Bundle Public Board Meeting 4 October 2024

Agenda
Final Agenda Public_Board_Meeting_4 October_2024

60 09:00 - Welcome, introductions and apologies

61 09:05 - Declarations of interest

62 Questions from members of the public

63 Minutes of previous meeting, action log and matters arising

63.a Minutes of the meeting held on: 3 September 2024
Item 63a Public Board Minutes 3 September 2024

63.b Action log: 4 October 2024
Item 63b Public Board Action log October 2024_

64 09:10 - Patient Story

65 09:30 - Chief Executive's report
Item 65 CEO report - 4 Oct 2024

66 09:40 - Digital, Data and Technology Strategy – and Year1 Business Case (reviewed by Business Committee September 2024)
Item 66i DDaT Strategy and Year 1 Business Case - TB 04102024 cover paper
Item 66ii DDaT_Strategy_2024-2027_V1.1
Item 66iii DDaT_Strategy_Draft_Business_Case_2024-25 V2.3 Final 26092024

67 09:55 - Children, Young People and Families Strategy 2022-25 (reviewed by Quality Committee September 2024)
Item 67 Trust Board CYPF strategy

68 10:05 - Workforce Report and Strategy Update - (reviewed by Business Committee September 2024)
Item 68i Board Workforce Headlines and Strategy Update September 2024 V1.0
Item 68ii Appendix 1 Workforce Strategy Measures Dashboard - Sept 24
Item 68iii Appendix 2 Progress narrative on Workforce Strategy measures September 2024 Update

69 10:15 - Quality Committee Chair's Assurance Report: September 2024
Item 69 QC Chairs assurance report Sep 2024 v1

70 10:30 - Business Committee Chair's Assurance Report: September 2024
Item 70 BC Chairs assurance report - Sept 2024 v2 3 10 2024

71 10:35 - Charitable Funds Committee Chair's Assurance Report: September 2024
Item 71 CFC Chair Assurance Report 10 09 2024

72 10:40 - Performance report
Item 72 Board Finance Report August 2024 v4 _

73 10:50 - Nominations and Remuneration Committee Chair's Assurance Report: September 2024
Item 73 Nom and Rem Assurance report September 2024 -Public Board

74 10:55 - Medical Director's Annual Report (reviewed by Quality Committee September 2024)
Item 74 Annual Medical Directors Report 23-24 Trust Board
Item 74ii
Annex-A-Professional-standards-framework-for-quality-assurance-and-improvement - FINAL for QC and Board 1

75 11:05 - Annual Workforce Equality, Diversity, and Inclusion Report 2023/24 (Incorporating Overarching Equality, Diversity, and Inclusion Improvement plan) (reviewed by Business Committee September 2024)

Item 75i Trust Board Paper (October 24) - Annual Workforce EDI Report 2023 - 24 (Incorporating Overarching EDI Improvement Plan)
Item 75ii Appendices A LCH Overarching EDI Improvement action plan 2024- 25
Item 75iii Appendice B WDES action plan 2024-25
Item 75iv Appendices C WRES action Plan 2024 - 25
Item 75v Appendices D NHS Staff survey results Haressment Bullying and Abuse
Item 75vi Appendices E WDES WRES harassment bullying and abuse 2019 - 2023

76 11:15 - Significant Risks and Risk Assurance Report
Item 76 Board Significant Risks report 041024

77 11:25 - Board Assurance Framework Quarterly Update
Item 77i Board Assurance Framework Quarterly update Sep 24 Cover
Item 77ii 2024_25_BAF_September2024 FINAL

78 11:35 - Board Members Service Visits Report
Item 78 Service visits report June_July_Aug 2024

79 11:40 - Any other business. Questions on Blue Box Items and Close

80 Infection Prevention Control Board Assurance Framework – reviewed by Quality Committee September 2024
Item 80i IPC BAF for Board
Item 80ii IPC BAF LCH V1.0 September 2024

81 Patient safety (including patient safety incident investigations) update report– reviewed by Quality Committee September 2024
Item 81 Patient safety including patient safety incident investigations update report March 2024-August 2024 Final for Quality Committee

82 Workplan
Item 82 Public Board workplan 2024-26 v5 25 09 2024

Leeds Community Healthcare NHS Trust

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

Date 4 October 2024
Time 9:00am – 11.45am
Chair Brodie Clark CBE, Trust Chair

AGENDA			Paper
2024-25 60	9.00	**Welcome, introductions and apologies** *(Trust Chair)*	**N**
STANDING ITEMS			
2024-25 61	9.05	**Declarations of interest** *(Trust Chair)*	**N**
2024-25 62		**Questions from members of the public**	**N**
2024-25 63		**Minutes of previous meeting, action log and matters arising** *(Trust Chair)* *For approval*	
63a		Minutes of the meeting held on: 3 September 2024	**Y**
63b		Action log: 3 September 2024	**Y**
2024-25 64	9.10	**Patient story**	**N**
STRATEGY AND PARTNERSHPS			
2024-25 65	9.30	**Chief Executive's report** *(Sam Prince)*	**Y**
2024-25 66	9.40	**Digital, Data and Technology Strategy – including sign off of Year1 Business Case** (reviewed by Business Committee September 2024) *(Andrea Osborne)*	**Y**
2024-25 67	9.55	**Children, Young People and Families Strategy 2022-25 - update** (reviewed by Quality Committee September 2024) *(Sam Prince)*	**Y**
2024-25 68	10.05	**Workforce Headlines and Strategy Update -** (reviewed by Business Committee September 2024) *(Jenny Allen/Laura Smith)*	**Y**
QUALITY AND SAFETY			
2024-25 69	10.15	**Quality Committee Chair's Assurance Report:** September 2024 *(Helen Thomson)*	**Y**
BREAK			
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2024-25 70	10.30	**Business Committee Chair's Assurance Report:** September 2024 *(Rachel Booth)*	**Y**
2024-25 71	10.35	**Charitable Funds Committee Chair's Assurance Report:** September 2024 *(Alison Lowe)*	**Y**
2024-25 72	10.40	**Performance report** *(Andrea Osborne)*	**Y**

WORKFORCE			
2024-2025 73	10.50	**Nominations and Remuneration Committee Chair's Assurance Report:** September 2024 *(Trust Chair)*	**Y**
2024-25 74	11.00	**Medical Director's Annual Report** (reviewed by Quality Committee September 2024) *(Stuart Murdoch)*	**Y**
2024-25 75	11.10	**Annual Workforce Equality, Diversity, and Inclusion Report 2023/24 (Incorporating Overarching Equality, Diversity, and Inclusion Improvement plan)** (reviewed by Business Committee September 2024) *(Jenny Allen/Laura Smith)*	**Y**
GOVERNANCE AND WELL LED			
2024-25 76	11.20	**Significant Risks and Risk Assurance Report** *(Sam Prince)*	**Y**
2024-25 77	11.30	**Board Assurance Framework Quarterly Update** *(Sam Prince)*	**Y**
2024-25 78	11.40	**Board Members Service Visits Report** *(Sam Prince)*	**Y**
CLOSING BUSINESS			
2024-25 79	11.45	**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 79.

***Blue Box**		
2024-25 80	**Infection Prevention Control Board Assurance Framework –** reviewed by Quality Committee September 2024	**Y**
2024-25 81	**Patient safety (including patient safety incident investigations) update report**– reviewed by Quality Committee September 2024	**Y**
2024-25 82	**Workplan**	**Y**

Agenda item:	2024-25 (63a)

Title of report:	Minutes Trust Board Meeting Held in Public: 3 September 2024

Meeting:	Trust Board Meeting Held in Public
Date:	4 October 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
	Helen Thomson Deputy Lieutenant (DL) (HT)	Non-Executive Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Khalil Rehman (KR)	Non-Executive Director
	Andrea Osborne	Executive Director of Finance and Resources
	Dr Ruth Burnett	Executive Medical Director
	Sheila Sorby	Interim Executive Director of Nursing and Allied Health Professionals (AHPs)
	Andrea North	General Manager, Specialist Business Unit (Deputising for the Executive Director of Operations)
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
Apologies:	Alison Lowe (AL) OBE	Non-Executive Director
	Sam Prince	Executive Director of Operations/Deputy Chief Executive
	Rachel Booth (RB)	Associate Non-Executive Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
In attendance:	Helen Robinson	Company Secretary
	Christine Pearson	Clinical Lead, Integrated Children's Additional Needs Service for Item 35
	Jill Crampton	Community Children's Nurse for Item 35
	Dr Nagashree Nallapetta	Guardian of Safe Working Hours for Item 48
	John Walsh	Freedom to Speak Up Guardian for Item 49
Minutes:	Liz Thornton	Board Administrator
Observers:	Liz Grogan	Head of Infection Prevention and Control Leeds Community Healthcare
	Helen Barwell	Named Nurse Safeguarding Adults, Leeds Community Healthcare
Members of the public:	None	

Item 2024-25 (31)

Discussion points:

Welcome introduction, apologies, and preliminary business

The Trust Chair opened the Board meeting and welcomed two members of staff; Liz Grogan and Helen Barwell who were attending the meeting as observers.

Apologies

Apologies for absence were received from Alison Lowe OBE, Sam Prince, Rachel Booth, and Jenny Allen.

Item 2024-25 (32)

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 (33)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2024-25 (34)

Discussion points:

Minutes of the last meeting, matters arising and action log

ai) Minutes of the meeting held on 7 June 2024

The minutes were reviewed for accuracy. Subject to the amendment set out below they were agreed to be a correct record.

Item 2024-25(11):

Business Committee Assurance Reports: 29 May 2024 (Verbal report) 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 incidents. ~~by 50%~~.*

aii) Minutes of the meeting held on 19 June 2024

The minutes were reviewed for accuracy and agreed as a correct record.

b) Action log 7 and 19 June 2024

The Board reviewed and noted the progress against the ongoing actions.

Item 2024-25 (35)

Discussion points:

Patient story: Cooper's story

The Interim Executive Director of Nursing and AHPs introduced the story and welcomed Cooper, Peter, Christine Pearson, Clinical Lead, Integrated Children's Additional Needs Service, and Jill Crampton, Community Children's Nurse.

Christine explained that the Trust had introduced the offer to give intravenous (IV) antibiotics to children and young people in their own homes in February 2024. Since then, 70 individuals had received this new way of receiving treatment.

Cooper, aged 12, said that he had received a course of antibiotics from the Children's Nursing Team at his home after being diagnosed with bacterial meningitis. He said that he was in the hospital for a short stay and when he stopped feeling unwell this service enabled him to be discharged home where he was visited by a nurse daily, for three days to compete his treatment.

He said he felt much more comfortable and relaxed receiving treatment at home and this had benefitted his overall recovery.

Cooper's father Peter said, that as a parent, the service was invaluable. It was great for moving patients through and out of hospital quicker to free up beds. Cooper had struggled to sleep because of the meningitis and because it was very noisy on the hospital ward, so coming home had been good for his recovery. The transition from hospital to home had been achieved very smoothly.

The Trust Chair invited questions and observations from Board members.

Non-Executive Director (IL) asked how many visits per day the Team made to deliver the service and how confident the nurses were in administering the drugs.

Christine said that on average there was one visit per day to deliver IV drugs. The service had worked closely with the Community Intravenous Antibiotic Service Team (CIVAS) to train and upskill staff and overall, the Team were enjoying the opportunity to deliver a service which was seen as having a positive impact on children, young people, and their families.

The relationship with Leeds Children's Hospital was reportedly very positive and so far, the discharge arrangements to enable the Trust to deliver the service were working well.

Non-Executive Director (KR) welcomed the introduction of the service which he felt was a great example of moving services out of hospitals to home or places closer to home. He suggested that an assessment of the financial value and impact of the service should be presented to the Business Committee.

The Trust Chair thanked Cooper and Peter for attending the meeting and telling their 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.

- Major pressures remained:
  - Financial situation – remained a key focus. Staff in the Trust now had a good understanding of the what the Quality and Value Programme was about, the decision-making process and the planned and expected outcomes.
  - The effect of Covid remained - resulting in a significant impact on the length of waiting lists which was causing serious concerns.
  - Changes to the Executive Team – brought new styles and challenges and offered valuable new experience.
  - The growing focus of healthcare provision closer to home was now a clear Government pledge. The Trust had a key role in shaping how it would work.

Finally, he said that day to day business must continue to be a key focus for the Trust and this was reflected in the agenda for the Board today.

2024-25 Item (36)

Discussion points:

a) Chief Executive's report

The Chief Executive presented her report which focussed on:

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

In relation to system flow she reported that the system has been relatively stable over the summer period with only occasional escalations. A reflective session on Winter 2023/24 had been held and a follow up meeting with NHS England was planned for September to inform preparations for Winter 2024/25.

Non-Executive Director (IL) queried whether the Trust was confident that capacity was sufficient to support the system over the coming Winter.

The Chief Executive provided assurance that the Trust was well prepared to enter into discussions with the Integrated Care Board (ICB) around capacity if required. A lot of work has been done in Leeds to reduce winter pressures such as Homefirst.

The Board discussed the Trust's response to the public disorder events recently across the city including an incident in Harehills and the impact of rioting by far-right groups nationally due to the nature of the Trust's work, going into people's homes and police custody.

A meeting had been held with staff network chairs to discuss how the Trust could support affected members of staff and provide specific support to individual members of staff who were feeling particularly vulnerable. Further work would be developed over the coming months including a review of the social media policy to ensure that effective safeguards were in place.

The Board agreed that the outcome of the social media policy work would be discussed at the Board workshop scheduled for 1 November 2024 along with a briefing on the Zero Tolerance guidance and support available to staff.

It was noted that the tender process has been completed for the Well Led Review and the contract awarded to Mersey Internal Audit Agency (MIAA). The intention was for the review to take place during the Autumn, and it would 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.

Outcome: the Board

- Received and noted the report.

Item 2024-25 (37)

Discussion points:

Third Sector Strategy 2024-2027

The General Manager, Specialist Business Unit presented the report on behalf of the Executive Director of Operations.

She reminded the Board that the Strategy for 2020-23 had been co-produced with Forum Central (FC) and approved by the Trust Board in August 2020.

The Third Sector Strategy Steering Group had reviewed the Strategy and directed a light touch refresh resulting in an updated strategy for the period 2024-27 with a decision to consolidate from seven objectives to four as listed in the report.

Non-Executive Director (HT) suggested that the Connect Better section of the workstream for 2023-24 should include a reference to West Yorkshire Ambulance Service in relation to their input in supporting falls.

Non-Executive Director (KR) referred to a recent Internal Audit report on Enhance and suggested that the Business Committee should receive a report on the accountability and governance frameworks for Enhance delivery partners to ensure that they were subject to the same level of scrutiny that was in place in the Trust, particularly around Information Governance and Finance.

Outcome: the Board

- Received and noted the report.

Item 2023-24 (38)

Discussion points:

Health Equity Strategy

The Executive Medical Director presented the report which provided an update on the health equity work and considered how to achieve a balance in progressing the statutory and Trust actions, in the current financial context.

She highlighted the challenges related to the complexity of measuring health equity and the steps the Trust was taking to improve the measurement of outcomes. She also drew attention to the very limited capacity of the Trust's Health Equality Team which increased the risk that the organisation was unable to deliver at the scale and pace required to reduce inequity or mitigate against worsening inequity, and the steps being taken to address this.

The Board discussed the potential for the Health Equity Team to make more connections with the Trust's Equality, Diversity and Inclusion Team, and the importance of embedding health equity structurally across the organisation and suggested progress could be benchmarked against other community providers.

Outcome: the Board

- Noted the progress on delivery of the Health Equity strategy and risks to the scale and pace of delivery.
- Noted that the Health Equity Team would work closely with Board members to ensure the equity measurement framework data reporting to Board was insightful and efficient going forwards.

Item 2023-24 (39)

Discussion points:

Research and Development Strategy

The Executive Medical Director presented the report which provided an update on the Research Strategy 2020-2025 including notable achievements since the last update was presented to the Board.

The Board noted that significant progress had been made on developing the strategy and commended the aspiration to work across boundaries to support community-based research and promote innovation and research collaborations with university partners across the region.

Outcome: the Board

- Received and noted the update report.

Item 2023-24 (40)

Discussion points:

Quality Committee Assurance Report: 22 July 2024

Non-Executive Director Helen Thomson DL (HT), Chair of the Committee presented the report and highlighted the key issues discussed:

- 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 Community Adolescent Mental Health Service (CAMHS) Quality and Value (Q&V) savings target had been set at £1.5m, 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.
- Waiting lists – the Committee had discussed the pressures and risks and felt that there was a lack of assurance around waiting lists and the risks associated with those waiting for various services. A position statement had been requested for the next Committee meeting in September 2024.

The Board noted that three of the five strategic risks assigned to the Committee had been assigned a **reasonable** level of assurance and two a **limited** level of assurance.

Outcome: the Board

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

Item 2024-25 (41)

Discussion points:

Patient Experience Report*:* Complaints, Concerns and Feedback – six monthly report

The Interim Executive Director of Nursing and AHPs presented the report which provided a review of complaints and concerns, feedback via surveys, engagement activity, and wider feedback for the six-month period 1 January 2024 to 30 June 2024 and included an overview of themes, learning and actions.

Non-Executive Director (IL) noted the increase in claims compared to the previous reporting period and requested that more detail about the nature of the claims was reported to the Board or Committees.

The Interim Director of Nursing and AHPs agreed to clarify the reporting process.

Action: Clarification on the process for reporting details of claims made against the Trust to the Board and Committees.

Responsible Officer: Interim Director of Nursing and AHPs

Outcome: the Board

- Received and noted the report.

Item 2024-25 (42)

Discussion Points:

Infection Prevention and Control Annual Report

The Interim Executive Director of Nursing and AHPs presented the report which informed the Board of the achievements within Infection Prevention and Control during 2023-24 and provided 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, in line with the 10 criterion. The report also provided an overview of the collaborative work throughout the Leeds system, as part of the cooperation partnership agreement with Leeds City Council.

The Board noted that the Trust's Infection Protection and Control Team had developed an e-Learning module focussed on working in the community which would be launched that day.

The Board commended the report and the excellent work of the Infection Protection and Control Team.

Outcome: the Board

- Noted the report and approved its publication.

Item 2024-25 (43)

Discussion points:

Safeguarding Annual Report

The Interim Executive Director of Nursing and AHPs presented the report which provided an overview of the review of the Trust's safeguarding practices, initiatives, and outcomes in 2023/24.

The Board commended the excellent work of the Safeguarding Team.

Outcome: the Board:

- Noted the report and approved its publication.

Item 2024-25 (44)

Discussion points:

Business Committee Assurance Reports: 24 July 2024

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

- Quality & Value – Committee had 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 information/approval. Service redesign was a 26-week programme so none had reached conclusion as yet.

- Third Sector strategy – an update had been received on the current and future (2024-27) strategy. Challenge lay in sharing records between organisations, Loop solution being implemented to address this.

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

Outcome: the Board

- Noted the update report from the Committee Vice Chair and the matters highlighted.

Item 2024-25 (45)

Discussion points:

Charitable Funds Committee Assurance Report

The Interim Director of Nursing and AHPs presented the report on behalf of the Committee Chair and highlighted the key issues discussed:

- Charitable development updates
- Finance Report
- Review of Terms of Reference

Outcome: the Board

- Noted the update report and the matters highlighted.

Item 2024-25 (46)

Discussion points:

Audit Committee Assurance Report: 12 July 2024

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

- 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.
- Internal Audit – The 2023/24 Internal Plan had been completed subject to agreed amendments during the year. The Head of Internal Opinion had provided significant assurance overall.
- Counter Fraud – quarterly update and 2023/24 Annual Reports were 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.

The Board noted that the strategic risk assigned to the Committee had been given 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 (47)

Discussion points:

Performance report

The Board noted that the development of a published version of the Performance Brief remained in progress. In the meantime, key updates and escalations would be outlined in a cover report to the Board.

The Chair stressed that it was important for the Board to receive performance reports at each meeting particularly around the data on waiting lists.

The Chief Executive reported that transition to a new reporting format was in development and provided assurance that there were no major issues to report to the Board by exception at this meeting. She confirmed that there had been no major change in the data on waiting lists since the reports made to the Committees in July 2024.

The Executive Director of Finance and Resources provided a verbal update on the current financial position. The Trust's finances were running according to plan. There were no significant financial risks to report to the Board at this meeting. The key highlight to note was the improvement on the position reported at month 2, reflective of the enhanced grip and control measures that had started to embed during the quarter, particularly around vacancies and variable pay. The Trust continued to forecast achieving the surplus.

The Executive Director of Finance and Resources said that whilst there were some positive signs around the grip and control and understanding the delivery profile of the Q&V programme over the coming months, it was critical to continue with the work.

Outcome: the Board

- Received and noted the update.

Item 2024-25 (48)
Discussion points:
Guardian of Safe Working Hours (GoSWH): Quarter 1 update
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 the following issues:

CAMHS ST historic rota compliance and payment issues update
This issue had reached a conclusion that has been put forward to affected Junior doctors. The Guardian reported that she was awaiting information regarding any actions/ plans that the affected junior doctors would like the Trust to consider as a part of the solution that could be offered.

Work in progress to address the impact of on-call work on community paediatric training needs
Junior Doctors had raised concerns that they were not receiving the required training due to not having enough training time as recommended by the Royal College guidelines. Useful ideas and suggestions had been put forward to Leeds Teaching Hospitals NHS Trust rota management team. The next meeting to discuss progress was scheduled for 3 September 2024.

Change of name of 'junior doctors'
The British Medical Association and Department of Health and Social Care had agreed to change the name of 'junior doctors' to 'resident doctors' from September 2024.

Foundation year doctors
The Trust had agreed to host two foundation year doctors on honorary contracts. Their primary placement would be in Community Paediatrics and Community Adolescent Mental Health Services (CAMHS) and as part of the Urology on call rota. This was noted as a positive new development and the Board was pleased that the Trust had been able to offer to host the foundation year doctors to support recruitment and retention in the profession.

