus access to NHS England Cyber Incident Response Team.
- Major incident plan
- System testing / desk top exercises
- Data back-up systems

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
Multi Factor Authentication application to remaining NHS Mail accounts and any further accounts identified with elevated permissions. Final clarification sought from regional NHS England cyber lead that technical controls in place meet required standards.	Executive Director of Finance and Resources	June 2024
EPRR compliance level	Executive Director of Operations	Q3 2024/25
Limited internal "specialist cyber" capacity unable to meet demand	Executive Director of Finance and Resources	August 2024
Implement recommendations of latest Penetration Test.	Executive Director of Finance and Resources	July 2024
Maintenance of Cyber Essentials Plus Certification, including regular scanning and patching of all software and hardware	Executive Director of Finance and Resources	March 2025

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Emergency preparedness (annual) including self-assessment (BC then Board) • EPRR quarterly compliance updates to Business Committee and Board	• Scrutiny of Major Incident Plan (annual) (BC then Board) • Reports regarding major incident exercises and deep dives (included in Emergency preparedness report (annual) (BC then Board) • Performance Brief (Responsive) (BC) • Information Governance Approval Group minutes (AC) • Statutory/mandatory training compliance (Performance Brief) (BC)	• Internal audit (BC/AC) • Data Security & Protection Toolkit audit (AC) • Cyber Essentials Plus Certification

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
EPRR Quarterly updates and annual assessment	Director of Operations – (Accountable Emergency Officer)	June 2024
Updated Cyber Incident Response Plan	Executive Director of Finance and Resources	June 2024

Link to Risk Register (material operational risks scoring 12 or above):
Risk 1187: Insufficient IT Resilience leading to the risk of extended outages of the infrastructure (12)
EPRR risk to be added to the risk register.

Leeds Community Healthcare NHS Trust

Agenda item
2024-25
(57)