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 GSWH with the work in relation to community paediatric training opportunities.
- Noted that there was a risk for the Trust of potential grievance case that could be raised by Junior doctors affected by the CAMHS historic rota issue.

Item 2024-25 (49)

Discussion points:

Freedom to Speak Up: Annual Report 2023-24

The Guardian presented the report which covered the period of 4 August 2023 to 3 September 2024 and provided a record of the work of speaking up at Leeds Community Healthcare NHS Trust (LCH) and wider work across the health and care system. He highlighted the following key points:

- There were 170 concerns raised overall. 41 concerns had been raised formally by staff members concerning services through the Freedom To Speak Up Guardian (FTSUG). A further 125 concerns were informally discussed or resolved via the FTSUG. The Speaking Up Champions had received three direct concerns.
- The Staff Survey results for 2023 – 24 were very positive. 76.6% of staff had said they had the confidence to raise concerns. This was an increase on the previous year (in 2022-23 it was 72.8%).
- Helen Thomson was the new Non-Executive Director for Speaking Up.

The Freedom To Speak Up Guardian service has:

- Work across the Trust with key partners to continue to share and embed the work.
- Work with the Quality and Value programme.

Non-Executive Director (KR) noted the significant rise in informal concerns and suggested that those related to race could be dealt with by the Race Equality Network Speaking Up Champions to ease the workload on the Guardian.

It was agreed that more information should in included in future reports about the nature of the informal element of the Guardian's work.

Outcome: the Board

- Noted the report and continued its support to embed the speaking up work in the Trust.

Item 2024-25 (50)

Discussion points:

Safe Staffing Report

The Interim Executive Director of Nursing and AHPs presented the report which set out progress in relation to maintaining safe staffing over the last six months at the mandated in-patient areas at Hannah House and the Wharfedale Recovery Hub.

Outcome: the Board

- Received and noted the report.
- Noted the level of assurance provided.

Item 2024-25 (51)

Discussion points:

Professional registration: Nursing and Allied Health Professions

The Interim Executive Director of Nursing and AHPs presented the report which provided an update on professions regulated by the 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.

She provided assurance that the organisation was aware of referrals to regulators and the processes to manage these situations as detailed in the professional registration policy were being followed.

Outcome: the Board

- Noted the positive position on nurse and AHP revalidation and re-registration.

Item 2024-25 (52)

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, due to an increase in service demand and high numbers of referrals. The second strongest theme related to patient safety. There was also a theme concerning compliance with standards and/or legislation.

Risk movement

There were two risks on the Trust risk register that had a score of 15 or more (extreme).
There were a total of ten risks scoring 12 (very high).

It was noted that four of the risks scoring 12 had not changed since the last report (static), these risks had been reviewed and the target dates to reduce the risks were not yet due.

The Board requested that future reports included more information about how and why decisions had been made to change the risk scores.

Action: Significant Risk Reports to include more information about how and why decisions had been made to changes in risk scores.

Responsible Officer: CEO/Risk Manager

Outcome: the Board

- Noted the changes to the significant risks since the last risk report was presented to the Board.
- Received assurance that planned mitigating actions would reduce the risks.

Item 2024-25 (53)

Discussion points:

Chief Executive Officer and Chair's Action:

Associate NED as member of Nominations and Remuneration Committee

The Company Secretary presented the report.

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 had been recently taken by the CEO and Chair outside of the Board's usual meeting schedule.

The Board was asked to ratify the decision.

Outcome: the Board

- Ratified the decision to approve the amendment to the Nominations and Remuneration Committee's Terms of Reference.

Item 2024-25(54)

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
Friday 4 October 2024 9.00am-12.00 noon

Additional items (Blue Box)

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

AGENDA ITEM 2024-25 (63b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) action log: 4 October 2024

Key		Key colour code
Total actions on action log	4	
Actions on log **completed** since last Board meeting on 3 September 2024 with a **proposal to close**	3	
Actions not due for completion before 4 October 2024: **progressing to timescale**	1	
Actions not due for completion before 4 October 2024: agreed timescales and/or requirements **are at risk or have been delayed**	0	
Actions outstanding at 4 October 2024**: not having met agreed timescales and/or requirements**	0	

Agenda Item Number	Action Agreed	Lead	Timescale/Deadline	Status
3 September 2024				
2024-25 (41)	**Patient Experience Report*:* Complaints, Concerns and Feedback – six monthly report:** • Clarification on the process for reporting details of claims made against the Trust to Board and Committees**.**	Interim Executive Director of Nursing and AHPs	Trust Board meeting 4 October 2024	Verbal update to Trust Board meeting 4 October 2024 – **Propose close**
2024-25 (52)	**Significant Risks Report:** • Significant Risk Reports to include more information about how and why decisions had been made to changes in risk scores.	Chief Executive /Risk Manager	Future reports to the Trust Board and Committees	Report presented to Trust Board meeting 4 October 2024 **Propose close**
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 - **Ongoing**
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	Verbal report to Trust Board 4 October 2024 **Propose close**

Agenda item:	2024-25 (65)

Title of report:	Chief Executive's report

Meeting:	Public Board
Date:	4 October 2024

Presented by:	Sam Prince (Deputy Chief Executive/Executive Director of Operations)					
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: • Non-Executive Director recruitment • The Darzi Review report: Independent investigation f the NHS in England • Quality and Value Programme • Collaboration • I Thrive/We Thrive programme • Audiology Service Review • Annual General Meeting (AGM)

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 Non-Executive Director Recruitment

I am delighted to announce that following a rigorous recruitment process led by NHS England, Rachel Booth has been successful in being appointed as Non-Executive Director for a term of two years from 1 October. Rachel has been with the Trust in the role of Associate Non-Executive Director for the past four years, and we are thrilled that she will now be a voting member of the Trust Board.

From the extremely strong pool of applicants, a candidate was also identified to replace Rachel as Associate Non-Executive Director. More information on this will follow once the appropriate checks have been undertaken.

➢ 3 Lord Darzi's Report on the state of the NHS

This important report was launched on the 12 September and highlights a number of areas for the Board to sighted on. Lord Darzi has undertaken a rapid investigation of the state of the NHS in England, assessing patient access, quality of care and the overall performance of the health system. He acknowledged that the NHS is in serious trouble and needs to rebuild trust with the public.

Whilst this was a stark report it did conclude several things that are particularly important to LCH. Firstly, that the principle of a health service that is taxpayer funded, free at the point of use, based on need not ability to pay, remains true. This is important as it moves the whole of the NHS away from the debate about moving to an insurance-based model. Darzi has highlighted three key recommendations for LCH to note:

1. Re-engage staff and re-empower patients. Despite all the challenges and low morale, NHS staff are profoundly passionate and motivated to raise the quality of care for patients. Their talents must be harnessed to make positive change. The best change empowers patients to take as much control of their care as possible.
2. Lock in the shift of care closer to home by hardwiring financial flows. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term conditions whose prevalence is growing rapidly as the population age. Financial flows must lock-in this change irreversibly or it will not happen.

3. Analogue to Digital. There must be a major tilt towards technology to unlock productivity. In particular, the hundreds of thousands of NHS staff working outside hospitals urgently need the benefits of digital systems. There is enormous potential in AI to transform care and for life sciences breakthroughs to create new treatments.

It is proposed that we take forward the above recommendations as part of the organisational strategy work in the autumn.

➢ 5 Quality & Value Programme

The programme continues to progress well. The Trust continues to forecast achievement of financial balance. To date, 86% of the £15.8m target has been identified, although 42% of this is due to grip and control measures and is not recurrent, and so it is vital for the quality and value workstreams to succeed. The Internal Audit review has concluded 'significant assurance'. The recent pulse survey for LCH highlights the need for communication on quality as well as value.

➢ 6 Collaborating in Partnership

Leeds City Council is a key strategic partner for LCH and as such I wanted to highlight that Tom Riordan has stepped down as the Chief Executive of the council to take up the role as the second permanent secretary for the Department of Health and Social Care. Mariana Pexton has been appointed as the interim Chief Executive Officer while a robust recruitment process is underway**.**

➢ 7 I Thrive/We Thrive Programme

I attended a session with our first cohort undertaking the I Thrive programme. The aim of the group is to increase and support colleagues from the global majority to be successful in their careers within the NHS. A celebration event will be held in December 2024 which Board members are invited to attend.

➢ 8 Audiology Service Review

In 2023, NHSE established a National Paediatric Hearing Services Improvement Programme, in response to the British Academy of Audiology's Independent Review into the Paediatric Audiology Service at NHS Lothian. In August 2023, ICB Executive Teams were asked to work with Paediatric Hearing Services to provide information against each of the recommendations to support a review of the quality of services and to determine any risk of harm. This review highlighted potential areas of concern in the majority of Trusts. LCH was rated as D (Serious Risk). A subsequent service visit and assessment was undertaken in June 2024, the results of which were received on 5 September 2024.

This stated: "In summary, the department is on a positive trajectory with a clear focus on patient care, staff support, and continuous improvement. The leadership team is effectively managing the current challenges and has established a solid foundation for future developments. The service's integration with the broader Trust and its commitment to high standards of care are evident and commendable. Moving forward, continued efforts to address waiting times, enhance inter-service collaboration, and pursue accreditation, and adopt innovative practices will further strengthen the department's capacity to provide exceptional care" and as a result

the Trust rating has been regraded to amber. LCH continues to actively engage with the regional paediatric audiology oversight group to deliver the recommended improvements across the region.

9 Annual General Meeting

Finally, a thank you to everyone involved in the AGM on 17 September 2024 at White Rose Park. In 2023/24 we delivered financial balance, improved patient outcomes and strong partnerships, with examples such as Homefirst highlighted as an example of best practice.

10 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
September 2024

Agenda item:	2024-2025 (66i)

Title of report:	Digital, Data and Technology Strategy and Year 1 Business Case

Meeting:	Trust Board
Date:	4 October 2024

Presented by:	Andrea Osborne – Executive Director of Finance and Resources Dawn Greaves – Associate Director of Digital Transformation					
Prepared by:	Dawn Greaves – Associate Director of Digital Transformation Richard Slough – Assistant Director of Business Intelligence					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	X

Executive Summary:	The Digital, Data and Transformation Strategy was originally presented to Business Committee in May as an early draft. Since then, it has been socialised with a variety of leadership and team meetings to ensure staff have the opportunity to input into its development. The Strategy covers a three year period from 2024-25 with a view to the Trust taking a decision on the strategic leadership arrangements for digital within this period. The year 1 business case is also presented, detailing plans for allocation of the third year of the National Frontline Digitisation funding and internal capital allocation and plans to cover the deficit in terms of requirements.

Previously considered by:	18/09/24 - Trust Leadership Team 24/09/24 - Digital Programme Board 25/09/24 – Business Committee

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	X
	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	X

Is Health Equity Data included in	Yes		What does it tell us?	

the report (for patient care and/or workforce)?	No	X	Why not/what future plans are there to include this information?	Delivering equitable services is at the heart of the strategy

Recommendation(s)	• Review and approve the Digital, Data and Transformation Strategy • Review and approve the year 1 business case for delivery of the strategy noting the key points around funding risks

List of Appendices:	N/A

NHS
Leeds Community Healthcare
NHS Trust

Digital, Data and Technology Strategy

2024-27

CONTENTS

1. Foreword:

Welcome to the Leeds Community Healthcare (LCH) NHS Trust's Digital, Data and Technology Strategy for 2024-27. The aim of the strategy is to support the Trust in its overall vision of **we provide the best possible care in every community.** The strategy is being introduced at a time when community health services play a key role in our health and care system, keeping people well at home and in community settings closer to their home. These services are central to ambitions to boost out of hospital care and in helping people maintain their independence in their preferred place of residence. The delivery of these services can't be done solely by one organisation, so it is imperative that we build and maintain collaborative relationships with other health and care partners across the Leeds City and wider West Yorkshire footprint.

The Trust is embarking on a Quality and Value programme where service teams will evaluate their service offering and ways of working with a view to delivering them in a more efficient way to provide savings and efficiencies. The Quality and Value programme is an exciting opportunity to showcase how clinically led, operationally driven and digitally enabled solutions can support service transformation to maximise quality care delivery in more efficient ways. It creates a drive for the organisation to embed data driven monitoring of programmes and utilisation of standardised reporting and processes. When developing this strategy, we have considered the scale of change taking place across the Trust, which does impact on the level of engagement our services can commit to support delivery of this strategy and we need to be mindful of this.

The new strategy showcases how digital will support transformation across the Trust. The strategy is underpinned by, and sets the direction for the Business Intelligence (BI), Clinical Systems, Information Technology (IT) and Information Governance (IG)/Cyber service's business plans as well as aiming to influence and respond to clinical and operational plans from the business units operating within the Trust. It seeks to reflect other current and developing Trust strategies, particularly the enabling strategies for Estates, Sustainability and Workforce and our services' priorities. This strategy succeeds the previous digital strategy which covered 2020-2023 and the business intelligence strategy which covered 2022-2025.

Our vision is to "Harness digital and data opportunities which allow us to work safely and better together, promoting health and wellbeing and ensuring the best possible care is provided to all those we serve".

Our direction of travel is towards increased integration with our health and care partners across primary care, across the city of Leeds and across our integrated care system, the West Yorkshire Health and Care Partnership. This strategy covers a three-year period rather than a longer period, acknowledging the rapid pace of change and development in the digital world, in health and care structures and in national and local priorities.

In developing this strategy, we made a concerted effort to listen to our staff's needs and perspectives. The Digital Maturity Assessment survey, completed by our staff, provided valuable insights into the areas where digital capabilities need enhancement. This feedback has informed the design of the Digital Strategy, ensuring that it addresses the real-world needs of our workforce, aligning digital initiatives with the practical challenges and opportunities they encounter daily. By doing so, we aim to create a strategy that is not only ambitious but also responsive and grounded in the realities of our frontline services.

The strategy seeks to identify how digital products and services can make our services more accessible to communities and patients and increase our effectiveness and efficiency. As well as implementing new and innovative technologies, we want to ensure we are achieving value from the existing products and services we already have access to within the Trust, as well as ensuring that we are offering a quality support service to the staff we are here to serve. We want to ensure any new innovative technologies provide the relevant data insights enabling performance monitoring, to ensure we can be confident they are supporting our transformation vision. We will put our service users and staff at the forefront of our plans, ensuring we are co-designing future solutions. We want to be ambitious; we want digital services and products to help transform the way we work and the services we deliver.

As described digital solutions will provide us with data. Beyond that our aim is to provide a robust, consistent system of information provision and performance monitoring that keeps data both secure from cyber-attack and compliant with legislation. One that provides intelligence and insight. Enabling the Trust to have a data driven culture, to deliver on its objectives, evidence the huge contribution that community services make to the system and demonstrate how effective we are at delivering care to patients.

We propose to achieve the aim of the strategy by focusing on the following key priorities:

- **Supporting staff**
- **Enabling digitally optimised services**
- **Supporting patients and carers**
- **Supporting the path to digital transformation**
- **Delivering insight and intelligence**
- **Ensuring our digital estate is compliant, well maintained and sustainable.**

The strategy document will explore how this vision will be achieved through the delivery of specific projects, initiatives, products and services, but it will only be achieved through the successful combination of people, process and technology working together.

We aim to connect service users and staff to reliable systems that are clinically safe, cyber secure, flexible, accessible and offer more choice in how care is accessed and delivered. This will require continued development in the infrastructure which underpins all the digital tools and services in use and the strategy recognises this with investments throughout 24/25 which support the replacement of key components such as the firewalls, switches and key upgrades to our wide area connections to ensure fast and reliable connectivity. The ongoing laptop replacement programme will deliver staff the best combination of performance (with a focus on battery life) and value for money, enabling staff to work more efficiently.

We aim to provide the organisation with mechanisms that enable a data driven culture by providing consistent processes to develop insight and intelligence on the priorities set by the Trust.

The Digital, Data and Technology strategy is the product of research, analysis and engagement with staff throughout the Trust. We particularly appreciate the input of our colleagues across the organisation, gained through face-to-face meetings, direct conversations, listening events and online surveys – these exchanges have helped us to shape our strategy and priorities in a more responsive way. This must be the start of an ongoing conversation with staff and stakeholders about our Digital, Data and Technology Strategy to help and inspire innovation across the Trust.

2. Vision, Values & Behaviours:

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

We have used the **magnificent seven behaviours** icons in **Section 5** to indicate which behaviours support each priority's achievement.

3. Context:

This Digital, Data and Technology Strategy is designed to support the Trust in its vision of **we provide the best possible care in every community**. To develop the strategy, we have considered in detail the context within which LCH works now and will work in the future recognising that the national, regional and local context in which the organisation operates converges to inform and shape digital and data priorities. This includes a broad range of political, economic, social and technological factors.

3.1 National context:

> *"Making better use of data and digital technology: we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data."*
>
> The NHS Long Term Plan. 2019

This strategy sits within a wider national context set out by the: -

NHS Long Term Plan (2019)

10-year strategy that identifies how digital technologies will support people in and out of hospital, giving them more control over their own health and wellbeing.

The What Good Looks Like Framework (2021)

Framework that builds on good practice to provide guidance for the same and secure digitisation of health and care services.

What Good Looks Like
Success measures for digital transformation:
1 – Well-led
2 – Ensure smart foundations
3 – Safe practice
4 – Support people
5 – Empower citizens
6 – Improve care
7 – Healthy populations

Digital Health and Social Care Plan
The three aims that underpin this plan:

1 – **Digitise**
Ensure all ICS constituent organisations have EPRs, minimum WGLL maturity and cyber resilience by March 2025

2 – **Connect**
Establish lifelong health and care records with appropriate effective population health management systems

3 – **Transform**
Use developments in the NHS App and prevention technologies to help shape the health market and delivery change

A Plan for Digital Health and Social Care (2022)

Policy paper directed at leaders in the health, social care and technology sectors focussing on laying the digital foundations that will deliver faster, more effective and more personalised care.

National Cyber Strategy (2022) **and NHS Cyber Strategy** (2023)

The National Cyber Strategy and NHS Cyber Strategy are the Government's plans to ensure that the UK remains confident, capable and resilient in an ever-changing digital world where new threats constantly arise.

The NHS Cyber Strategy sets out a specific vision for reducing the cyber security risk to health and social care organisations, protecting service user and staff data, and implementing measures to ensure organisations are able to recover quickly from cyber-attacks and other information security incidents when they do occur.

The Trust needs to ensure that we in turn continue to adapt, innovate and invest to protect the service user and staff data we are responsible for.

NHS Community Health Services (CHS) Data Plan 2024/25 to 2026/27 (2024)

This publication identifies actions for providers around collation, data quality and provision of community data to improve care delivery and National reporting.

These and many other national publications and reports all emphasise the unique opportunity digital and data technology provides and the importance of embedding new ways of working to transform and improve health and social care services in helping to meet demand whilst resources are limited.

3.2 Regional context

Our Digital, Data and Technology Strategy forms a part of a wider geographical digital agenda that spans the West Yorkshire Health and Care Partnership and enables the Trust to play its full part in supporting out of hospital care developments and in the provision of a regional shared care record in the form of the Yorkshire and Humber Care Record (YHCR). The Partnership also has a Digital Strategy that was published in 2022.

> *"We have a vision for the future of technology, where people have a choice to use digital channels to access services and monitor their own health, where services are designed using evidence from data, where a member of staff can work from anywhere in the region and access the information that they need to care for the individual person."* West Yorkshire Health and Care Partnership Digital Strategy 2022

3.3 Leeds context

A key priority is the Digital Strategy for the Leeds Health and Care Partnership 2022. The strategy has been written to underpin the Leeds' Best City Ambition for Health and Wellbeing, Inclusive growth and Zero carbon.

> *"Leeds has mirrored the 'life course approach' used in the Best City Ambitions to clearly articulate the impact of our plans for digital at every stage of a person's life from early years to older age – Starting well, Living well, Working well and Ageing well."* Leeds Health and Care Partnership Digital Strategy 2022

Starting well

Using modern data technologies and techniques we will analyse population health and other data to understand and what determines a person's health and life chances from birth through to old age. This will help us to reduce inequalities and design impactful services for the people who need them the most.

We will achieve this by:

- Using data to identify and eliminate inequities
- Introduce new ways to stay healthy including education and services
- Ensuring that all children have the opportunity to access and use technology

What this means for Leeds:

- Better outcomes for children
- Improved life opportunities
- Improved parent and child health

Living and ageing well

We will utilise new technologies to deliver health and wellness services tailored for individuals and ensure that peoples information follows them through their journey regardless of the organisation they are interacting with. We will help people to stay healthy using innovative tools such as wearable monitors, augmented reality apps or coaching tools.

We will achieve this by:

- Ensuring information can be shared between partner organisations, adhering to rigorous information governance policies and procedures
- Making services easier to find and access
- Using automation technology to make services better
- Launching new ways for people to stay healthy using technology

What this means for Leeds:

- Better access to services
- Improved health and wellbeing
- More effective public services
- Services delivered closer to home

Working well

We will build on existing collaboration by improving information flow between organisations and supporting the city's inclusive growth ambitions. Our thriving digital community, modern infrastructure and skilled workforce will attract new and established businesses to Leeds.

We will achieve this by:

- Investing in infrastructure to support the services we deliver
- Supporting our vibrant digital economy that creates inclusive growth
- Taking a #TeamLeeds approach to dealing with cyber threats
- Building and coordinating an innovation network that is accessible to all

What this means for Leeds:

- Inclusive growth and more opportunities for business and employment in Leeds
- New ideas that improve services
- People will be able to build digital skills
- Confidence that personal data is protected

The landscape across the city is dynamic and complex, with organisations and partnerships such as the GP Confederation and Primary Care Networks, necessitating flexible, integrated systems and infrastructure allowing staff to move across organisational boundaries. This flexibility will be a key requirement both now and in the future as LCH pursues its strategy of integration and partnership and the strategy will deliver an infrastructure which can respond to the continually changing organisations which make up the city's health and care setting.

Whilst Leeds is a large business hub for health technology, with good infrastructure, there remains areas with poor or no connectivity, which limits access to digital solutions in these areas. Influencing partners to undertake an assessment of coverage and resolve any "dead spots" will be a key priority.

3.4 Leeds Community Healthcare NHS Trust context

The Digital, Data and Technology strategy works alongside other key organisational strategies and plans, including the Trust's five strategic goals, its vision, values and behaviours as well as the other enabling strategies for Workforce, Organisation and Development, Estates (including the Green Plan) and Quality & Value.

The Trust's five strategic goals are:

- Work with communities to deliver personalised care.
- Enable our workforce to thrive and deliver the best possible care.
- Collaborating with partners to enable people to live better lives.
- To embed equity in all that we do.
- Use our resources wisely and effectively both in the short and longer term.

The future landscape needs to provide flexibility to accommodate commissioning changes. There is now a renewed focus on lead and collaborative provider models of service delivery, where multiple organisations work together to deliver services. This places a substantial strain on existing Electronic Patient Record systems and IT networks, which were designed to support services in very linear ways within clearly defined organisational boundaries.

LCH is seeking to develop new services and respond to new service commissioning requirements, often in partnership with other organisations. The strategy must respond to new pathways of care, potentially being delivered across organisational boundaries. There is likely to be increased used of LCH estate by 3rd parties which will need to be supported in terms of digital access and integration. The challenge will be how to join the "people-process-systems" together to achieve a common aim.

Digital and data technology is a key enabler in strengthening community services and supporting people in their community to achieve better health care outcomes following national guidance and supporting local digital plans.

LCH provide a range of community-based health services across the Leeds region within the most appropriate setting for patients, whether it is in their own home, a local health centre, or a community hospital. LCH is comprised of 56 services, organised into 3 groups – Adult's Services, Children's Services and Specialist Services. A 3000 strong workforce includes Nurses, Therapists, Doctors, Dentists, Pharmacists, registered and non-registered clinical staff. Alongside colleagues in social care, there are also 13 Neighbourhood Teams across Leeds based around GP registered practices.

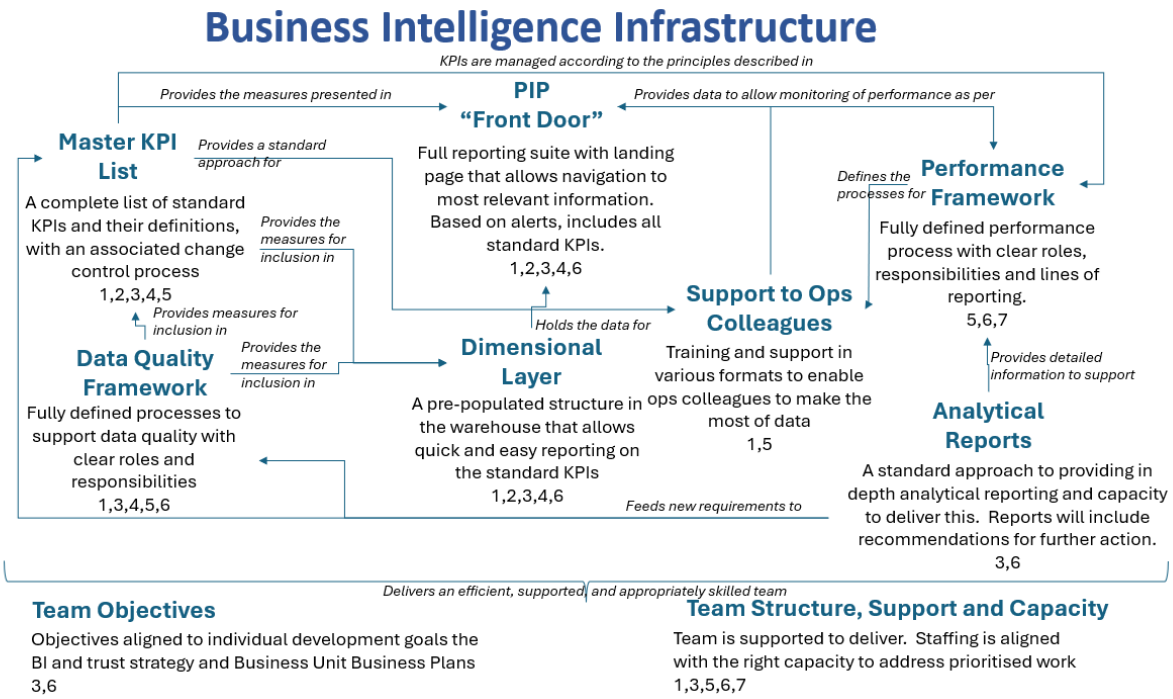
> *"Patients need to be able to communicate with us about appointments and administrative issues in the way they run the rest of their lives – email, text messaging and apps are a much-needed evolution from the mountain of letters we post. No service should refuse to communicate electronically about these issues with a patient where they would previously have sent a letter.*
>
> The future of healthcare: our vision for digital, data and technology in health and care. 2018

There were previously separate strategies for Digital and Business Intelligence. The previous Strategies were impacted by the Covid-19 pandemic. In some aspects, this increased the pace of change for technologies such as utilisation of digital tools to consult with patients virtually, and in other aspects it slowed or stopped delivery as there were more pressing clinical issues to deal with. The implementation plans highlighted elements of work which are already in progress and a summary of the work achieved to date can be found in Appendix B. Some items of work will continue into the new strategy work plan.

A clear role in the place and system in relation to business intelligence and the ability to capitalise on place and system-wide infrastructure – working relationships with the Leeds Integrated Care Board (ICB) have been strengthened over the last three years. There has been an agreement in principle for us to use the West Yorkshire (Leeds hosted) Power BI tenancy rather than procure our own separate instance. We are in the process of developing a dashboard on that tenancy to support system visibility work.

We have started to make use of information produced by the ICB rather than produce it ourselves and are receiving data from them on a regular basis to use in our warehouses rather than procure our own.

There is still work to be done in relation to the previous strategy. The diagram below shows a series of products and the deliverables they relate to. Each of the products relate to each other and together provide an infrastructure upon which to deliver an effective business intelligence service. These products are in various stages of implementation. Significant progress on these is planned for 2024/25.



> *"Within 20 years 90% of all jobs in the NHS will require some element of digital skills. Staff will need to be able to navigate a data-rich healthcare environment. All staff will need digital and genomics literacy… We need to tackle differences in the digital literacy of the current workforce linked to age or place of work.* Health Education England Topol Review 2019.

The Trust continues a trajectory towards a much greater level of integration with Primary Care. The strategy must support this by remaining focussed on supporting staff and direct patient care and not tying the digital and data infrastructure to the organisation itself. The provision of "industry standard solutions" rather than bespoke systems is a core piece of this strategy.

In line with the Estates Strategy/Green Plan, there is a requirement to support plans to achieve a reduction in CO2 emissions for energy, waste and business travel. At LCH we will foster and embed a sustainability consciousness across all our sectors and departments to maximise the effects we can have as a Trust. Sustainable practice and reduction in our carbon emissions will not only reduce our environmental impact and contribute towards climate change, but in turn will have positive effects on the health of the population we serve. The use of digital services will continue to play their part in this ongoing objective.

The most recent NHS digital maturity self-assessment exercises against "What Good Looks Like" highlighted specific areas of strengths in the Trust such as Digitisation of Records, Assessments and Plans, Strategic Alignment and Resourcing. However, Medicines Optimisation, Electronic Test Management, patient self-triage and management as well as Electronic Transfers of Care are well below the levels seen at

other NHS trusts. It also highlighted gaps in our digital leadership, governance and sustainability agenda. This Digital, Data and Technology Strategy supports the increase in maturity in these areas.

There is National recognition that to sustain digital maturity and advancements there is a need to reposition the underlying digital and data services to agree with industry standards which means that it is recommended that IT budgets of 4-5% of revenue ongoing for digitally mature organisations. To put this into context for the Trust existing pay and non-pay operational budgets for the current "Digital and Data" team are approximately £1.9m, excluding specific major project expenditure. To sustain a digitally mature LCH, this figure would need to increase recurrently by between £1m-£2m.

The Trust's digital transformation will be measured; ambitious for the benefits that can be realised but recognising the limit on resources for digital investment and organisational capacity for change. We will aim firstly to ensure any "technical debt" is made good in the early years of the strategy but then we will aspire to be outstanding in our use of digital and data services.

4. Our Organisational Culture:

Essential to the successful delivery of the Digital, Data and Technology Strategy is the need to link to the organisational development agenda. Digital innovation is not discrete. It is part of the whole organisation environment that supports new and creative thinking; it cannot be enacted through a single strategy.

Initial steps have been made to engage staff in developing the strategy, through joining forces with the Trust Strategy listening events, via attendance at business unit management and/or team meetings, via the Administration Celebration event. An Innovation Event held in May 2024, gave staff the opportunity to hear about how other community organisations have gained benefit from the use of digital solutions and staff will have an opportunity to meet with suppliers to discuss opportunities for service transformation.

We will continue and extend this engagement. There will be firmer links to other strategies such as clinical, workforce and organisational development to establish and embed robust mechanisms to harvest ideas from within the organisation and to enable them to become a reality. We will develop a culture of "push and pull" where the digital experts will "push" new digital technologies or ideas out towards services for their consideration about how they fit in with or can replace current ways of work. However, just as importantly, there needs to be a "pull" from clinical and corporate services demanding digital solutions to service problems or to keep pace with evolution seen elsewhere. We aim to engender a digital first culture across the whole organisation.

To support this cultural shift, we will develop a network of digital champions, both clinical and non-clinical, across the Trust. These champions will play a pivotal role in driving digital change and adoption at the frontline of clinical care. The champions will act as

advocates for innovative technologies, providing peer support, and bridging the gap between frontline staff and digital subject matter experts. Their development will be supported by a structured governance framework that ensures they have the necessary training, resources and authority to effectively influence digital transformation within their teams. This governance will also ensure that the champions are aligned with the broader strategic goals of the Trust, fostering a cohesive and coordinated approach to digital innovation.

A new focus on data to support organisational initiatives is required. As we progress through 2024/25, the need for robust, quality information to monitor and manage progress is imperative. A new performance framework will clarify roles and responsibilities in the organisation and has set out a plan for improvement. Supplementing this will be the development of data literacy among staff, to ensure they can record, make sense of and use high-quality data throughout the organisation in an ethical and legally compliant manner, and that the culture changes to be that of data driven decision making.

5. Priorities:

This Digital, Data and Technology Strategy has six key priorities that support LCH's vision and strategic goals.

1. **Supporting staff:** our staff need appropriate technology that is reliable, secure and supports care delivery, as well as having the right level of skills and confidence to use the devices, data and systems available.
2. **Enabling digitally optimised services:** to support services to ensure that they are enabled to deliver existing and new models of care in the most effective and efficient ways using digital technology, leveraging data insights to transform care delivery and ensuring good data handling procedures are in place to minimise risk and threats to the Trust.
3. **Supporting patients and carers:** to support patients and carers to ensure that they benefit from improved, patient-centred, personalised care and experience through digital technology.
4. **Supporting the path to digital transformation**: to support the Trust and its stakeholders on the path to digital transformation, enabling staff and patients to take advantage of new digital products. Co-designing new solutions to ensure they meet the needs of the stakeholders and ensuring that data and cyber protection by design are built into these digital products.
5. **Delivering insight and intelligence:** to provide the organisation with mechanisms that enable a data driven culture by providing consistent processes to develop insight and intelligence on the priorities set by the Trust.
6. **Ensuring our digital estate is compliant and well maintained:** Using the Digital Maturity Index Assessments and outcomes of the independent resilience review, to ensure that our digital estate is compliant and well maintained so that it

is secure, effective and efficient. Delivering an appropriately resourced Digital, Data and Technology service, being adaptive to Trust requirements. Ensuring that adequate standards of cyber and information security are in place across the estate.

Each priority is underpinned by a set of objectives, which will be detailed in a separate implementation plan.

6. Achievability of the Strategy:

An implementation plan will be developed separately that details the plan for delivering the strategy. This strategy sets an ambitious timeframe for delivery. Successful delivery of the priorities will require the following to be in place: -

Leadership – the Trust Board will to provide the "drive" for the organisation and embrace "a digital first and data driven" approach as the normal way of working, acting as the role models where appropriate, to showcase the benefits which are attainable from the use of digital and data products and services and will be key in championing and embedding the performance processes required to ensure effective organisational monitoring. The Trust will consider the sustainable leadership arrangements for digital and data services, in line with Trust requirements and National guidelines.

Implementation resource – We will work towards ensuring sustainable arrangements are in place to enable a standardised delivery approach for digital and data implementations and replacement programmes. In our drive to achieve our vision we will look to prioritise resources where possible. There is a recognition that the financial landscape is fluid and complex and so where internal resources cannot be identified our approach to implementation will ensure we are well placed and ready to accept national funding to be able to proceed at pace with achieving our stated aims and objectives.

Workforce - The Business Intelligence, Clinical Systems, IT and IG/Cyber teams will also have a significant part to play in leading and championing the change, helping to identify "the art of the possible" to turn ideas into proof of concepts and ultimately business cases where demonstrable benefits can be identified and realised. However, as a healthcare organisation it is the clinical services and the patients at the centre of those services that have key roles in implementing the change. Digital, Data and Technology is not something done "to" services and patients. It is done "with" services and patients. A user centred co-design approach is key to delivering the strategy successfully. Digital changes must be clinically lead, operationally driven and digitally enabled. We must ensure that the changes do not increase health inequalities or threats to information security, so we provide the best possible care for all the communities we serve.

In line with our commitment to delivering high-quality care and services, our Workforce approach to digital will focus on integrating technology to enhance the management of our workforce, improve operational efficiency, and elevate the employee experience. By

automating key processes, we will create a seamless and supportive journey for our staff as they join and progress within our organisation, while also freeing up valuable time.

We will leverage data interfaces and automation tools to streamline data entry, ensuring that information is captured once and used effectively across multiple platforms, thereby enhancing accuracy and efficiency. Our approach includes exploring and embedding new technologies, such as an Applicant Tracking System, Service Desk and HR Case Management solutions, while continuously improving our existing systems like HealthRoster and ESR.

Additionally, we remain focused on centralising our data within a dedicated Data Warehouse, advancing the development of PowerBI Dashboards, and collaborating closely with our BI colleagues to generate meaningful insights. We aim to empower our staff with the critical insights needed to perform in their roles, ultimately enabling them to deliver the highest standard of care to our patients and communities.

We need to ensure we have the right level of digital expertise in the Trust to drive forward a smooth implementation of any new solution or enhancements, as well as ensuring we have the right skills and infrastructure to support the solutions to run sustainably on an ongoing basis for transition to business as usual.

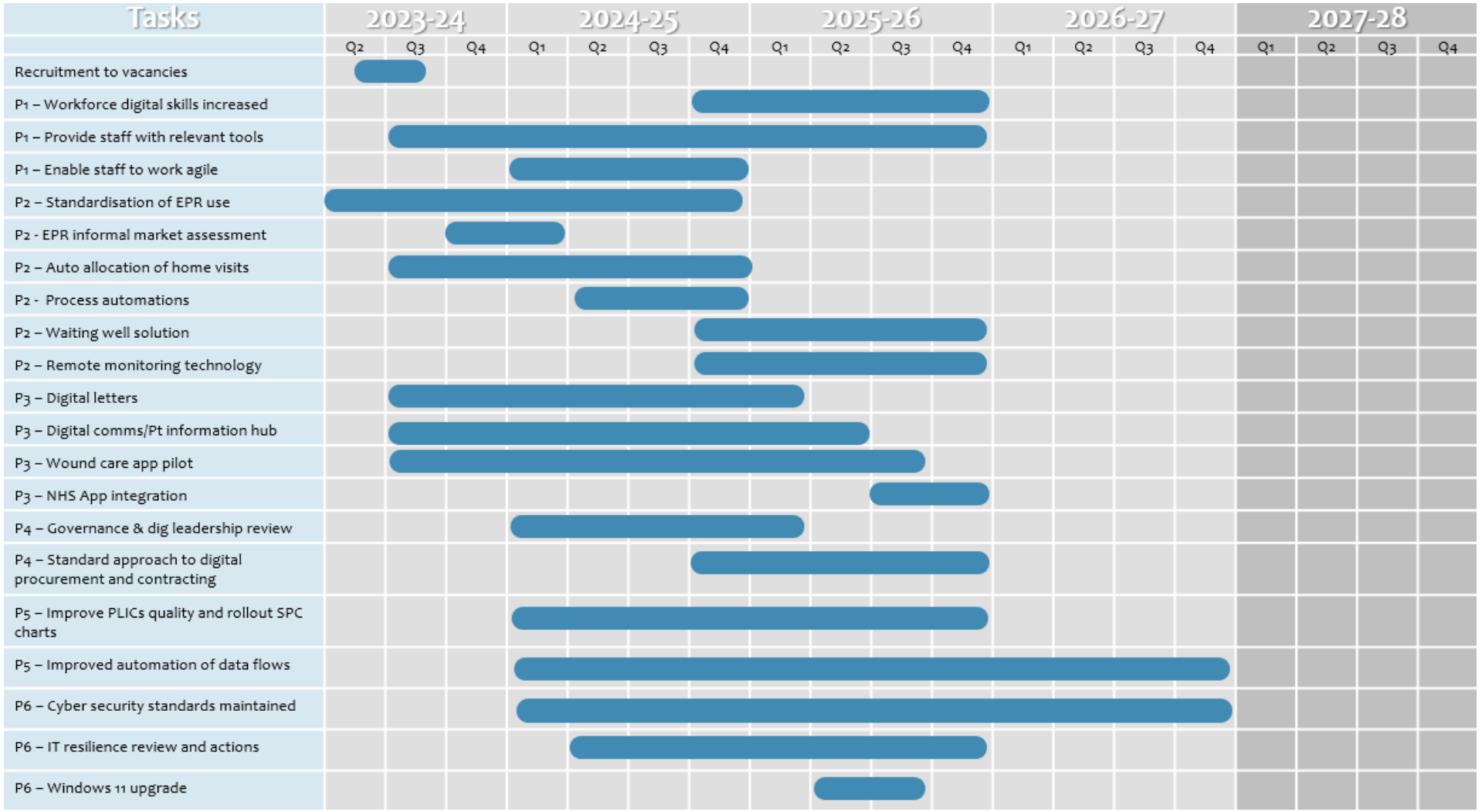
The true benefits possible from digital and data technologies will require a much closer connection of Equity and Inequalities, Finance, Workforce / Organisational Development and Estates strategies, which traditionally have been developed and operated in isolation. To really take advantage of digital innovation, the technology needs to work in partnership with the workforce and in an estate which has been designed around the routine use of digital solutions such as appropriate areas to make and receive video call and collaborate digitally. We need to seek opportunities where digital solutions can drive efficiencies and reduce the burden on staff, enabling the use of resources in a more efficient way.

Embracing the opportunities of having the Digital Programme Board that feeds into the Trust Quality and Value Programme Board, with Executive support. Many of the digital innovations will have major change consequences for the organisation and consideration will need to be given to ensure there is robustness to the governance mechanisms that critically assess and challenge the business cases behind each of the initiatives.

The high-level timeline is shown in Figure 6.1 in Appendix A. Also detailed overleaf is a graphical view of our current and planned future state vision.

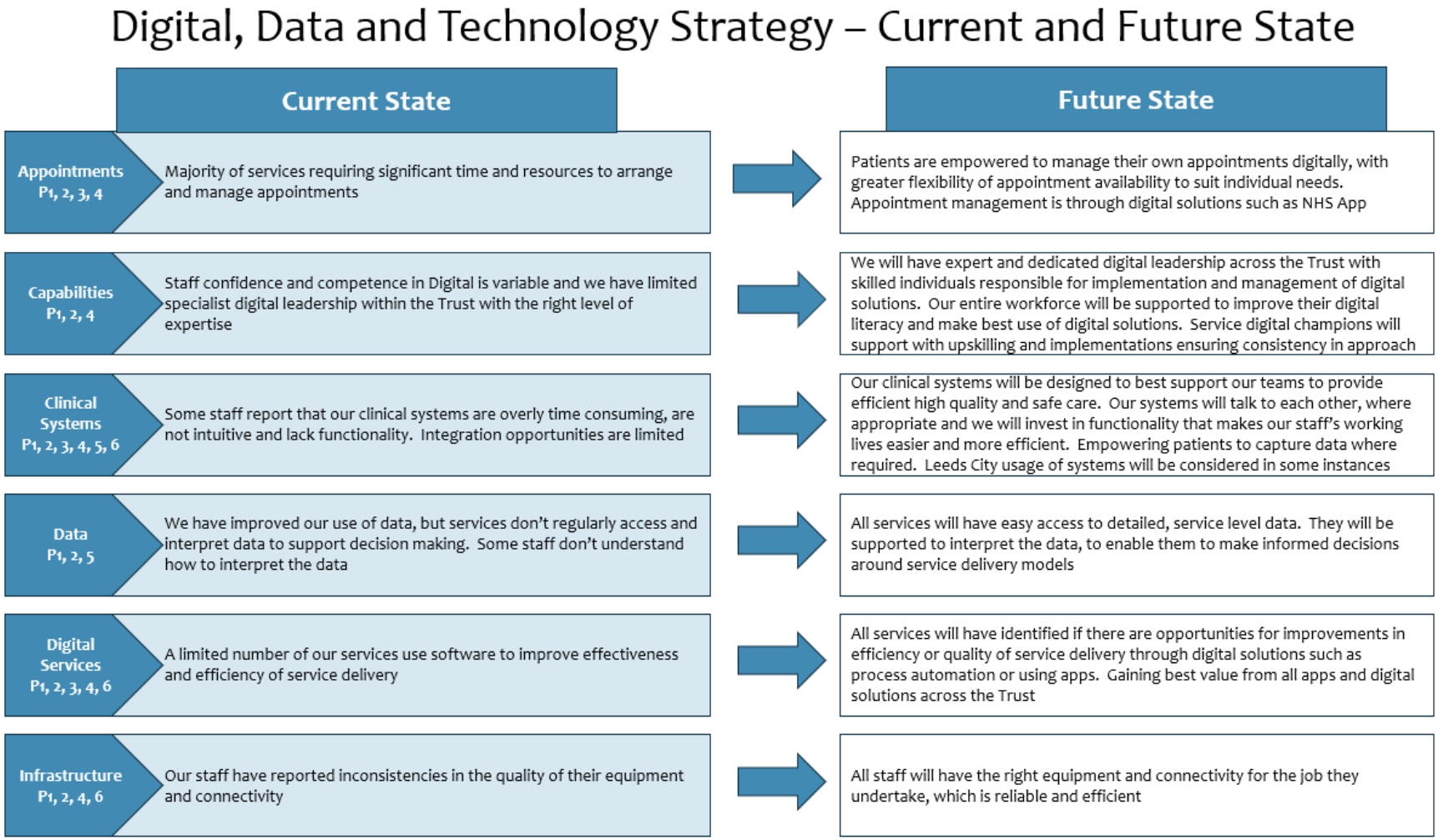
6.1 High Level Timeline

A high level timeline is displayed below. A more detailed implementation plan will be developed separately.