Public Board workplan 2024-26
Version 3: 21 08 2024

TOPIC	Frequency	Lead officer	BAF Strategic Risk	7 June 2024	19 June 2024- Annual Report and Accounts only	3 September 2024	4 October 2024	6 December 2024	6 February 2025	3 April 2025	5 June 2025	25 June 2025- Annual Report and Accounts only	4 September 2025	2 October 2025	4 December 2025	5 February 2026
STANDING ITEMS																
Declaration of interests (table from Declare)	every meeting (from April 2024)	CS	N/A	X	X	X	X	X	X	X	X	X	X	X	X	X
Minutes of previous meeting	every meeting	CS	N/A	X		X	X	X	X	X	X		X	X	X	X
Action log	every meeting	CS	N/A	X		X	X	X	X	X	X		X	X	X	X
Board workplan	every meeting	CS	N/A	X		X	X	X	X	X	X	X	X	X	X	X
Patient story	every meeting	EDN&AHPS	N/A	X		X	X	X	X	X	X		X	X	X	X
STRATEGY AND PARTNERSHIPS																
Chief Executive's report - including Sytem Flow (from September 2024)	every meeting	CE	All	X		X	X	X	X	X	X		X	X	X	X
System flow (part of CE report from Sept 2024)	Every meeting	EDO	SR 10	X												
Organisational (Trust) priorities (for the coming year) for approval	Annual March	EDFR	SR 6,8							Final X						
Trust priorities update	3x year (Feb, June and Oct)	EDFR/EDN&AHPS	SR 6,8	X			X		X		X			X		X
Third Sector Strategy	2x year (Feb and Sept)	EDO	SR 10			X			X				X			X
Estate Strategy	2xyear (Mar and Oct)	EDFR	SR 6				X -Blue box			X -Blue box				X -Blue box		
Digital Strategy	2x year To be confirmed	EDFR	SR 3,6	Deferred to Oct 2024			X									
Business Development Strategy	2x year(Mar and Oct)	EDO	SR 6				X -Blue box			X -Blue box				X -Blue box		
Business Intelligence Strategy	2x year (Feb and Sept)	EDFR				X -Blue box Deferred	X -Blue box		X -Blue box							X -Blue box
Learning and Developement Strategy	2x year (Mar and Oct)	EDN&AHPS	SR 1				X -Blue box							X -Blue box		
Engagement Strategy	2xyear (March and Oct)	EDN&AHPS	SR 1				X -Blue box	X -Blue box		X				X -Blue box	X -Blue box	
Patient Safety Strategy	2x (March and Oct)	EDN&AHPS	SR 1,2,4				X			X				X		
Health Equity Strategy	3 x year(March, Sept and December)	EMD	SR1,9			X		X		X			X		X	
Children, Young People and Families Strategy	2xyear (Mar and Oct)	EDO					X -Blue box		X - Blue box item				X -Blue box			X - Blue box item
Quality Strategy	2xyear(June and December)	EDN&AHPS	SR 1,4	X - Blue box item				X - Blue box item			X - Blue box item				X - Blue box item	
Workforce Report and Strategy update	3x year (Feb, June and Oct)	DW	SR 4,8	X			X		X		X			X		X
Research and Development Strategy	annual	EMD				X										
QUALITY AND SAFETY																
Quality Committee Chair's Assurance Report	every meeting	CS	SR 1,2,3,4	X		X	X	X	X	X	X	X	X	X	X	X
Quality account	Annual	EDN&AHPS	SR 1	X							X					
Mortality Annual report	Annual (June)	EMD	SR 1,4	X							X					
Patient Safety Incident Investigations Report (formerly Serious incidents report and patient safety report combined report)	2 x year (Mar and October)	EDN&AHPS	SR 2,4				X -Blue box			X -Blue box				X -Blue box		
Patient experience: complaints and concerns report	2 x year (Feb and Sept)	EDN&AHPS	SR 1,2			X			X				X			X
Infection prevention control assurance framework	2x year(March and October)	EDN&AHPS	SR 1,4				X -Blue box			X -Blue box				X -Blue box		
Infection prevention control annual report	annual (Sept)	EDN&AHPS	SR 1			X							X			
Care Quality Commission inspection reports	as required	EMD	All													
Safeguarding -annual report	annual	EDN&AHPS	SR 1,4			X							X			
FINANCE PERFORMANCE AND SUSTAINABILITY																
Business Committee Chair's Assurance Report	every meeting	CS	SR 2,3,4,5,6,7,8	X		X	X	X	X	X	X	X	X	X	X	X
Charitable Funds Committee Chair's Assurance Report	4 x year (Mar, Sept, Oct and Feb)	EDN&AHPS	N/A			X	X		X							X
Performance Brief	every meeting	EDFR	SR 1,2,3,4,7,8,10	X		X	X	X	X	X	X		X	X	X	X
Performance brief: High Level Performance Indicators for inclusion in the performance brief	Annual	EDFR	SR 1,2,3,4,7,8,10							X						
Annual report	annual	EDFR	All		X							X				
Annual accounts	annual	EDFR	SR 5		X							X				
Letter of representation (ISA 260)	annual	EDFR	N/A		X							X				
Audit opinion (Internal)	annual	EDFR	N/A		X							X				
Sustainability report	2x year (June and Dec)	EDO	SR 4,6	x				X			x			X		
WORFORCE																
Staff survey	annual	DW	SR 8							X						
Safe staffing report	2 x year (Feb and Sept)	EDN&AHPS	SR 2,8			X			X				X			X
Freedom to speak up report	2 x year (Feb and Sept)	FTSUG	SR 8			X +Annual Report			X				X Annual report			X
Guardian for safe working hours report	4 x year (Mar, June, Sept, Dec)	GoSWH	SR 8	X + Annual Report		X		X		X	X Plus Annual report		X		X	
Medical Director's annual report	annual	EMD	SR 4			X -deferred to Oct 2024	X						X			
Professional registration: Nursing and Allied Health Professions	annual	EDN&AHPS	SR 4			X							X			
WDES and WRES -annual report and action plan	annual	DW	SR 8,9				X							X		
GOVERNANCE AND WELL LED																
Well-led framework	as required	CS	N/A													
Audit Committee annual report	annual	CS	N/A	X							X					
Standing orders/standing financial instruction	annual (Dec)	CS	N/A					X							X	
Going concern statement	annual	EDFR	N/A							X						
Code of Governance compliance	annual	CS	SR 4							X						
Committee terms of reference review	annual	CS	N/A	X						X	X					
Register of sealings	4 x per year (Mar, June, Sept, Dec)	CS	SR 5	X None for this meeting		X None for this meeting		X		X		X	X		X	
Significant risks and risk assurance report	every meeting	CS	All	X		X	X	X	X	X	X		X	X	X	X
Board Assurance Framework - update report	quarterly from June 2024	CS	All	X			X	X		X						
Board Assurance Framework -process update (July Audit Committee)	annual	CS	All			X - Blue box item							X - Blue box item			
Risk appetite statement (part of corporate governance report March)	annual	CS	All							X						
Management of Risk Policy & Procedure (3 yearly)	(Next due for review in Oct 2025)	CS	All													
Declarations of interest/fit and proper persons test (part of corporate governance report March)	annual	CS	N/A							X						
Board Members Service Visits Report	3xyear (June, October,February) from June 2024	CE	N/A	x First Report			X		X		X			X		X
Business Continuity Management Policy	as required	EDO	SR 2,7													
Policy for the Development and Management of Policies (3 yearly)	(Next due for review Jan 2026)	EDN&AHPS	N/A													
Health and Safety Annual Plan	Annual	EDFR	SR 4			X - Blue box item							X - Blue box item			
Health & Safety Policy (3 yearly)	(Next due for review Feb 2026)	EDFR	SR 4													
Information Governance Annual Report	annual	EDFR	SR 4,7						X							X
FOR INFORMATION																

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