6.2 Current and Future State Vision

As part of the research to develop this strategy, engagement with staff have highlighted a number of issues. Stakeholders want to ensure this new strategy addresses these. Under each heading shows which of our six digital priorities each item supports.



7. Risks to Delivery and Resourcing:

The key risks to delivery of the priorities and initiatives set out in the Digital, Data and Technology Strategy, set out in the table below, together with mitigating actions.

Risk	Likelihood	Severity	Total	Mitigation
Untried or untested integration technologies may not work	3	3	9 (High)	Undertake proof of concepts. Ensure specifications are precisely detailed and contracts for any new major digital investments protect the Trust from failure to deliver by a supplier.
Workforce Lack of capacity within services to change working practices to adapt to digital ways of working means the benefits of digital transformation may not be fully realised. Lack of suitably qualified digital expertise will either slow down the pace of delivery or cause problems with implementation.	3	3	9 (High)	Senior Leadership acting as role models and giving staff groups the time and space for change. Using clinical specialists and digital champion network to promote use of digital solutions Ensure benefits of new digital solutions are publicised, so services can see the opportunities to support their service transformation journeys. Promote access to “up to date” training and development such as the Digital Skills Development Network for staff working on digital projects. Ensure detailed scrutiny of expertise takes place when recruiting to new positions. Consider whether we have sufficient resources to deliver, and develop business cases to increase staffing levels where needed
Financial Resources Insufficient funding to procure and maintain	3	3	9	Exploit all opportunities to benefit from National funding.

Risk	Likelihood	Severity	Total	Mitigation
new solutions. Reliance on capital funding for digital solutions adds restrictions. Cloud solutions generally require revenue funding.			(High)	Internal review of all available funding based on priorities and likely return on investment. Consider options to capitalise cloud solutions. Ensure future cost pressure are fully recognised in the Trusts long term plans. Detailed examination and challenge of business cases to ensure any productivity or efficiency gains identified can be realised.
Quality and Value programme and requirement to reduce costs may impact ability to progress with new digital procurements and sustainable support arrangements to maintain new products	3	4	12 (High)	Ensure new business cases identify areas for invest to save opportunities. Plan implementations to enable benefit achievement as early as possible
Lack of procurement support capacity may delay any future procurement exercises and contract negotiation due to inexperience of staff internally	3	4	12 (High)	Plan renewals and procurement timeline in advance to seek appropriate support. Prioritise procurement support for high value renewals/ procurements
New products or services may expose the Trust to risk if they are not adequately assessed for data protection or information security threats	2	3	6 (Moderate)	Ensure that any new services are assessed using controls such as DTAC, DPIA and review of contractual relationships

8. Recommendation:

In conclusion, this strategy is designed around six key priorities which are linked to the Trust's values and behaviours. The immediate priorities are designed to ensure we get the basic infrastructure right with more innovative and complex products and services coming into place to enable transformation of our service delivery model. We need to ensure that we consider the reporting requirements for any new implementations and how we turn the data into intelligence.

Along with the need to get the right levels of resources to deliver and then sustain the digital transformation is the need to ensure this strategy is linked to the Finance, Workforce and Estates/Sustainability Strategies both now and in the future to ensure they work in harmony.

Staff engagement has played a significant role in the development of this document, and it has provided an important starting point for the conversation about digital and data needs and priorities as the strategy develops, a vital aspect will be to maintain that conversation.

It is recommended that the priorities within this strategy are agreed. Business cases will be developed, in line with the timeline for delivery, for each of the priorities. The Trust will ensure investment is prioritised to support procurement and delivery to meet these priorities.

Appendix A: LCH Values and Behaviours

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

Appendix B: Previous Strategy Deliverables

The previous Digital Strategy was impacted by the Covid-19 pandemic. In some aspects this increased the pace of change for technologies such as utilisation of digital tools to consult with patients virtually, and in order aspects it slowed or stopped delivery as there were more pressing clinical issues to deal with. The implementation plan highlighted 20 elements of work which are already in progress. Below is a summary of the work achieved to date.

Mobile device management – implemented and controlling all new mobile phones purchased by the Trust.

Assessment process for new digital requirements – process for assessment built into all new tendering responses/bidding opportunities.

eRostering – roll out completed for staff.

Single sign-on – implemented but further opportunities exist to be rolled out to additional staff groups.

Leeds care record – promoted for wider use across services to support availability of clinical information to support deliver of patient care.

Cyber security – Cyber essentials and Cyber Essentials plus accreditation completed and Trust is now fully Windows 10 compliant along with Office365 for additional security features.

HSCN migration – achieved complete migration to the secure network.

Axe the fax – full removal of all fax machines from use.

Cloud migration – decommissioned local file servers and migrated to cloud storage.

The previous Business Intelligence Strategy had the following aims: -

- One source of standard information
- Support and upskill colleagues.
- Deliver strategically aligned analytics.
- Work in partnership
- Exploit and explore new opportunities.

Of the seven identified key deliverables, below is a summary of the work completed.

An established set of organisation-wide measures available at all organisational levels to all relevant parties via one source – A reference list of indicators relevant to the organisation is in draft, further development of this is planned for 2024/25 for launch in 2025/26. Power BI has been rolled out (more information below) and consideration about how these measures can be presented in an easily understandable format has begun.

The ability to assess each of the organisation-wide measures for different populations to assess health equity – There are new measures included in the Performance Brief for this year that report on the equity for patients accessing care in IMD1 versus IMDs 2 to 10. The Business Intelligence Team have contributed to discussions relating to health equity and ensure that their approaches align with those across the city.

Delivery of Business Intelligence technologies and processes that have freed up resources to provide more in depth, specialist support – A major success story is the launch of Power BI. The Business Intelligence Team have been trained in this new software and a number of dashboards are now available. Work is underway to gradually replace existing reports with Power BI dashboards.

We have created a new role within the team to take a lead on developing the dimensional model in our data warehouse. This model will help us more efficiently structure and use data and is a key building block to delivering self-service reporting. We are currently awaiting banding and approval for this post.

Robust organisation-wide data quality processes with measurable outcomes – The Data Quality Framework has been approved. An action plan for implementation is due for development in 2024/25. A post to support data quality in corporate information systems was not approved. Support has been provided to other corporate teams, but this has not been extensive.

Training and support to colleagues in services enabling them to embed the use of data and information in their day-to-day work – This work was earmarked for the 3rd year of the strategy. Supporting resources are being produced to support use of the key products that will support the Quality and Value programme.

More efficient and better aligned business intelligence resource within the existing Business Intelligence team and wider corporate teams – two matrix managed posts have been recruited to. These provide specific support to the workforce and finance teams to progress the required reporting. They are line managed and sit within the Business Intelligence team so that appropriate professional support is available and so that consistent methods can be applied. This is working very successfully.

A clear role in the place and system in relation to business intelligence and the ability to capitalise on place and system-wide infrastructure – working relationships with the Leeds Integrated Care Board (ICB) have been strengthened over the last three years. There has been an agreement in principle for us to use the West Yorkshire (Leeds hosted) Power BI tenancy rather than procure our own separate instance. We are in the process of developing a dashboard on that tenancy to support system visibility work.

We have started to make use of information produced by the ICB rather than produce it ourselves and are receiving data from them on a regular basis to use in our warehouses rather than procure our own.

Appendix C: Glossary

Acronym / Abbreviation	Meaning
CCIO	Chief Clinical Information Officer: The Chief Clinical Information Officer (CCIO) is a position that exists within the healthcare industry, that combines the expertise of a long-practicing medical clinician with the IT knowledge of a CIO role
CHS	Community Health Services: delivery of care that cover a wide range of services for people from birth to the end of their life. Services are mainly delivered in people's homes (this includes care homes) but also in community hospitals, intermediate care facilities, clinics and schools.
EPR	Electronic Patient Record: comprises a series of software applications which bring together key clinical and administrative data in one place
ICB	Integrated Care Board: statutory organisation which is responsible for developing a plan for meeting the health needs of the local population
LCH	Leeds Community Healthcare NHS Trust
LTHT	Leeds Teaching Hospitals NHS Foundation Trust
PCN	Primary Care Network
YHCR	Yorkshire and Humber Care Record: Regional shared care record across Yorkshire and Humber

Digital, Data and Technology Strategy Year 1

Business Case V2.2 Final

Project Title	Digital, Data and Technology Strategy – Year 1
Directorate / Service	Trust wide
Project Manager	N/A
Project Sponsor	Andrea Osborne
Date	26/09/24
Author	Dawn Greaves
Version	V2.1 Final
Appendices	Appendix A – Costing Tables Appendix B – Proposed Funding Appendix C - Proposed Digital Programme Management Office Structure Appendix D - Benefits Realisation

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1. Overview

1.1. Context and Background

This business case has been developed to enable delivery of the year 1 priorities of the Trust's Digital, Data and Technology Strategy, including utilisation of the National Frontline Digitisation funding that has been allocated to the Trust for 2024-25. The aim of the strategy is to support the Trust in its overall vision of "we provide the best possible care in every community". The strategy is being introduced at a time when community health services play a key role in our health and care system, keeping people well at home and in community settings closer to their home. These services are central to ambitions to boost out of hospital care and in helping people maintain their independence in their preferred place of residence. The delivery of these services can't be done solely by one organisation so it is imperative that we build and maintain collaborative relationships with other health and care partners across the Leeds City and wider West Yorkshire footprint.

The Trust is embarking on a Quality and Value programme where service teams will evaluate their service offering and ways of working with a view to delivering them in a more efficient way to provide savings and efficiencies. The Quality and Value programme is an exciting opportunity to showcase how clinically led, operationally driven and digitally enabled solutions can support service transformation to maximise quality care delivery in more efficient ways. It creates a drive for the organisation to embed data driven monitoring of programmes and utilisation of standardised reporting and processes.

The new strategy showcases how digital will support transformation across the Trust. The strategy is underpinned by, and sets the direction for the Business Intelligence, Clinical Systems, Information Technology (IT) and Information Governance (IG)/Cyber service's business plans as well as aiming to influence and respond to clinical and operational plans from the business units operating within the Trust.

Our direction of travel is towards increased integration with our health and care partners across primary care; across the city of Leeds and across our integrated care system, the West Yorkshire Health and Care Partnership. This strategy covers a three year period rather than a longer period, acknowledging the rapid pace of change and development in the digital world, in health and care structures and in national and local priorities.

The strategy seeks to identify how digital products and services can make our services more accessible to communities and patients and increase our effectiveness and efficiency. As well as implementing new and innovative technologies, we want to ensure we are achieving value from the existing products and services we already have access to within the Trust, as well as ensuring that we are offering a quality support service to the staff we are here to serve. We want to ensure any new innovative technologies provide the relevant data insights enabling performance monitoring, to ensure we can be confident they are supporting our transformation vision. We will put our service users and staff at the forefront of our plans, ensuring we are co-designing future solutions. We want to be ambitious, we want digital services and products to help transform the way we work and the services we deliver.

1.2. Rationale

To support the Trusts Digital, Data and Technology Strategy and enable delivery of year 1 priorities, the business case proposes that the Trust invests in new patient systems, business intelligent services and hardware as outlined in Section 7.1 costs. The business case will outline how the Trust will invest the Front-Line Digitisation and internal capital funding to meet year 1 priorities.

Due to the significant investment required the preferred option will result in overspends against capital and revenue allocations. The overspends in year 2 onwards will be mitigated by additional bid funding flowing into the Trust and expected benefits that will flow from the investments.

The Digital, Data and Technology Strategy is currently being socialised with key stakeholders within the Trust to ensure it fully encompasses the requirements of our patients, staff and services. The plan is that the strategy will be fully approved by the Business Committee in September and Trust Board in October. However, to enable progression with delivery of key projects, and to ensure we are able to secure our allocation of National Frontline Digitisation funding, this business case is being submitted for approval to ensure work can commence on the year 1 priorities. This is the final year of funding as part of the National Frontline Digitisation programme. However, there is new National funding anticipated for 2025-26 for three years. We are awaiting clarity in terms of whether there will be a Trust allocation or a bidding process to follow.

The Trust is being assessed annually in relation to our level of digital maturity. We are one of the least digitally mature organisations across West Yorkshire. Our year 2 assessment shows our maturity has officially reduced from 2.3 in year 1 to 2.03 this year, which is due to the scoring changes within the assessment. Table 1 shows the scores of the local community and mental health Trusts for comparison.

All Trusts have seen a reduction due to this issue. We feel we have remained the same in terms of our capabilities. However, we did purchase a number of products in March 2024, which are yet to be implemented, which will have a significant impact on our maturity and delivery of the elements within this business case will significantly increase our maturity for future year assessments.

Provider	BRADFORD DISTRICT CARE NHS FOUNDATION TRUST		LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	LEEDS COMMUNITY HEALTHCARE NHS TRUST		LOCALA COMMUNITY PARTNERSHIPS CIC	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	
WGLL Pillars	Community	Mental Health	Mental Health	Community	Mental Health	Community	Community	Mental Health
Well Led	3.33	3.33	2.33	1.67	1.67	2.33	2.67	2.67
Ensuring Smart Foundations	3.00	3.00	2.46	2.38	2.08	2.85	2.71	2.77
Safe Practice	2.25	2.25	3.25	3.00	3.00	4.00	2.50	2.50
Support People	2.67	2.67	3.00	1.67	1.67	2.67	3.33	3.33
Empower Citizens	1.50	1.50	1.67	1.67	1.67	1.67	2.33	2.33
Improving Care	1.40	1.40	1.00	1.40	1.40	2.00	1.60	1.20
Healthy Populations	2.00	2.00	2.00	1.80	1.80	2.60	2.60	2.60
Total	2.36	2.34	2.21	2.03	1.92	2.59	2.53	2.49

Table 1

Bringing this set of deliverables into a project lifecycle and providing the resource and support for implementation will ensure a more timely and efficient approach to realising benefits whilst minimising risk of delays with delivery.

1.3. Deliverables

The business case is aiming to achieve the following deliverables to increase the Trust's digital maturity.

1. Automation
Utilising automation technologies such as robotic process automation and Microsoft Power Automate, the Trust will look to bring efficiencies to services by automating manually intensive processes. This will reduce the administration burden on the Trust and increase capacity within teams for direct patient care.

2. Digital patient communications
The Trust will implement digital options to enable patients to communicate with services digitally. Patients will be enabled to self-refer, manage their appointments and request prescriptions/medications (where services allow this). Patients will access these digital services from the patient information hub, as the front door for access. There are a number of solutions available to the Trust to achieve this ambition and each will be assessed.

3. Digital patient letters
The Trust has procured a new contract that will transport patient letters. The aim is to provide patients with the opportunity to receive their letters digitally in the first instance. Where patients access their letter digitally, they will be offered the opportunity to say if they can or can't attend their appointment. If they are unable to attend, an administrator will be notified to re-arrange the appointment. This should significantly reduce DNA rates.

Where patients don't accept the letter digitally, they will automatically receive a printed/posted paper letter. The Trust is aiming to achieve a minimum of 75% of letters to be accessed digitally.

4. EPR optimisation
The Trust uses SystmOne as its electronic patient record (EPR) and this system has been in place for a long period of time. There are issues in terms of how the individual units have been established, with no common data model and issues in some areas around the way data is recorded. An EPR optimisation approach has commenced in some services. The recommendation is that the Trust informally assess the market to determine whether there are any more suitable solutions available. The market for EPRs for community Trusts is limited but assessment should be made for confirmation. Should there be another product that is more suitable, a future recommendation would be made to consider options of a procurement exercise. Should the Trust determine that SystmOne is the most suitable solution available, recommendations should be made around the level of resources required to complete the optimisation exercise.

5. Hardware/Technical
The Trust has implemented a technical replacement programme to ensure devices are replaced at the 5 year period as standard. This will ensure devices are working and fit for purpose throughout their lifecycle to enable staff to undertake their roles without fear of diminishing devices and batteries.

A number of additional security services are also being extended to ensure the Trust remains proactive and secure in its cyber security approach.

6. HEARTT

The Trust has procured the HEARTT algorithm from University Hospitals Coventry and Warwickshire NHS Trust to support the prioritisation of patients on waiting lists. The algorithm identifies patients in the bottom 20% by index of multiple deprivation (IMD) to enable care to be prioritised for these cohorts.

7. Patient information hub

The Trust has undertaken a procurement exercise to implement a new patient information hub. The hub will be the single front door for patients to access information from and about the Trust and its services. Each service will publish key details about their offering, patient information leaflets and can design self-management pathways. The pages will be designed to suit the cohort of patients who will be accessing the hub. All information will be available to patients in an accessible format with inbuilt accessibility toolbar.

8. PowerBI

The Trust will continue to roll out PowerBI as the software we use to deliver online interactive reporting via the patient information portal (PIP). It will be used for all new reports unless there is a specific reason why other solutions are more beneficial. We will continue to align our reporting mechanisms to Leeds ICB where appropriate and continue to contribute to the System Visibility Dashboards developed for the HomeFirst Programme.

9. Patient Level Information Costings

We will use our patient level information costing (PLICs) data to effectively assess the financial impact of clinical changes in the Trust. The first step of this is underway. We will soon begin to receive a PLICs data extract from the Synergy system and will import this into the data warehouse. Once this is available, we will be able to assess the data and present and determine whether improvements to the data are required to allow reliable reporting that meets the needs of the Trust.

10. Remote monitoring

The Trust is looking to procure a solution to enable the monitoring of patients remotely. The solution would support our virtual wards and enable patients to provide details of their metrics ie blood pressure, weight, heart rate etc. This would alert services to any patients who start to deteriorate to enable proactive intervention to prevent deterioration. This would also enable services to prioritise their home visits to the patients who are more unwell than others.

11. Waiting well

The Trust is looking to procure a solution to provide a level of monitoring and assurance of our patients who are waiting to receive care. Once a patient is placed on a waiting list, they would be asked to use an app to undertake levels of self-management, provide metrics on their circumstances such as mood/pain score/mobility etc. This would alert services to any patients who start to deteriorate to enable intervention, or where patients are progressing well may be discharged from the waiting list without the need to receive direct care. This solution works alongside the HEARTT algorithm to help prioritise waiting lists. This is likely to bring huge efficiencies to the Trust.

12. Wound care

The Trust will pilot the use of a wound care app to support improved care of wounds remotely. With neighbourhood team staff taking a photo of the wound, which is then directly uploaded to SystmOne, wounds can be monitored remotely. On return visits, when a new photo is taken, the app will use AI technology to assess changes to the wound, reducing the need for clinical assessment and ensuring the right level of care is given to the patient. The pilot will take place in the Morley neighbourhood team and if successful, recommendations will be made to extend usage.

2. Aims & Objectives

2.1. Aims

The overall aim of this business case is to ensure the Trust progresses with increasing its digital maturity. Supporting service transformation, providing digital enablers, to support the Quality and Value programme. This in turn will support our staff to be more efficient, improve quality of care and enhance patient experience, support our patients and carers to be digitally connected and more involved in their own health and wellbeing as well as enabling digitally optimised services. We will use the data we are collating to provide greater insights and intelligence to inform our future service delivery models. We will also ensure our digital estate is compliant, well maintained and sustainable.

2.2. Objectives and Success Criteria

Objective	Success Criteria
To implement a digital letter solution across all LCH services	• Compliance with the Accessible Information Standards • Trust-wide consistency of digital approach to provision of information to patients between services
To give patients greater control of own healthcare through the provision of information digitally and opportunity to communicate with the Trust digitally (e.g. phones, tablets, computers), with an opt-out to initiate a 'print to send' function	• Improved patient journey and pathway • Increased patient ownership of own healthcare – e.g. self-management • Improved patient outcomes • Availability of information (e.g. 24/7, no phones queues)
To reduce service inefficiencies through the adoption of a standardised approach to patient communication	• Compliance with the Accessible Information Standards • Trust-wide consistency of digital approach to provision of information to patients between services • Accessible information that is provided, updated, changed more quickly. • Reduction in DNAs • Increased communication efficiency and response times • Increased digitisation of workplace and processes
Increase competence and confidence of our workforce to develop in a digital workplace	• Improved efficiency of staff • Increased knowledge of opportunities to make data-driven decisions • Increased confidence to accept new technologies and processes
Improve the information available and processes to support performance management	• Management are able to make informed, data-driven decisions • Increased productivity by identifying areas of priority
To achieve a cost benefit savings	• Reduction in cost associated with staff time • Reduction in printing and mailing costs • Reduction in travel costs • Increased organisational resilience and sustainability • Contribution to the reduction in carbon footprint

Table 2

3. Option Appraisal

3.1. High-Level Summary of Options

Option 1 - Do nothing [not recommended]

Continue with the current level of digital maturity. This is not an option we can progress with, due to the level of investment already received from NHS England through Frontline Digitisation. It will also preclude the Trust from achieving benefits towards the Quality and Value programme.

Pros:

- No resource or financial costs.
- Able to focus on other projects and developments prioritised within the Trust.

Cons:

- Potentially would need to repay funding received from NHS England for Frontline Digitisation.
- Would not be able to realise some substantial benefits, as well as significant staff and service efficiency as well as cost saving benefits.
- Would not increase the Trust's digital maturity.

Option 2 - Only complete work as part of National Frontline Digitisation Programme from 2023-24 [not recommended]

This option requires additional implementation resource to ensure products and services that were procured using the National Frontline Digitisation funding are able to be fully utilised and achieve benefits realisation. This will not progress the Trust any further forward in terms of digitisation.

Pros:

- Would enable full implementation of already procured products and services.
- No additional procurements to undertake.
- Implementing these solutions will enable some elements of service transformation in terms of savings and efficiencies to support the Quality and Value programme.

Cons:

- Would not progress our digital maturity sufficiently.
- Would not support full utilisation of our Frontline Digitisation allocation for 2024-25.
- Would potentially lower staff satisfaction as there is an expectation that the Trust will significantly improve the level of digitisation.

Whilst this option would allow some elements of digitisation to progress, it's not favourable as it restricts the level of progress we can make and benefits we can achieve.

Option 3 - Full delivery of recommendations for year 1 of the Trust's Digital, Data and Technology Strategy [recommended option]

Working towards full delivery of the strategy will allow the Trust to make significant progress with the level of digitisation; fully utilise the National Frontline Digitisation funding and achieve significant benefits realisation to support the Quality and Value programme.

Implement a permanent core digital programme management function to enable transformation to continue beyond year 1. The team would scale up and down based on the level of work to be undertaken each year and also bearing in mind any National funding we are allocated each year.

Pros:

- Would enable full implementation of already procured products and services.
- Would enable significant levels of service transformation in terms of savings and efficiencies to support the Quality and Value programme.
- Would enable us to deliver the best solutions for various requirements.
- Would enable full utilisation of the National Frontline Digitisation funding and internal capital allocations.
- Would provide a level of digital expertise to the Trust to ensure future digital implementations are streamlined.

Cons:

- Services may not have capacity to engage in this level of transformation.
- Capital and revenue overspend in year 1. Year 2 to year 5 will be offset by potential new funding and benefits realisation from digital investments.

4. Recommended Option

4.1. Option Rationale

Option 3 - Full delivery of recommendations for year 1 of the Trust's Digital, Data and Technology Strategy

Working towards full delivery of the strategy will allow the Trust to make significant progress with the level of digitisation; fully utilise the National Frontline Digitisation funding and achieve significant benefits realisation to support the Quality and Value programme. It also supports the journey to further digitisation in future years, as detailed in the

new Digital, Data and Technology Strategy that is being socialised currently, with plans for formal approval at Trust Board in October 2024.

4.2. Funding Allocation

The Trust have been allocated funding from the National Frontline Digitisation programme for 2024-25. This has been confirmed and we are expecting to receive the funding in October 2024, subject to approvals of our formal submission, which will be made by September 2024. Values are shown in Table 3, along with other internal funding allocations/ budgets.

Funding source	24/25 Capital Funding	24/25 Revenue Funding	Total Funding
National frontline digitisation	£1,306,000	£371,000	£1,677,000
Internal digital capital allocation	£700,000		£700,000
Existing Synertec letters budget		£179,000	£179,000
Existing Trust website budget		£2,900	£2,900
TOTAL	£2,006,000	£552,900	£2,558,900

Table 3

4.3. Identified Stakeholders

The key stakeholder groups and their representative are as follows:

- Andrea Osborne – Interim Director of Finance and Resources
- Dawn Greaves – Associate Director of Digital Transformation
- Richard Slough – Assistant Director of Business Intelligence
- Geraint Jones – Chief Clinical Information Officer
- Paul Elwell – Head of Electronic Patient Record
- Anita Simey – Digital Programme Manager
- Nicola Day – Project Manager – Digital Letters
- Samantha Morgan – Project Manager – Patient Information Hub
- Victoria Douglas-McTurk – Head of Business Intelligence and Performance
- Dan Barnett – Head of Strategy, Change and Development
- Jo-ann Watson – Revenue Finance Lead
- Annette Clough – Capital Finance Lead
- Lucy Shuttleworth – General Manager – ABU
- Caroline McNamara – Clinical Lead – ABU
- Janet Addison – General Manager – CBU
- Hannah Beal – Clinical Lead - CBU
- Andrea North – General Manager – SBU
- Mandy Young – Clinical Lead - SBU
- Aaron Wray – Head of Administration
- Alan Sewell – Workforce Lead
- Em Campbell – Health Inequalities Lead
- Andrew Davies – Procurement Manager
- Rachel Benn – 100% Digital

The projects are managed by the newly established Digital Programme Management Office and progress will be reported via the Digital Innovations Projects Board and Steering Groups to the Digital Programme Board following the governance structure shown in figure 2:

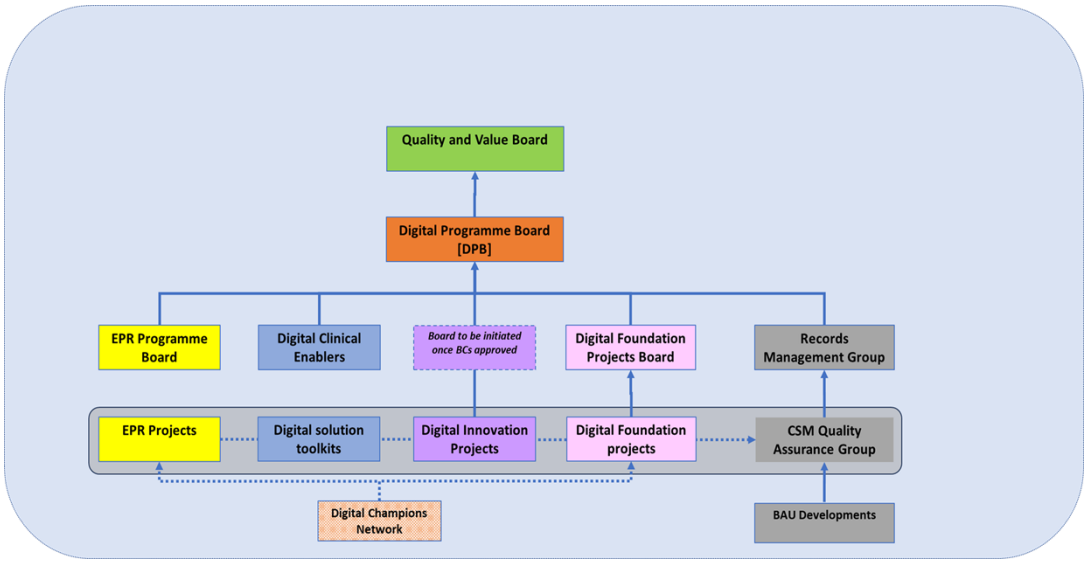


Figure 2

5. Benefits of Recommended Options

Detailed benefits realisation plans will be managed as a live document as part of the project implementation life cycle. However, table 4 provides details of expected benefits to be achieved.

Benefits	Financial Benefits	Non-Financial Benefits
Patient Choice • Communication in the format patient desires. Meets the requirement of patients to receive correspondence in a manner they prefer. • Supports meeting the requirements of providing 'accessible' correspondence through electronic media otherwise difficult to meet via paper. (e.g. text to voice)	• Save staff time and be more efficient • Reduction in paper, printing and postage costs	• Improve patient care and experience • Accessibility of information in a format of choice, available 24/7 • Improved patient ownership of their own health and wellbeing
Reduction in DNAs • Reduction in undelivered letters relating directly to missed appointments. • Patients can respond electronically, therefore more likely to let us know if any issues, need to change appointment time etc, and can reduce DNAs. • NHS Trusts deploying electronic letters solutions do report reduction in DNA rates.	• Shorter waiting lists • Reduction in the number of DNAs	• Improve patient care and experience • Effective use of clinical and none clinical time
Sustainability • Reduction in the use of paper and printing has a positive environmental and carbon footprint.	• Reduction in returned post • Reduction in travel costs	• Improved patient experience
Patient Safety • Reduction in IG breaches.	• Reduction in IG breaches caused by multiple letters placed in same envelope.	• Reduce administrative time of printing and posting letters.

Table 4

6. Risks, Assumptions, Issues, Dependencies and Constraints for Recommended Option

6.1. Key Risks identified to date.

Risk	Likelihood	Severity	Total	Mitigation
Untried or untested integration technologies may not work	3	3	9 (High)	Undertake proof of concepts. Ensure specifications are precisely detailed and contracts for any new major digital investments protect the Trust from failure to deliver by a supplier.
Workforce Lack of capacity within services to change working practices to adapt to digital ways of working means the benefits of digital transformation may not be fully realised. Lack of suitably qualified digital expertise will either slow down the pace of delivery or cause problems with implementation.	3	3	9 (High)	Senior Leadership acting as role models and giving staff groups the time and space for change. Using clinical specialists and digital champion network to promote use of digital solutions Ensure benefits of new digital solutions are publicised, so services can see the opportunities to support their service transformation journeys. Promote access to “up to date” training and development such as the Digital Skills Development Network for staff working on digital projects. Ensure detailed scrutiny of expertise takes place when recruiting to new positions. Consider whether we have sufficient resources to deliver, and develop business cases to increase staffing levels where needed
Financial Resources Insufficient funding to procure and maintain new solutions. Reliance on capital funding for digital solutions adds restrictions. Cloud solutions generally require revenue funding.	3	3	9 (High)	Exploit all opportunities to benefit from National funding. Internal review of all available funding based on priorities and likely return on investment. Consider options to capitalise cloud solutions. Ensure future cost pressure are fully recognised in the Trusts long term plans. Detailed examination and challenge of business cases to ensure any productivity or efficiency gains identified can be realised.

Risk	Likelihood	Severity	Total	Mitigation
Quality and Value programme and requirement to reduce costs may impact ability to progress with new digital procurements and sustainable support arrangements to maintain new products	3	4	12 (High)	Ensure new business cases identify areas for invest to save opportunities. Plan implementations to enable benefit achievement as early as possible
Lack of procurement support capacity may delay any future procurement exercises and contract negotiation due to inexperience of staff internally	3	4	12 (High)	Plan renewals and procurement timeline in advance to seek appropriate support. Prioritise procurement support for high value renewals/ procurements
New products or services may expose the Trust to risk if they are not adequately assessed for data protection or information security threats	2	3	6 (Moderate)	Ensure that any new services are assessed using controls such as DTAC, DPIA and review of contractual relationships

Table 5

Risk scores and mitigations will further be expanded upon within individual project PIDs and EQIAs relevant to the solution being implemented.

6.2. Key Dependencies identified to date.

- Drawdown of NHS Frontline Digitisation funding for 2024/25.
- Prioritisation of internal capital funding.
- Corporate services review as part of the Quality and Value programme.

7. Achievability

7.1. Costs

1. **Option 1 – Do nothing** [not recommended]

   No additional investment above current revenue and capital budgets. Frontline digitisation funding will be held and not invested.
   There will be no additional financial impact on the Trust's financial position. No need for match funding.

Option 1	Do Nothing - Use the current internal capital budget of £0.7m				
Source of Capital	Internal Capital Allocation				
Period	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000	2028/29 £000
Available Capital	700	900	900	900	900
Capital Investment	(1,327)	(1,037)	(1,188)	(831)	(2,242)
Surplus/(Deficit)	**(627)**	**(137)**	**(288)**	**69**	**(1,342)**
Source of Revenue	Internal Budgets				
Available Revenue Funding	500	640	680	680	680
Revenue Spend	0	(265)	(473)	(710)	(877)
Revenue Surplus/(Deficit)	**500**	**375**	**207**	**(30)**	**(197)**

Table 6

Some staff are already in post and currently charged to capital. As funding is only currently approved to 31 March 2025 and is a pre-commitment from Frontline Digitisation funding this option is not recommended. The total cost of staff in post is £0.723m and will be a cost pressure as Frontline Digitisation funding will not be available if this option is selected.

2. **Option 2 - Only complete work as part of National Frontline Digitisation Programme from 2023-24** [not recommended]

Frontline Digitisation revenue and capital funding will be utilised to support the capital and revenue plans. Any shortfalls will be supplemented through already approved internal capital resources and established revenue budgets with no additional resources provided.

Option 2	Use the current internal capital budget and FLD £1.306m				
Source of Capital	FLD and Internal Capital Allocation				
Period	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000	2028/29 £000
Available Capital	2,784	900	900	900	900
Capital Investment	(2,353)	(1,037)	(1,188)	(831)	(2,242)
Capital Surplus/(Deficit)	**431**	**(137)**	**(288)**	**69**	**(1,342)**
Source of Revenue	FLD and Internal Budgets				
Available Revenue Funding	1053	682	682	682	682
Revenue Spend	(600)	(1,093)	(1,234)	(1,432)	(1,598)
Revenue Surplus/(Deficit)	**453**	**(411)**	**(552)**	**(750)**	**(916)**

Table 7

There will be a revenue surplus of £375k as there will be no additional depreciation costs in year 1. From year 2 there will be revenue deficits due to depreciation charges and dividend charges with no benefits realised to offset these costs.

Capital and revenue investments under this option will not meet the requirements of the Trusts Digital, Data and Technology Strategy. For this reason, this option is not recommended.

3. Option 3 - Full delivery of recommendations for year 1 of the Trust's Digital, Data and Technology Strategy [recommended option]

Digital is an enabler for the Quality and Value Programme. This is a significant programme of work, and the Trust will require a large number of resources as well as purchase of additional hardware and software to complete the ambition for year 1 of the strategy. A detailed breakdown of the costs can be found in Appendix A but table 8 shows the overarching funding requirements.

Option 3	Full delivery of recommendations				
Source of Capital	FLD and Internal Capital Allocation				
Period	2024/25 £000	2025/26 £000	2026/27 £000	2027/28 £000	2028/29 £000
Available Capital	2,784	900	900	900	900
Capital Investment	- 2,353	- 1,037	- 1,188	- 831	- 2,242
Project Management Office (Capitalised staff costs)	- 431	- 584	- 584	- 584	- 584
Capital Surplus/(Deficit)	(0)	(721)	(872)	(515)	(1,926)
Source of Revenue	FLD and Internal Budgets				
Available Revenue Funding	1,053	822	862	862	862
Revenue Spend	- 670	- 1,242	- 1,486	- 1,786	- 2,065
Revenue Surplus/(Deficit)	383	(420)	(624)	(924)	(1,203)
Recurrent Benefits (Currently Quantified)	0	355	644	924	1,208
Totals	383	(65)	20	(0)	5

Table 8

Option 3 proposes the following:

1. Capital investment of £2.784m in 2024/25. This will be funded by Frontline Digitisation funding of £1,306k and internal capital budgets of £1,478k. This follows a detailed review of the 24/25 capital plans and a reprioritisation allowing a reallocation of funds previously earmarked for Estates and Clinical equipment. It is anticipated that any future shortfall on capital will be managed through a combination of internal capital, following a prioritisation process, as well as ensuring readiness for access to further National funding and/or movements in either the Trust or system CDEL. A high level 5 year capital plan will be developed to support this process.

   The PMO posts are required on a permanent basis to enable the continuation of projects and to establish a core team that will enable digital implementations/ transformations to be undertaken in a standard way, meeting National standards and reducing the burden on our service teams. See Appendix C for proposed staffing structure Digital Programme Management Office staff costs will be capitalised, however capacity will be flexed across new projects expected to form part of the Year 2 and 3 digital strategy ambitions.

   A post implementation review will be undertaken for every individual project. If the anticipated benefits are not achieved, the Trust may take the decision to reassess the strategy and potentially disband the PMO. If this decision is taken, an options appraisal will need to be undertaken to consider associated costs to the Trust.

2. Revenue investment of £7.250m over 5 years is required, this includes depreciation/PDC costs of £4.440m. A stocktake of existing budgetary provision identifies a funding stream of £7.592m, which is an overall revenue benefit of £0.342m. £3.312m of the £7.592 identified funding stream relates to recurrent identified benefits. This investment will enable the Trust to;

   a. Use the foundations of the Digital Strategy ensuring readiness to access National funding streams to improve digital maturity and innovation. Funding was originally signalled in the 2024/25 financial planning round, we await further clarification as part of the 2025/26 planning process and development of the NHS 10 year plan.
   b. Utilise the digital PMO capacity to stretch and target opportunities for a higher return on investment seeking to recover full costs as well as contributing to the Trusts Q&V programme.
   c. Potentially access additional central funding for depreciation noting that in 2024/25 the Government agreed additional revenue resources for the NHS to support depreciation and amortisation expenditure. The purpose of this additional funding is to mitigate the risk that the cost consequences of technical items could impact on the funding available for patient care and service delivery.

To note: -

- The level of resources requested in the business case are to enable digital implementations to progress at pace to support the objectives as set out in the Digital Strategy.
- Digital letters funding requirements is an estimate. Not all letters use the existing Synertec contract, so numbers have been estimated. Actual costs are likely to reduce over time based on how many letters are accessed digitally rather than being printed, however estimates informing the business case remain prudent until this has been worked through.
- Staffing costs for vacancies are based on people being in post from November but this may not happen unless there are people on the redeployment register, so actual requirements will reduce and can't be confirmed until we have recruited and confirmed start dates.
- Future affordability of implementation of the Digital Strategy will continue to be monitored and evaluated, staffing structures will be continually reassessed through the established Quality and Value process to ensure value for money and outcomes are achieved as planned.

7.2. High Level Timeline

At the time of submitting this business case, the digital letters and patient information hub projects are fully underway and have their own project plans. A high level plan for the year 1 work within the business case is shown in table 9.

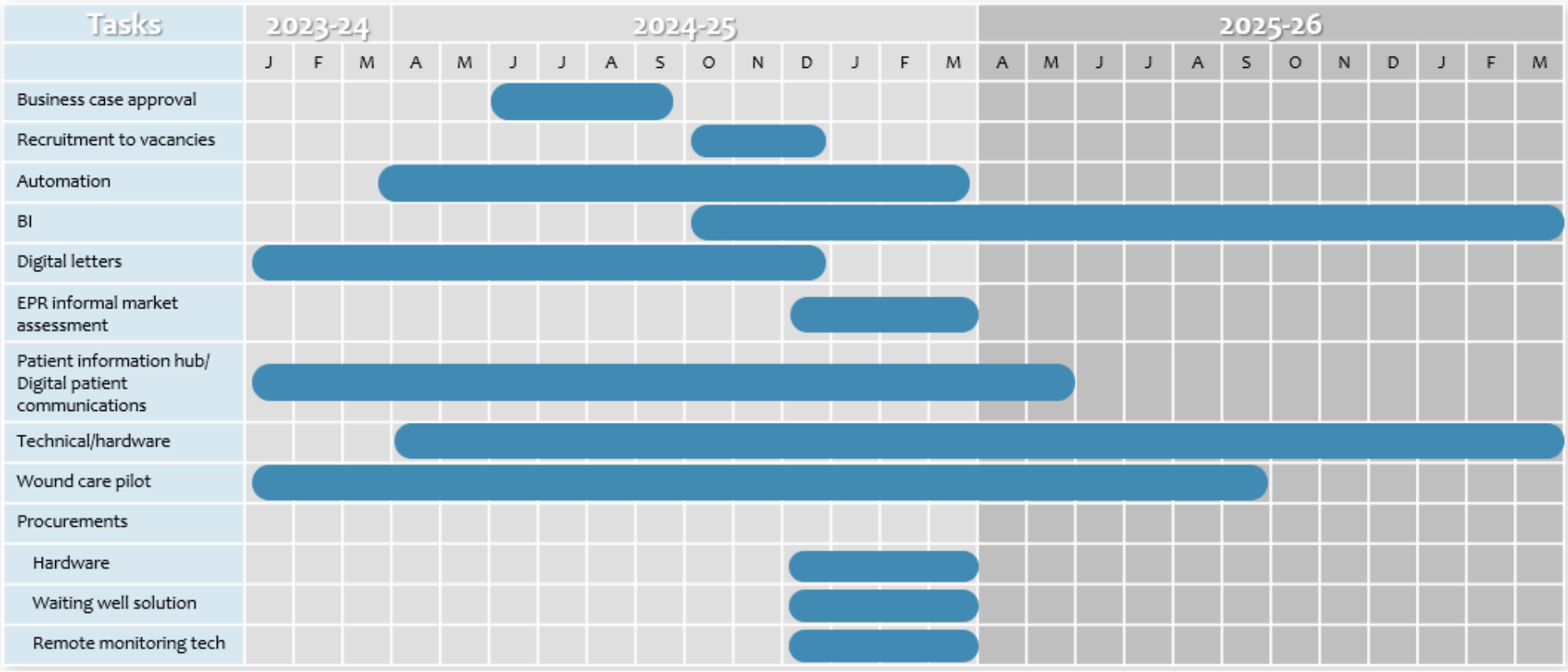


Table 9

8. Conclusion/Recommendation

This business case has been developed based on option 3, to enable delivery of the year 1 priorities of the Trust's Digital, Data and Technology Strategy, including utilisation of the National Frontline Digitisation funding that has been allocated to the Trust for 2024-25. The aim of the strategy is to support the Trust in its overall vision of "we provide the best possible care in every community". The strategy is being introduced at a time when community health services play a key role in our health and care system, keeping people well at home and in community settings closer to their home. These services are central to ambitions to boost out of hospital care and in helping people maintain their independence in their preferred place of residence. The delivery of these services can't be done solely by one organisation, so it is imperative that we build and maintain collaborative relationships with other health and care partners across the Leeds City and wider West Yorkshire footprint.

The Trust is being assessed annually in relation to our level of digital maturity. We are one of the least digitally mature organisations across West Yorkshire. Our year 2 assessment shows our maturity has officially reduced from 2.3 in year 1 to 2.03 this year, which is due to the scoring changes within the assessment. All Trusts have seen a reduction due to this issue. We feel we have remained the same in terms of our capabilities. However, we did purchase a number of products in March 2024, which are yet to be implemented, which will have a significant impact on our maturity and delivery of the elements within this business case will significantly increase our maturity for future year assessments.

Within the business case we have considered a number of different approaches with option 3 being recommended, which is full delivery of recommendations for year 1 of the Trust's Digital, Data and Technology Strategy. Working towards full delivery of the strategy will allow the Trust to make significant progress with the level of digitisation; fully utilise the National Frontline Digitisation funding and achieve significant benefits realisation to support the Quality and Value programme. It also supports the journey to further digitisation in future years, as detailed in the new Digital, Data and Technology Strategy that is being socialised currently, with plans for formal approval at Trust Board in October 2024.

The case seeks approval for :

- Capital investment of £2.784m in 2024/25, funded by Frontline Digitisation funding of £1,306k and internal capital budgets of £1,478k following a review of the 24/25 capital plans and a re-allocation of funds previously earmarked for Estates and Clinical equipment.

- A pre-commitment against future years capital noting that this will ultimately need to be managed within the Trusts overall CDEL limit.

- Revenue investment of £7.250m over 5 years noting that funding, and therefore affordability, is underpinned by the expected release of revenue savings, £3.312m over 5 years.

- Establish the Digital Programme Management Office with recurrent pay costs of £0.584m. The PMO posts are required on a permanent basis to enable the continuation of projects and to establish a core team that will enable digital implementations/transformations to be undertaken in a standard way, meeting National standards and reducing the burden on our service teams. See Appendix C for proposed staffing structure. A post implementation review will be undertaken for every individual project. If the anticipated benefits are not achieved, the Trust may take the decision to reassess the strategy and potentially disband the PMO. If this decision is taken, an options appraisal will need to be undertaken to consider associated costs to the Trust

9. Document Review and Control

9.1. Version History

This table records the status and version history of this document

Version	Revision Date	Summary of Changes	Author
0.1	14/06/2024	Document creation	Dawn Greaves
0.2	05/07/2024	Additional updates following discussions with digital senior leadership team	Dawn Greaves
0.3	15/07/2024	Additional updates following review by Anita Simey and costs added from Martin Harris. Also updated following release of our DMA scores	Dawn Greaves
0.4	02/08/2024	Updates following discussions with Richard Slough	Dawn Greaves
0.5	06/08/2024	Updates following further review by Richard Slough and additions to finances	Dawn Greaves
1	09/08/2024	Submission for TLT approval	Dawn Greaves
1.2	15/08/2024	Additional updates following discussions with Andrea Osborne	Dawn Greaves
1.3	16/08/2024	Additional updates following discussions with Yasmin Ahmed/Andrea Osborne	Dawn Greaves
1.4	20/08/2024	Additional updates following discussions with finance colleagues	Dawn Greaves
1.5	06/09/2024	Additional updates following discussions and updates from finance colleagues	Dawn Greaves
2.0	17/09/2024	Final version	Dawn Greaves
2.1	18/09/2024	Amendments following review at TLT	Dawn Greaves
2.2	26/09/2024	Amendments following review at Business Committee	Dawn Greaves

9.2. Authorisers

This table records the authorisers accountable for the quality of this completed document

Name	Role	Date of sign off
Digital Programme Board	Approval	24/09/2024
Trust Leadership Team	Approval	18/09/2024
Business Committee	Approval	25/09/2024
Trust Board	Approval	04/10/2024

9.3. Reviewers

This table records the reviewers responsible for recommending authorisation of this document

Name	Role	Response
Andrea Osborne	Interim Director of Finance and Resources	Approved
Richard Slough	Assistant Director of Business Intelligence	Approved

9.4. Consultees This table records subject matter experts consulted about this document		
Name	**Role**	**Response**
Victoria Douglas-McTurk	Head of Business Intelligence	
Paul Elwell	Head Of EPR	
Martin Harris	Head of IT	
Anita Simey	Digital Programme Manager	
Dan Barnett	Head of Strategy, Change and Development	
Jo-Ann Watson	Revenue Finance Lead	
Annette Clough	Capital Finance Lead	
Bheki Thomola	Assistant Director of Finance	

10. Appendices

Appendix A: Costing Tables

This is a significant programme of work, and the Trust will require the posts detailed below to support the implementation of the strategy.

Role	Band	R/NR		WTE	Notes	Gross cost	24-25 cost	25-26 cost	26-27 costs			Recruiting Options	Source of Funding
Associate Director of Digital Transformation	B8D	NR	Capital	1.00	Apr 24 - Dec 25	105,866	111,688	83,766	0			In post	Frontline digitisation
Capital Finance Lead	B8C	NR	Capital	0.25	Apr 24 - Mar 25	102,747	27,099					In post	
Revenue Finance Lead	B8B	NR	Capital	0.25	Apr 24 - Mar 25	86,580	22,835					In post	
Associate Chief Clinical Information Officer	B8A	NR	Capital	1.00	Nov 24 - Mar 27	72,254	31,762	76,228	76,228			Vacancy	Frontline digitisation to Mar25/internal revenue onwards
Digital Programme Manager*	B8A	R	Capital	1.00	Apr 24 onwards	72,254	76,228	76,228	76,228	76,228	76,228	In post	Frontline digitisation to Mar25/internal revenue onwards
Digital Project Manager**	B7	R	Capital	2.00	Apr 24 onwards	62,906	132,732	132,732	132,732	132,732	132,732	In post	Frontline digitisation to Mar25/internal revenue onwards
Digital Innovation Lead	B7	R	Capital	1.00	Jul 24 onwards	62,906	66,366	66,366	66,366	66,366	66,366	In post	Frontline digitisation to Mar25/internal revenue onwards
Clinical Safety Officer	B7	NR	Capital	1.00	Jul 24 onwards	57,702	25,365	60,875	60,875			Vacancy	Frontline digitisation to Mar25/internal revenue onwards
Finance Officer	B7	NR	Capital	0.50	Apr 24 - Mar 25	57,702	30,438					In post	
Business Analyst	B6	R	Capital	1.00	Sep 24 - onwards	44,110	46,536	46,536	46,536	46,536	46,536	In post	Frontline digitisation to Mar25/internal revenue onwards
Implementation Officers	B5	NR	Capital	4.00	Oct 24- Mar 27	38,017	80,216	160,433	160,433			Vacancy	Frontline digitisation to Mar25/internal revenue onwards
IT Trainer	B5	NR	Revenue	1.00	Nov 24- Mar 27	38,017	16,712	40,108	40,108			Vacancy	Frontline digitisation to Mar25/internal revenue onwards
Project Support Officer	B4	R	Capital	1.00	Nov 24 - onwards	34,117	14,997	35,993	35,993	35,993	35,993	Vacancy	Frontline digitisation to Mar25/internal revenue onwards
Clinical Advisor	B7	NR	Capital	1.00	Nov 24 - May 25	62,906	27,652	11,061				Vacancy	Frontline digitisation to Mar25/internal revenue onwards
Digital Content Management Specialist	B7	R	Capital	1.00	Nov 24 - onwards	57,702	25,365	60,875	60,875	60,875	60,875	Vacancy	Frontline digitisation to Mar25/internal revenue onwards
System Configuration Specialist	B6	R	Capital	1.00	Nov 24 - onwards	44,110	19,390	46,536	46,536	46,536	46,536	Vacancy	Frontline digitisation to Mar25/internal revenue onwards
Digital Project Manager	B7	NR	Capital	1.00	Oct 24 - Mar 25	62,906	33,183					In post	Frontline digitisation
Clinical Advisor	B7	NR	Capital	1.00	Nov 24 - Mar 25	62,906	27,652					Vacancy	Frontline digitisation
IT Technician	B2	NR	Capital	2.00	Apr 24 - Mar 25	28,820	60,810					In post	Frontline digitisation
IT Deputy Manager	B6	R	Capital	1.00	Nov 24 - onwards	44,110	19,390	46,536	46,536	46,536	46,536	Vacancy	Internal revenue
IT Officer	B4	R	Capital	2.00	Nov 24 - onwards	34,117	29,994	71,986	71,986	71,986	71,986	Vacancy	Internal revenue
Senior Digital Project Manager	B8A	NR	Capital	1.00	Dec 24 - Mar 25	72,254	25,409	0				Vacancy	Frontline digitisation
Clinical Advisor	B7	NR	Capital	2.00	Apr 24 - Mar 25	57,702	121,751					In post	Frontline digitisation
Web Developer/Warehouse Efficiency Offic	B7	NR	Revenue	1.00	Nov 24 - Mar 26	62,906	27,652	66,366				Vacancy	Frontline digitisation to Mar25/internal revenue onwards
Costing Analyst	B7	NR	Capital	1.00	Nov 24 - Mar 26	57,702	25,365	60,875				Vacancy	Frontline digitisation to Mar25/internal revenue onwards
Data Warehouse Analyst	B6	NR	Capital	1.00	Apr 24 - Mar 25 (alr	44,110	46,536	0				In post	Frontline digitisation
Information Manager	B7	NR	Capital	1.00	Nov 24 - Mar 26	57,702	25,365	60,876				Vacancy	Frontline digitisation
							1,198,489	**1,204,376**	**921,432**	**583,788**	**583,788**		

The following items/services are required to be procured to support delivery of the strategy (costs are estimated):

Item/Service Requirements	Total NR costs	Total R costs 25-26 onwards	26-27	27-28	28-29	Date Require	Source of Funding
Hardware/Networking							
Replacement of aging devices (laptops and phones)	1,170,960					Dec-24	FD Capital/Internal capital
Existing Systems Renewals							
PRTG network monitoring		10,806	10,806	10,806	10,806	Feb-25	Internal revenue - paid from FD revenue 23/24
LogPoint security information and event management		40,200	40,200	40,200	40,200	Feb-25	Internal revenue - paid from FD revenue 23/24
Microsoft automation implementation	196,800					Sep-24	FD Capital
New Systems							
Digital letters	Purchased 2024/25	305,738	305,738	305,738	305,738		Internal revenue from existing budget
Patient information hub	62,532	4,152	4,152	4,152	4,152	Sep-24	FD Capital to Mar25/internal revenue onwards
SystmOne connect		35,000	35,000	35,000	35,000	Sep-24	FD Revenue/internal revenue onwards
Waiting well solution	100,000	50,000	50,000	50,000	50,000	Mar-25	FD Capital to Mar25/internal revenue onwards
Remote monitoring technology	100,000	50,000	50,000	50,000	50,000	Mar-25	FD Capital to Mar25/internal revenue onwards
Business Intelligence Services							
External review of performance processes	40,000					Dec-24	FD Revenue
Data hub flow - RLDatix		20,000	20,000	20,000	20,000	Dec-24	FD Revenue/internal revenue onwards
	1,670,292	**515,896**	**515,896**	**515,896**	**515,896**		
Depreciation Per Annum		401,200	401,200	401,200	401,200	From 25/26, based on a 5 year life	
PDC Dividend Per Annum	70,210	63,189	49,147	35,105	21,063	from 24/25	
Finance Costs	**70,210**	**464,389**	**450,347**	**436,305**	**422,263**		
Capital	1,170,960	0	0	0	0	Hardware	
	459,332					Systems	
Revenue	40,000	515,896	515,896	515,896	515,896		
	1,670,292	**515,896**	**515,896**	**515,896**	**515,896**		

Where people are already in post, funding is only approved to 31 March 2025. Note some posts are required on a longer or permanent basis to enable the continuation of the Digital Programme Management Office. This will enable digital implementations/transformations to be undertaken in a standard way, meeting National standards, increasing digital maturity of these staff over time and reducing the burden on our service teams.

The business case is based on costings to run until 31 March 2025. Resources required in future years will also be added to the year 2 and 3 business case to secure funding. There will hopefully be more clarity around National funding allocations for 2025/26 onwards.

Appendix B: Proposed Funding

Capital	24/25	25/26	26/27	27/28	28/29
	£'000	£'000	£'000	£'000	£'000
Capital Funding					
Frontline Digitisation	1,306	-	-	-	-
Internal Capital	1,478	900	900	900	900
Total Capital Funding	**2,784**	**900**	**900**	**900**	**900**
Capital Costs					
Hardware	(567)	-	-	-	-
Systems	(459)	0	0	0	0
Replacement as per Asset Register	(604)	(523)	(890)	(831)	(2,242)
Staffing - FLD Costs	(723)	(514)	(298)	0	0
Staffing - Project Management Office	(431)	(584)	(584)	(584)	(584)
Total Capital Spend	**(2,784)**	**(1,621)**	**(1,772)**	**(1,415)**	**(2,826)**
Capital Shortfall	**(0)**	**(721)**	**(872)**	**(515)**	**(1,926)**

Revenue Excluding Depreciation	24/25	25/26	26/27	27/28	28/29
	£'000	£'000	£'000	£'000	£'000
Revenue Funding					
Frontline Digital Revenue	371	-	-	-	-
Internal Synertec Budget	179	179	179	179	179
Internal Trust Website Budget	3	3	3	3	3
Total Revenue Funding Excluding Depreciation	**553**	**182**	**182**	**182**	**182**
Revenue Spend					
Staffing	(44)	(106)	(40)	0	0
Systems Maintance Costs	(556)	(516)	(516)	(516)	(516)
Total Revenue Expenditure Excluding Depreciation	**(600)**	**(622)**	**(556)**	**(516)**	**(516)**
Revenue (Shortfall)/ Surplus before savings	**(47)**	**(440)**	**(374)**	**(334)**	**(334)**
Recurrent Savings	-	355	644	924	1,208
Gross (Shortfall)/Surplus after savings	**(47)**	**(85)**	**270**	**590**	**874**

Depreciation	24/25	25/26	26/27	27/28	28/29
	£'000	£'000	£'000	£'000	£'000
Depreciation Funding:					
Internal	-	140	180	180	180
FLD	500	500	500	500	500
Total Depreciation/PDC Funding	**500**	**640**	**680**	**680**	**680**
Depreciation Charges					
Systems & Hardware Depreciation	-	(205)	(205)	(205)	(205)
Asset Replacement Programme	-	(121)	(225)	(403)	(570)
PDC	(70)	(63)	(49)	(35)	(31)
Staffing	-	(231)	(450)	(627)	(743)
Total Depreciation/PDC Costs	**(70)**	**(620)**	**(930)**	**(1,270)**	**(1,549)**

Appendix C: Proposed Digital Programme Management Office Structure

Digital Programme Management Office		
Post	**AFC Band**	**WTE**
Digital Programme Manager*	B8A	1
Digital Project Manager**	B7	2
Digital Innovation Lead	B7	1
Business Analyst	B6	1
Project Support Officer	B4	1
Digital Content Management Specialist	B7	1
System Configuration Specialist	B6	1

Appendix D: Benefits Realisation

Work to quantify benefits has only commenced for the projects that are currently underway in year 1. Further work will be undertaken to quantity benefits from the other schemes in due course.

No	Benefit Title / Name	Benefit Details	24/25	25/26	26/27	27/28	28/29	Total
1	RPA: Automation of admin processes.	Automation of numerous different admin processes between various EPR and corporate systems across all operational and corporate services	-	275,763	484,657	685,267	969,314	**2,415,001**
2	Digital Patient Letters: Decreased postage costs	Decreased postages and paper costs.	-	76,435	152,869	229,304	229,304	**687,911**
3	Digital Patient Letters: Reduction in carbon emissions	Reduction in the amount of paper and ink used in production of paper letters, and carbon footprint associated in the delivery of.	-	3,133	6,370	9,672	9,672	**28,847**
		Total Savings	**-**	**355,331**	**643,896**	**924,242**	**1,208,290**	**3,131,759**

Agenda item:	2024-25 (67)

Title of report:	Children, Young People and Families Strategy 2022-25, 6 monthly update

Meeting:	Trust Board Held in Public
Date:	Friday 4 October 2024

Presented by:	Sam Prince, Executive Director of Operations					
Prepared by:	Debra Gill, Head of Service for Operations, Children's Business Unit.					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion	X	Approval	

Executive Summary:	The Children, Young People and Families Strategy 2022-25 was approved by the Trust Board in 2022. This paper provides a 6 monthly update on the progress made against the eight objectives as defined in the Strategy. The overarching aim of the strategy is to deliver high quality healthcare in the most appropriate setting for children, young people, and their families. We achieve this by working in partnership with children, young people, and families, integrating with other organisations and by developing our services and colleagues across the Children's Business Unit. The progress should be noted in the context of the challenges in the Business Unit including the focus on Quality and Value and the need to address waiting times

Previously considered by:	Quality Committee, Monday 23 September

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	X
	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	X
	Embed equity in all that we do	X

Is Health Equity Data included in	Yes		What does it tell us?	

the report (for patient care and/or workforce)?	No		Why not/what future plans are there to include this information?	Data is not included as this is an update of the Strategy however there is evidence within the report of how we are working towards personalised care, improved communication to meet the needs of our children, young people and families and continued engagement across forums and our Youth Board to inform progress

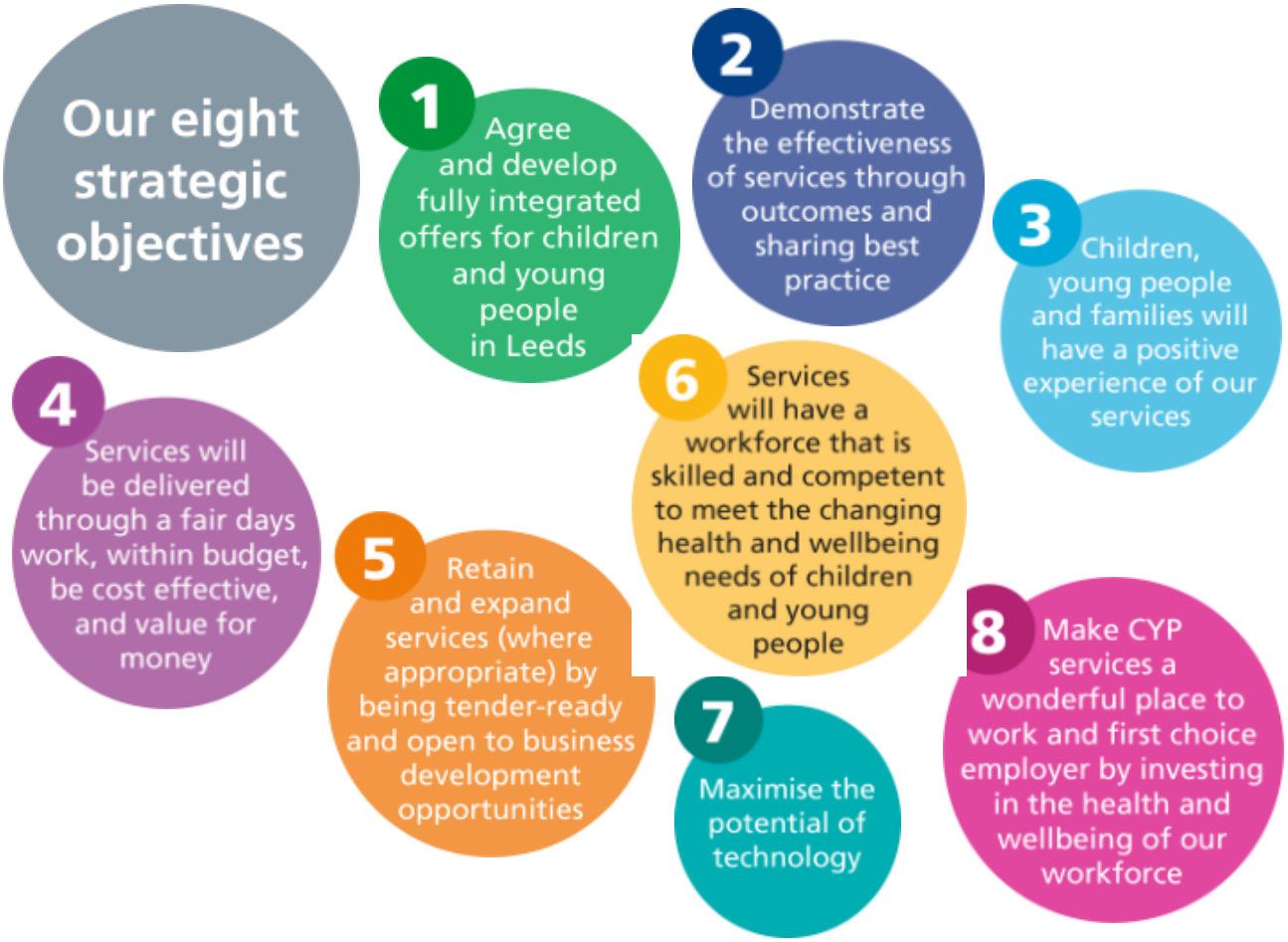
Recommendation(s)	To note the contents of the report as progress against the 8 objectives set out in the Children, Young People and Families strategy 2022-2025

List of Appendices:	None

Executive Summary

The paper provides an update for the LCH Quality Committee on the progress made against the objectives as outlined in the Children, Young People and Families Strategy 2022-25. This covers the progress made on the Strategy in the period March 2024 to August 2024. The progress should be noted in the context of the challenges in the Business Unit including the focus on Quality and Value and the need to address waiting times

The overarching aim of the strategy is to deliver high quality healthcare in the most appropriate setting for children, young people, and their families. We achieve this by working in partnership with children, young people, and families, integrating with other organisations and by developing our services and colleagues across the Children's Business Unit. The Children's Young People and Families Strategy 2022-25 is organised into our 8 objectives:



This paper provides a progress update on each of the objectives as set out in the Children Young People and Family Strategy 2022-25 and some of the achievements within CBU.

Please note due to the Quality and Value programme several of the strategic objectives are progressing at pace to reflect the focus on efficiencies and delivering services within a reduced financial envelope.

Progress update

Objective 1: Agree and Develop fully Integrated Offers for Children and Young people in Leeds

We continue to work on our Communication offer with a plan to implement the offer over a 2–3-year period with further engagement, roll out and evaluation. We continue to work with Local Authority partners and 3rd sector organisations in the development of the Offer.

The Emotional Health and Well-Being Offer has been mapped out across the health and social care system and will be reviewed in line with CAMHS Quality and Value Programme and the revised service offer.

The progress on the initial 6 Offers has been delayed due to staff capacity to lead and engage on the Offers. As part of the Quality and Value programme it is hoped that the Offers will be considered as a quantity of the review of service remodelling. The Children's Business Unit Clinical Lead maintains oversight on the progress of the Offers to date.

Objective 2: Demonstrate the Effectiveness of Services through Outcomes and Sharing Best Practice

We continue to progress our Goal Based Outcome measures across the business unit.

We have a new process for recording Goal Based Outcomes on SystmOne which will allow us to report on the aggregated numeric scores so we can measure our effectiveness. However, as our Business Intelligence support is focused primarily on the Quality and Value programme, we are unable to progress with reporting on aggregated scores. This concern has been escalated through performance panels.

Sharing Good Practice/ Research – as a business unit we now have links with the regional children's research forum and the Leeds Children's research forum. From these fora we are made aware of relevant research projects being conducted which we can participate in. For example, the ELSA study related to screening for type 1 diabetes in children was struggling to recruit healthy child participants in Leeds via LTHT. 0-19 are linking with LTHT to potentially support recruitment.

There are several research studies currently being undertaken in the business unit – ICAN - are now open to recruitment to the SPELL and ROBUST studies; 2 randomised controlled trials investigating the effectiveness of stretching and strengthening programmes for children with cerebral palsy.

0-19 – Stepping Stones study – Kings College London study exploring best practice for women experiencing drug dependence in pregnancy

CYPMHS – INSPYRE wellbeing while waiting study. University College London study exploring how social prescribing can help young people waiting for NHS mental health support

Objective 3: Children, Young People and Families will have a Positive Experience of our Services.

All initial contact letters for our services now include information in the top ten languages that are

spoken by children, young people and families as recorded on the communication annexe on SystmOne. There is also a service specific telephone number. This has

improved access to services and helped to reduce Was Not Brought (WNB)/Did Not Attend (DNA) lost appointments.
Further work on improving DNA/WNB has been developed in collaboration with admin colleagues as part of our 2nd Phase of Fair days' work. A standardised process and reminder text messaging has now been implemented across the business unit
The Youth Board is fully embedded within the Children's Business Unit and supports numerous pieces of consultation and project work including the governance process for the CYPF Strategy.

The Youth Board has recently held its 2nd AGM at Leeds Library which was attended by 12 members and was very successful. Young people shared their experiences of being involved in the youth board which included;

- Supporting the interviews for the Director of Nursing, Allied Health Professionals and Psychological Professions
- Attending the training for Quality Walks and then joining their first Quality Walk which is something the Youth Board would like to grow in terms of having children and young peoples' voices in our LCH services

Quiz time with Young People from the Youth Board at the AGM

The involvement champions have regular monthly drop ins and have helped to recruit a wider cross section of young people from across Leeds to the youth board.

Objective 4: Services will be Delivered through a Fair days' Work, within Budget, be Cost Effective and Value for Money.

All services in the Children's Business Unit are working on a "A Fair Day's Work - Phase 2" self-assessment of their services.

		0-19 PHINS	ICAN	CCNS	CYPMHS	SLT	Notes
Budget allocation & tracking							
Action	Ensure all staff have an allocated budget						
Action	If certain members of staff are not allocated to a budget, please complete the table on Sheet 3: Staff Budget Lines						
Action	Create a cost pressure list of WTE & Band if staff do not have an allocated budget						
Action	Review any non-pay spend over or under spend - reallocate where necessary						
Action	Review any non-pay spend over >£10k						
Action	Review vacancies not recruited to for over >1 years and plans to address / skill mix / mitigate impact						
Action	If the service holds vacancies for more than 1 year, please complete Sheet 4: Vacancies						
Locum staff optimisation							
Action	Review where locums are being used and articulate clear evidence for locum use						
Action	Where possible, negotiate locum staff to join CLaSS						
Awareness	Consider plans for reducing locums if & in preparation for direction by LCH						
Awareness	Review & update any wider Workforce plans						
Understanding your service data							
Awareness	Understand DNA rate, reasons for DNA & any areas of health equity						
Action	Articulate plans to reduce DNA rate where DNA rates are above norm						
Action	Review PiP & make yourself aware of reports & data related to your service inc. new reports such as Responsiveness dashboard, Activity and Data Quality						
Benchmarking							
Awareness	Look at how service compares against national structures, productivity, banding & WTE						
Clinical vs non-clinical work							
Action	Review % of 60/40 clinical vs non-clinical contacts						
Action	Implement consistent approach to clinical vs non clinical activity						
Producitivity improvement							
Awareness	Review teams clinical contacts and clinical related work - is this evidence based?						
Service pathway and caseload management							
Awareness	Locate service specifications and make yourself aware of what the service offer is (ie are we over/under service offer?)						
Awareness	Full awareness of service offer and pathways						
Action	Clear clinical supervision process						
Action	Clear caseload management process						
Referrals and capacity							
Awareness	Review if the service has demonstratable evidence of increased contacts and complexity in caseload						
Categorisation of 'C' services							
Action	Review previous categorisation of services & update where necessary						
Benchmarking: cost							
Awareness	Make self aware on national comparison of cost						
Capacity & demand assessment							
Action	Review capacity & demand tools (if relevant) and how often these are used						
Service improvement, development & projects							
Awareness	Conduct a stocktake of service improvements, developments & projects and have awareness of prioritisation						
Risks							
Action	Review the Risk Register and ensure the risk is clearly articulated, with an owner (Clinical or Operational) and score & mitigation is updated						
Health & wellbeing initiatives							
Action	Review the HWB opportunities for staff						
Awareness	Ensure all staff are aware of development opportunities						

The “Self-assessment process “and the document produced is an integral piece of work that has become crucial for services to understanding the baseline level of their services. The self-assessment encourages services to obsess about budgets and financial monitoring, benchmarking & productivity, understanding their capacity and demand and ensuring pathways and service offers are understood and adhered to across their services.

The Quality & Value Programme has been rolled out across the business unit with CAMHS being the first portfolio within the business unit to undertake the methodology.

“The key message for services going through Q&V is communication with staff and colleagues in the service even if there is nothing to report, keep the lines of comms open “

The Children’s Nursing portfolio has had its first ideas workshop and is on course to run its integrated design office in September.

Objective 5: Retain and Expand services by being Tender Ready and Open to Business Development Opportunities.

As part of the Quality and Value programme opportunities in services are being looked at to develop and to expand our services,

Mind Mate Support Teams are certainly the 'growth' in CAMHS. Recruitment is underway for team 5, team 5 will take the service offer up to 68% coverage of Leeds education settings - the roll out plan is aligned with the Leeds cluster areas.

The Children’s Community Eye Service has completed a service review, and a new service offer has been developed. The new model will be delivered within budget ensuring a cost-effective sustainable service that children, young people and their families have asked for through engagement.

As a business unit supported by corporate partners, we meet monthly with colleagues from the Leeds Place Integrated Care Board which continues to strengthen relationships guaranteeing we are partners in any development opportunities to expand our services.

As a business unit we are continually looking for income generation opportunities, the Infant Mental Health team have developed 3 training programmes, the programmes have been praised by Dept of Health. A consultant within the ICAN service has also developed a training programme for paediatric consultants, Child

Protection, Recognise, and Respond, this training will be delivered twice a year. We are also in talks with our provider university regarding a Speech and Language training course that one of our colleagues developed.

Objective 6: Services will have a Workforce that is Skilled and Competent to meet the Changing Health and Wellbeing Needs of Children and Young People

We are continuing to support several colleagues across the business unit with apprenticeships, covering a variety of roles including speech and language therapists, social workers and 3 nurses in CCNS,2 have already graduated and are now employed in the CCN team, and the third one will graduate by the end of the year. ICAN continue to develop, Advanced Clinical Practitioners (ACP's)posts, with a qualified practitioner new into post by September ,24.
SALT apprentice has completed the 1st year of a 4-year course, "*We are certainly benefiting from the growth and development of her skills, and we have worked with the Speech and Swallowing team to ensure she has access to adult SLT placements too."*
CAMHS are supporting 2 ACP to undertake the course, this is part of their workforce plan and implementation of the new service offer under the framework of the quality and value programme. These roles will support opportunities for nursing and allied health professionals to develop their skills to work in an extended role. This will encompass clinical practice, leadership and management, education, and research.
We have developed an Internal Transfer process for the business unit, which complies with the new ECF process and vacancy management, in line with Quality and Value programme. This is to enable the retention of our staff and ensuring we are retaining the skills and knowledge base within the business unit, while developing colleagues career ambitions.
In May 2024 the business unit employed a care leaver to work part time in our speech and language therapy admin team until the end of March 2025. This followed an initiative from NHSE called Project Hope to offer care leavers paid employment experience with the hope that this would provide them with experience to gain future permanent employment somewhere. Our Project Hope young man has settled in well and is proud to have an NHS badge and bought a fishing rod with his first wages.

Objective 7: Maximise the Potential of Technology

The Children's Business Unit Digital Steering group will have a reset over the next quarter, the meeting has struggled to be quorate for some time. As a business unit we are acutely aware of the need to embrace the digital innovations to enable the efficiencies and smarter ways of working, practitioners have some brilliant ideas. As part of 'A Fair Day's Work Phase 2' conversations, we are engaging with staff on challenges and ideas for making the most of technology to ensure productive and efficient delivery of services.
At the CCNs ideas workshop (part of Q&V programme) the CCNS agreed they wanted to develop online training programmes to support the training offer from all 4 teams within the CCNS. An online platform would allow both internal and external training to take place in a timelier manner and would be more efficient in terms of cost and staff time
The CBU services are keen to support the Patient Information Hub and are ready to improve access to resources for children, young people and families and other supporting adults.

The development of the Partnership working ,3rd sector directory /web pages has been shared with service leads and with practitioners across the business unit, this will enhance the knowledge, and the understanding of the breadth of the 3rd sector organisations working across Leeds that support families and young people
We continue to explore how technology can improve communication with children, young people, and their families. Through the DNA/WNB work we have developed a text reminder message with the support of admin colleagues, for all services in the business unit to ensure the families receive timely reminders of appointments which will hopefully reduce DNA/WNB
The Youth Board has been unsuccessful in opening a X account a suggestion to use 0-19 platform on Instagram has also proved challenging and has not progressed. The YB has decide to use existing school platforms/networks to promote the YB across the city.
As a business unit we are very keen to be part of any digital projects, recognising that this will support many of the initiatives that will be formed as part of the services Quality and Value programme.
One project that will cover all services in the business unit is digital generation of appointment letters, the new provider goes live in October with a programmed rollout across services
This will be managed centrally, which will alleviate pressure and workload in individual services

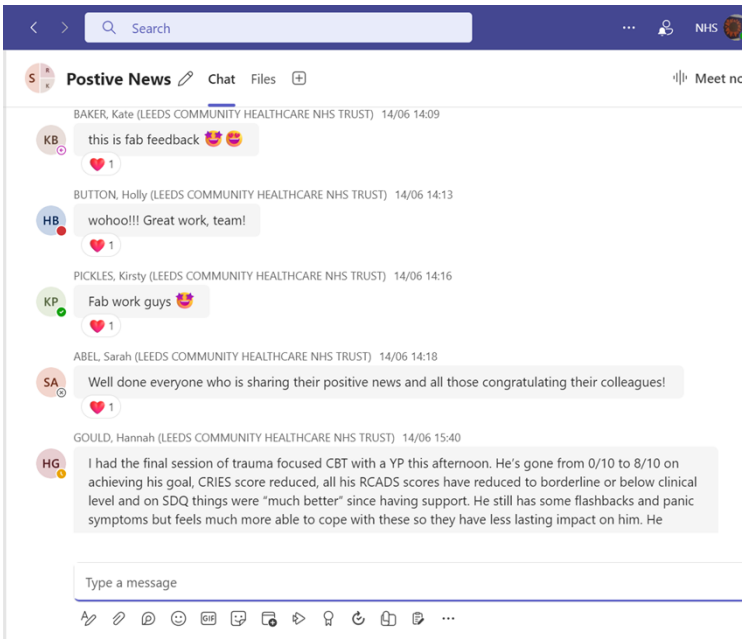
Objective 8: Make Children and Young people's Services a Wonderful Place to Work and First Choice Employer by Investing in the Health and Wellbeing of our Workforce

With several of our services going through the Quality and Value programme over the next financial year it has never being more important to support staff through these challenging times
Communication with staff regarding the Quality and Value programme is a priority for the business unit with events, team meetings, 121, newsletters a priority for managers and leaders.
CAMHS: as part of their Quality and Value project and the first of our services to go through the programme, have developed a standard for communicating the progress of the project to colleagues and staff. This has ensured that colleagues stress and anxiety has been managed to a minimum with staff and colleagues always displaying professional behaviours and been very supportive of the process

- Weekly catch-up meetings with a member of CAMHS leadership team (In response to Q&V project)
- Fortnightly catch up with leaders from CAMHS teams (Team managers and senior clinicians) (In response to Q&V project)
- Support to team managers (through operational weekly meeting)
    - Team managers to address wellbeing as usual in Line Management.
    - Addressing any specific issues by bringing people together in 'away spaces' and having set times focussed on wellbeing.

The Business Unit has focused on supporting colleagues to train as Wellbeing Champions. These colleagues along with our Mental Health First aider capacity has provided a great resource for business unit colleagues to access if they are concerned about their wellbeing and/or require signposting to wellbeing support. Several services have initiated wellbeing check-in points.

- Mind Mate Support teams have established a Positive News Teams Channel which is a repository for colleagues to post good things that have happened during the day



- Children's Speech and Language Therapy have had bi-monthly wellbeing catch ups – usually revolving around snacks for colleagues to attend
- Children Nursing have launched a Quality and Value Live teams meeting to help the teams catch up with the latest info and ideas
- 0-19 have Health & Wellbeing boards in bases sharing key messages and signposting to LCH support such as CRISSP, Freedom to Speak Guardian and Clinical Psychologist support. The service is piloting a Trauma Informed practice approach with support from a clinical psychologist for both staff in the Inner West team and all the Clinical Team Managers. The plan is to roll out citywide across the service.

The 2nd phase of fair days' work is an ongoing project within the business unit. We have developed a supporting document that ensures we are continually looking at the fair allocation and consistent allocation of work, productivity, caseload management, referrals and capacity within teams and any health and wellbeing initiatives developed. This will support colleagues to understand their service offer and facilitate their inclusion on any changes and developments to their services

The business unit has a strong commitment to Appraisals and supportive conversation our data and performance is evidence of our drive and passion to our practitioners, ensuring they feel heard and supported
Appraisals: Overall, 91% in June (May-24, 91.2**%**).

As always with the publication of the staff survey results the leadership team have had the opportunity to discuss the results and themes across the Business Unit. All teams are now discussing their results, celebrating any areas of improvement, and considering action that teams feel need to be undertaken.

Conclusion

As a Trust and Business Unit we are facing significant financial challenges over the coming 3 years.
As a business unit we have made good progress on our financial obligations over the first 2 quarters of the year while ensuring we deliver on *business as usual*, we give credit to our Heads of Service and budget holders on delivering within the financial requirements and the proactive manner they have shown in looking at efficiencies and savings within their services.
As a business unit we are providing assurance to the Quality and Value programme board of our continued commitment to delivering a robust financial and business plan while monitoring the governance with the new models being implemented.
The strategy's review date will be postponed ensuring we capture all the developments and service offer changes that will be developed through the Quality and Value programme.
As services progress through their projects the strategy's objectives will continue to inform the changes that will be implemented through the Quality & Value programme ensuring implementation and progress will be maintained against all objectives with clear evidence of achievements throughout the year. As with any enterprise, there is risk that the current pressures and the volume of work have the potential to impact on the timely delivery of the objectives.
Areas of focus over the coming months will be engagement from services on the Quality and Value programme. Ensure the business plan is integral to the Strategy objectives, which will in turn evidence clear outcomes for families, retain and develop our staff and services, ensure our Offers and pathways are clear and accessible for all children and young people

Recommendation

The Trust Board are recommended to:

- Note the contents of the report as progress against the 8 objectives set out in the Children, Young People and Families strategy 2022-2025
- Receive the paper from Quality Committee for approval

Debra Gill
Children, Young People and Families Strategy 2022-25, 6 monthly update
1 September 2024

Agenda item:	2024-25 Item 68

Title of report:	Workforce Headlines & Strategy Update

Meeting:	Trust Board Held in Public
Date:	4 October 2024

Presented by:	Laura Smith / Jenny Allen, Director of Workforce					
Prepared by:	Laura Smith / Jenny Allen, Director of Workforce Hannah Stankler, Workforce Project Manager					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	X

Executive Summary:	This paper provides the Board with information about key headlines linked to the LCH Workforce portfolio. It is produced three times a year. It is reviewed and discussed at Business Committee prior to coming to Trust Board. The paper also provides an update on the progress made against LCH Workforce Strategy's outcome measures during the first months of 2024/25; and overall position against the Strategy's outcome measures to date.

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	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	X

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?	Paper is Workforce-focused. It includes EDI data and considerations

Recommendation(s)	It is recommended that the Board:

	• Notes the Workforce Headlines presented in this report • Notes the progress achieved in pursuit of the target measures set out in the current LCH Workforce Strategy. • Approves the proposal to extend the current LCH Workforce Strategy to 31 March 2026

List of Appendices:	Appendix 1: Workforce Strategy Progress Dashboard Appendix 2: Workforce Strategy narrative headlines

Workforce Strategy Update & Headlines

1. Introduction

This paper provides the Board with information about key headlines linked to the LCH Workforce portfolio.

It also provides an update on the progress made against LCH Workforce Strategy's outcome measures during the first months of 2024/25.

Key headlines in this month's report include:

- A focus on people within the **LCH Quality & Value Programme**
- Update on **Executive Team Recruitment**
- Update on the **BME Talent Development Programme**
- **Support for employees** following riots and demonstrations
- News about the **transformation agenda for the Workforce Directorate**
- Intent to extend the current **LCH Workforce Strategy** to 31 March 2026

2. Workforce Headlines, April 2024 – September 2024

2.1 People Focus within the Quality & Value Programme

A People Task Group has been convened to share intelligence and discuss support mechanisms for LCH employees, related to the Quality & Value Programme. The Group assesses quantitative data from the Quarterly Pulse Survey, Freedom to Speak Up records, and the recent external audit survey.
It also uses qualitative data arising from group members' own work, to "take the temperature" of the organisation and to make or recommend decisions to assist in supporting the workforce through the programme.

In addition to LCH's existing support offers for staff (including for example the LCH Health & Wellbeing offer and the Freedom to Speak Up service), specific support related to the Quality & Value programme has been introduced this year.

Examples of specific support include the new LEAD programme, ODI expert support to Service Redesign events, and the development of a new approach to communicating headlines about the Quality & Value programme to meet employee needs.

2.2 Executive Team recruitment:

Following a successful selection process, the Trust's new **Director of Nursing and Allied Health Professions** will commence in post in early October 2024, following the retirement of the previous incumbent during the summer.

Pending the new appointment, interim cover for the role is being provided by the substantive Deputy Director of Nursing.

Following a second selection process for the permanent **Director of Finance & Resources** in June 2024, the successful candidate has taken up the role, having joined the Trust as Interim Director of Finance & Resources in February 2024.

2.3 Update on the BME Talent Development Programme

Quarter 4 of 2023/24 saw the successful commencement of LCH's **BME Talent Development Programme**; which had previously received support from the Business Committee.

The programme includes a leadership course called *I Thrive* (18 delegates) and an accredited coaching course (24 delegates); with modules running throughout 2024 / 25.

With 3 sessions left of the *I Thrive* programme, feedback is positive and participants report growing in confidence. Following a recent session on recruitment and interview presentation, an example of feedback submitted is *'This course is really helpful in me being positive and having real self-belief to apply for higher grade jobs'*

In addition, a parallel programme called *We Thrive*, delivered by the *I Thrive* course provider, seeks to develop the line managers of the *I Thrive* participants to more effectively engage with their team members in conversations about race and cultural issues.

The *We Thrive* course is also attracting positive feedback, with an example being, *'The sessions have developed my Cultural humility and given me a feeling of cultural sensitivity'*
The Chief Executive's personal support of the programme has been particularly welcomed. She met with the *I Thrive* group in September and a number of the group are taking up her offer to shadow her for a day.

An end-of-course celebration will take place on 12 December 2024. Board members, Race Equality Network leaders, and other LCH senior leaders, will be invited to share in and celebrate the *I Thrive* participants' participation and success.

A more detailed evaluation of the programme will be available in Q4, following the conclusion of the course, using the feedback received from each module, individual stories and reflective writing.

In addition, the provider is undertaking some benchmarking evaluation, and the career journey of participants will be, with their permission, followed in the aftermath of the course.

2.4 Support for Employees following riots and demonstrations

Between 29 July and 7 August 2024, an estimated 29 anti-immigration demonstrations and riots took place across 27 towns and cities in the UK. Many of these were violent, with participants attacking mosques and hotels housing asylum seekers. Known far-right activists promoted and attended the riots. *[information sourced from The House of Commons Library]*

Although Leeds was not one of the 27 towns and cities described above, the impact of the violent disorder has been strongly felt by employees, with a number of employees from Black and Minority Ethnic groups and Muslim colleagues in particular describing a sense of reduced safety as a result.

In addition to the measures taken during the summer to directly protect and support employees' personal safety; LCH continues to seek to foster an environment of cultural inclusion and psychological safety.

Clear communications were shared in the organisation during the summer, developed jointly with the leadership of LCH's Race Equality Network (REN), condemning the racism that appeared to underpin the riots and signposting support offers.

Joint working continues to support employees, between Trust leaders, the REN, Staff Side colleagues, the Freedom to Speak Up Guardian and the OD team, with "Safe Space" listening sessions being offered during September, for affected staff.

Specific support and conversations are also in place for employees in LCH's Police Custody suites, where there have been increases in service users associated with the riots and protests, following the arrest and charging (as at 30 August 2024) of 1,280 and 796 people* respectively.

*. *[information sourced from The House of Commons Library]*

2.5 Workforce Directorate Transformation

The Workforce Directorate is undertaking a Transformation exercise to develop a future plan for its services, digital ambitions, and structures.

This exercise aims to fit the Workforce Directorate for the future by increasing the efficiency and responsiveness of its services; and striving to achieve its Quality & Value Programme financial target.

Engagement has commenced with the Workforce Directorate workforce and key stakeholders on a draft proposal. This is expected to lead in due course to a more formal Case for Change and consultation exercise.

3. Workforce Strategy Delivery Progress – September 2024

The dashboard at ***Appendix 1*** shows at-a-glance RAG-rated progress against the measures set out in the Workforce Strategy 2021-25.

Meanwhile, ***Appendix 2*** provides bullet points highlighting progress made since the last update, together with some brief narrative explaining the RAG status of each measure.

The RAG rating key is as follows:

	Will not achieve target by 31 March 2025
	Improvement or progress made, may be slower than originally planned
	Current trajectory indicates target will be achieved by 31 March 2025
	Target achieved or superseded

A minority of items are currently RAG-rated amber, for example in relation to service specifications of Workforce functions; where the developing specifications are now subject to a the Workforce Directorate Transformation work described in the Workforce Headlines section of this paper, aligned with the Quality & Value Programme.

Some Staff Survey results have also been marked amber, where it is difficult to predict with certainty that the improvements already made over the past 3 Staff Surveys will continue at a trajectory that will meet their Workforce Strategy targets.

Still marked amber is the Inclusion target of 14.5% of the workforce being from a BME background by 31 March 2025. Measures introduced in the past year to support representation are correlating with an improved trajectory of improvement, however that trajectory of improvement is still too shallow to be certain of achieving the target within 2024/25.

Overall, work on the Workforce Strategy overall continues to progress in line with the stated plans. The majority of targets remain on track and RAG-rated green; with a number of targets already complete.

It is now intended that the successor document to the current Workforce Strategy will be developed in the context of the anticipated new LCH Organisational Strategy. This will ensure that LCH's medium and long term workforce plans and initiatives are designed to deliver the ambitions of the Organisational Strategy.

To enable this, it is proposed that the tenure of the current LCH Workforce Strategy is extended to 31 March 2026.

4. Conclusion

This paper seeks to show, in a condensed format, progress towards achievement of the Workforce Strategy's objectives; and to ensure that the Board is sighted on important Workforce headlines outwith the Workforce Strategy itself.

5. Recommendations:

It is recommended that the Board:

- Notes the Workforce Headlines presented in this report
- Notes the progress achieved in pursuit of the target measures set out in the current LCH Workforce Strategy.
- Approves the proposal to extend the current LCH Workforce Strategy to 31 March 2026

Laura Smith / Jenny Allen and Hannah Stankler
Director of Workforce and Workforce Project Manager
18 September 2024

Appendix 1:

LCH Workforce Strategy Update Sept 2024

Leeds Community Healthcare NHS Trust

This table provides an overview of all the measures with the Workforce Strategy and their current rag status.

Theme	Measure	Rag Status	Theme	Measure	Rag Status
Resourcing	Bank Fill Rates increase by 10% and active bank capacity increases by 20%	On target	Organisational Design	Resourcing plans are in place for each Business Unit and refreshed annually	Improving
	Turnover is below 13%, with stretch target of 11%	On target		The overall LCH Workforce Plan reflects system partnership approaches to specific pathways, careers or roles	On track
	Vacancy fill rates achieve 90%, with more applicants for hard-to-recruit roles than in 2020/21	On target		eRostering is fully implemented, enabling systematic skills and capacity planning by services	Completed
	Range of advertising and marketing options is increased, with regular targeted campaigns for high priority roles / services	On target		Hybrid Working is fully embedded, supporting and informing the design and delivery of LCH approaches to Estates, Sustainability and Digital	On target
	Recruitment Service offer is clearly specified, with associated KPIs regularly monitored and achieved	In progress		A new LCH approach to Flexible Working is developed and introduced, with some form of flexible working taken up by >50% of LCH staff	Completed
Leadership	Quarterly and National Staff Survey results evidence overall improvement of at least 5 percentage points in staff experience of their leaders, with areas implementing Leadership Development action plans seeing specific improvement in scores	On target	Inclusion	14.5% of the LCH workforce have a Black, Asian & Minority Ethnic background, increasing from 10% in 2021 and working towards 18% by 2028	Improving
	New managers have attended an LCH Leadership Essentials module, or provided evidence of recent equivalent training with a previous employer	Superseded		LCH talent management programme cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career	Completed
	Every member of the LCH Senior Leadership team has undergone 360 degree assessment and has a resulting individual development plan to address any gaps and / or opportunities for improvement	Completed		Staff Survey results evidence reduction of at least 50% in the gap in discrimination experience of disabled and BAME respondents, with aspirations towards complete closure of the gap	On target
	LCH talent management programme cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career	Completed		100% of new starters and middle managers have been offered training in LCH's approach to inclusion via the LCH Leadership Essentials course	Completed
Wellbeing	Our "lead indicators" from the Staff Survey around staff engagement, motivation, and support from line managers, improve year on year between the 2021 and 2024 Staff Surveys	On track	System Partner	A minimum of 4 recruitment or training exercises per year, on average, are carried out collaboratively with ICP or ICS partners	On track
	Absence due to stress / anxiety / depression is reduced, with overall annual sickness below 5% by 2025	Improving		The GP Confederation has a full suite of pay, terms & conditions protocols	On track
	Long term sickness absence rates return to target levels of <3.5%, with a stretch target of 3%	On track		LCH staff in multiple services are working beyond LCH's organisational boundaries in support of LCH and system goals	Completed
	Staff reporting that LCH takes positive action on HWB rises by 5%	Improving		LCH staff join ICP and ICS colleagues in undertaking collaborative and system leadership training opportunities	Completed
	Health & wellbeing conversations are embedded as a regular part of employee / leader conversations, supported by LCH leadership training	On track			
Foundations	Service specification with KPIs is in place for Resourcing, Workforce Information and HR	In progress	Foundations	Core KPIs including "time to recruit"; "average length of formal ER case" are met and within benchmarked norms	In progress
	A co-produced Organisational Training & Development offer and approach is in place, in partnership with QPD	On track			

LCH Workforce Strategy Update Sept 2024

Leeds Community Healthcare NHS Trust

RESOURCING

- Implementation of Applicant Tracking system in July 2024
- Supported the Quality and Value panel with new process for vacancies
- Temporary Staff Bank have worked on mapping out all agency and temporary staff processes, which led to refreshed guidance for staff and managers

MEASURE 1

Bank Fill Rates increase by 10% and active bank capacity increases by 20%

Bank fill rates **+25.9%**
Bank capacity **+ 111%**

ON TARGET

MEASURE 2

Turnover is below 13%, with stretch target of 11%

Turnover avg 24/25 **9.5%**

ON TARGET

MEASURE 3

Vacancy fill rates achieve 90%, with more applicants for hard-to-recruit roles than in 2020/21

ATS implemented and number of vacancies reduced significantly

ON TARGET

MEASURE 4

Range of advertising and marketing options is increased, with regular targeted campaigns for high priority roles / services

Social media campaign live and in place

ON TARGET

MEASURE 5

Recruitment Service offer is clearly specified, with associated KPIs regularly monitored and achieved

Review required in line with ATS implementation

IN PROGRESS

LCH Workforce Strategy Update Sept 2024

Leeds Community Healthcare NHS Trust

ORGANISATIONAL DESIGN

- New Well Led dashboard developed and automated monthly
- Implemented roster improvement workstream with new approach to refresh roster demand templates

MEASURE 1

Resourcing plans are in place for each Business Unit and refreshed annually

Business unit have draft plans

IMPROVING

MEASURE 2

The overall LCH Workforce Plan reflects system partnership approaches to specific pathways, careers or roles

LCH Workforce Plan has been submitted

ON TRACK

MEASURE 3

eRostering is fully implemented, enabling systematic skills and capacity planning by services

eRostering fully implemented

COMPLETED

MEASURE 4

Hybrid Working is fully embedded, supporting and informing the design and delivery of LCH approaches to Estates, Sustainability and Digital

Principles embedded and supporting key LCH strategic work

ON TARGET

MEASURE 5

A new LCH approach to Flexible Working is developed and introduced, with some form of flexible working taken up by >50% of LCH staff

Flexible working embedded. 80% staff can talk openly about flexible working.

COMPLETED

LCH Workforce Strategy Update Sept 2024

Leeds Community Healthcare NHS Trust

LEADERSHIP

- LCH have received a certificate in recognition achievement in improving the experience and engagement of colleagues within your organisation
- Developed and rolled out a LEAD programme for managers to support through quality and value programme

MEASURE 1

Quarterly and National Staff Survey results evidence overall improvement of at least 5 percentage points in staff experience of their leaders, with areas implementing Leadership Development action plans seeing specific improvement in scores.

Average increase in scores relating to leaders **+4.3%**

IMPROVEMENT

MEASURE 2

New managers have attended an LCH Leadership Essentials module, or provided evidence of recent equivalent training with a previous employer

This course is no longer in place.

SUPERSEDED

MEASURE 3

Every member of the LCH Senior Leadership team has undergone 360 degree assessment and has a resulting individual development plan to address any gaps and / or opportunities for improvement

All senior leadership team completed a 360 assessment in 21

COMPLETED

MEASURE 4

LCH talent management programme cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career

LCH Talent management programme in place for BME staff

COMPLETED

LCH Workforce Strategy Update Sept 2024

Leeds Community Healthcare NHS Trust

INCLUSION

- BME Talent development programme in place with 42 delegates
- WRES overall figures have been improving since April
- BME fair recruitment process operationalised and is in practice

MEASURE 1

14.5% of the LCH workforce have a Black, Asian & Minority Ethnic background, increasing from 10% in 2021 and working towards 18% by 2028

WRES Overall **13.3%**

IMPROVING

MEASURE 2

LCH talent management programme cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career

LCH Talent management programme in place for BME staff

COMPLETED

MEASURE 3

Staff Survey results evidence reduction of at least 50% in the gap in discrimination experience of disabled and BAME respondents, with aspirations towards complete closure of the gap

Reduced gap from 5.45% to 1.11%

IMPROVING

MEASURE 4

100% of new starters and middle managers have been offered training in LCH's approach to inclusion via the LCH Leadership Essentials course

All new starters complete inclusion e-learning course

COMPLETED

LCH Workforce Strategy Update Sept 2024

Leeds Community Healthcare NHS Trust

WELLBEING

- Disability, Neurodiversity and Long-term conditions staff group in place
- LCH has become a carer confident accredited employer
- Health and safety committee received presentation on deep dive into absence due to stress/anxiety and depression

MEASURE 1

Our “lead indicators” from the Staff Survey around staff engagement, motivation, and support from line managers, improve year on year between the 2021 and 2024 Staff Surveys

Average increase in scores relating to leaders **+4.3%**

ON TRACK

MEASURE 2

Absence due to stress / anxiety / depression is reduced, with overall annual sickness below 5% by 2025

Rates are trending improvement however overall sickness remains at **6.8%**

IMPROVING

MEASURE 3

Long term sickness absence rates return to target levels of <3.5%, with a stretch target of 3%

Rates are trending as an improvement but remains at **4.3%**

ON TRACK

MEASURE 4

Staff reporting that LCH takes positive action on HWB rises by 5%

Staff survey 2024 results have improved by **3.1%**

IMPROVING

MEASURE 5

Health & wellbeing conversations are embedded as a regular part of employee / leader conversations, supported by LCH leadership training

Appraisal paperwork revamped to include these conversations

ON TRACK

LCH Workforce Strategy Update April 2024

SYSTEM PARTNER

- New Service Level agreement agreed for provision of HR&OD services to the GP Confederation
- Updates agreed to Employ / Deploy arrangements for Primary Care Networks
- Reciprocal support provided / received between LCH and ICB on specific workforce matters

MEASURE 1

A minimum of 4 recruitment or training exercises per year, on average, are carried out collaboratively with ICP or ICS partners

Collaborative recruitment. Stakeholder engagement in exec appointments

ON TRACK

MEASURE 2

The GP Confederation has a full suite of pay, terms & conditions protocols

T&Cs governance and suite of policies in place

ON TRACK

MEASURE 3

LCH staff in multiple services are working beyond LCH's organisational boundaries in support of LCH and system goals

Multiple examples across LCH suite of services

COMPLETED

MEASURE 4

LCH staff join ICP and ICS colleagues in undertaking collaborative and system leadership training opportunities

Examples include ICB fellowship and leadership programmes

COMPLETED

LCH Workforce Strategy Update April 2024

Leeds Community Healthcare NHS Trust

FOUNDATIONS

- Workforce Transformation project will look to refresh the service model for the directorate as well as fully document our service offer

MEASURE 1

Service specification with KPIs is in place for Resourcing, Workforce Information and HR

Review taking place as per the Workforce Transformation project

IN PROGRESS

MEASURE 2

Core KPIs including “time to recruit”; “average length of formal ER case” are met and within benchmarked norms

Core KPIs measured for ER cases. Implementation of ATS underway.

IN PROGRESS

MEASURE 3

A co-produced Organisational Training & Development offer and approach is in place, in partnership with QPD

Learning and Development strategy has been drafted

ON TRACK

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	**Report to:**	Trust Board 4th October 2024
Date of Meeting:	23rd September 2024	**Date of next meeting:**	25th November 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
•	

Advise

- QAIG key issues for escalation – issues relating to servicing medical devices had been highlighted through a deep-dive in August, and an action plan was being worked through to address the issues.
- Update on Diabetes Development – via the update report the Committee concluded that more development was required in general regarding reporting on health inequalities, in particular demonstrating how the data is being used to drive improvements. This would be added to the workplan and an update brought back in 12 months.
- Waiting Lists position Statement – the Committee received a breakdown of the figures sitting behind the waiting lists, and actions being taken where possible to address them. Areas of concern remained within SBU, and severe issues were reported within CBU. Although the Committee felt assured the Trust had a grasp on the numbers, assurance was lacking around what the Trust was currently delivering within current funding levels.
- Service spotlight – a presentation was shared regarding the quality improvement progress of the Leeds Falls Service model and Leeds Falls Pathway, and how it was supporting collaborative working with system partners to provide the right care in the right place at the right time.
- Performance Brief – the use of SPC charts was welcomed by the Committee, whilst noting that it was a work in progress.
- Patient Safety Report – the Committee received the report and concluded that the overall theme of a lack of staff needed to be better reflected in the Trust's risk register due to impact on delivering a quality service.
- Quality & Value Programme – progress against target and workstream updates were reported. Committee noted that 11 service redesigns were ongoing, with 5 at the implementation stage. The Committee heard how the focus on the 'quality' element of the programme was being re-emphasised following disappointing Pulse survey results. The 6 month infographic was shared and well-received by Committee.

Assurance

Committee Escalation and Assurance Report

- Quality Plan - the six proposed Quality Plan 2024-2027 priorities were approved by the Committee, noting that the priorities would sit underneath the Trust's overarching Strategy once developed. Health equity would be clearly articulated as a golden thread.
- Medical Director's Report 23/24 – the Committee received this report, which included information and activity relating to the Trust responsibilities regarding employment of medical and dental staff; based on the four key principles identified in the handbook and guidance regarding "Effective Clinical Governance to support revalidation" published by the GMC in 2024.

Risks Discussed and New Risks Identified

- Waiting list pressures

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	Risk score (current)	Overall level of assurance provided that the strategic risk is being managed (or not)	Additional comments
Risk 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	Reasonable overall but Limited in terms of equity - although it was felt positive that the Committee was having increasing conversations across numerous papers it was agreed there was still more work to be done.
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 limited assurance around action on waiting lists but Committee was pleased to hear and understand the detail and the challenge presented in the position statement.
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)	Reasonable	The early benefit of the SPC reporting approach was noted, as was the positive digital approach in the CYP&F strategy.

Committee Escalation and Assurance Report

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	N/A

Author:	Helen Robinson/Helen Thomson
Role:	Company Secretary/Committee Chair
Date:	25/9/2024

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 4th October 2024
Date of Meeting:	25th September 2024	**Date of next meeting:**	30th October 2024 (workshop)

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 business development strategy update where the short term beds item was discussed, due to a potential conflict of interest. The Deputy Chair of the Committee stood in for this item.

Alert	Action

Advise

- Boston Matrix update paper demonstrated how the session outputs were supporting where Q&V goes next; how it will help inform the business plans and developing LCH's offer to the system.
- The Digital, Data & Technology Strategy was presented and content was well received. Recommended option within the Year 1 implementation Business Case was debated (see risk section below). Whilst the investment sought is essential to LCH strategy and for digital maturity, there is a financial gap, Committee was assured there are pathways to achieve affordability but will inevitably need to proceed with some risk. Committee suggested greater clarity for the Board paper around the financial plan and justification of project management costs.
- Active Recovery business case was presented and Committee supported the recommended option to continue with single care record. Benefits for clinical risk management were acknowledged.

Assurance

- Q&V update received – good progress on delivery against target but some risks beyond current year for non-recurrent savings. Internal audit had concluded significant assurance in relation to programme management. There will continue to be a focus on dialling up the quality agenda and people engagement. Programme data for reporting to Committees continues to evolve.
- Procurement update – refocussed offer from LYPFT, KPIs and performance metrics continue to be developed, improvements in performance and tighter contract management were welcomed.
- Workforce strategy update – update on BME talent programme was discussed and success data being developed; a request to extend life of the current workforce strategy to March '26 was debated. Committee felt it was a long period but recognised the change and transformation which needed to land ahead of any refresh so was prepared to support the extension.

Committee Escalation and Assurance Report

- The waiting list position was discussed, including potential solutions for addressing the MindMate SPA backlog. Data on 52+ week waits and other higher risk waiting lists was presented. CBU remains area of highest risks due to demand outstripping capacity but some encouraging ideas for restructuring the service offer which are being considered. Committee remains concerned about the wait times and volumes in high risk areas but takes reasonable assurance that the leadership team are well sighted on risk and are doing all they reasonably can to manage risk and innovate to tackle wait times.
- Enhance service internal audit report (limited assurance) was discussed – management actions agreed to improve data capture to demonstrate positive impact of the service and value for money. Consideration for the Committee on how to receive reporting on that data for assurance.
- A number of other papers for assurance were received and discussed including the Performance Brief with finance report; EPRR update and Estates Management report. Committee was assured on performance management.

Risks Discussed and New Risks Identified

- A number of "new" risks now appear on the Risk Register – it was explained to the Committee that some of these are not new risks but ought to have been on the register previously; some are IT/digital risks arising from the new strategy and Year 1 plan.
- Digital Year 1 business case was discussed and the preferred option was recommended for approval by the Board but the risks around financing the plan were debated.
- Waiting times – a review into the MindMate SPA referrals backlog was discussed along with plans to address the backlog and "waiting well" strategies.

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 (see comments above) the Committee remains concerned about waiting list volumes and wait times for some higher risk services and would welcome ongoing debate and Board oversight of Trust activity to manage waiting lists.

Committee Escalation and Assurance Report

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
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

Committee Escalation and Assurance Report

Author:	Rachel Booth
Role:	Committee Chair
Date:	25/09/24

Committee Escalation and Assurance Report

Name of Committee:	Charitable Funds Committee	**Report to:**	Trust Board 4 October 2024
Date of Meeting:	10/9/2024	**Date of next meeting:**	17 December 2024
Chair:	Alison Lowe	**Parent Committee:**	Trust Board

Introduction

This report identifies the key issues for the Board from the Charitable Funds Committee held on 10 September 2024. Quorate meeting with good debate on key topics

Alert	Action
No alerts	

Advise

- More work to do on promoting Microhive (previously Pennies from Heaven) through local communications
- The Charitable Funds Officer is developing local networks to support further development of the LCH Charity
- Hannah House forward plan approved in principle, subject to fundraising and grants to fund this
- Draft annual report and accounts received. Subject to audit requirements and Audit Committee approval, the final report will be received at December Charitable Funds Committee.

Assurance

- Committee heard of the fundraising activity since the last committee meeting including the Trust summer show, “A slice of Saturday night” 1 year celebration event at White Rose Park and a Hannah House Moveathon.
- One application for charitable funds from Liaison & Diversion discussed. This was declined with support for other grant applications that the service are being supported to progress.
- Committee were very grateful to hear of a recent legacy donation for the charity.
- Committee heard the pipeline of partnerships and fundraising events being explored for the forthcoming 12 months and further consideration to be given to providing updates to steering group and Trust Board.
- Finance report covering April – June 2024 received and accepted

Risks Discussed and New Risks Identified

No new risks identified

Committee Escalation and Assurance Report

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	Risk score (current)	Overall level of assurance provided that the strategic risk is being managed (or not)	Additional comments
Risk 2 Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage	12 (high)	Reasonable	Reports and updated received as above

Author:	Sheila Sorby
Role:	Interim Director of Nursing and Allied Health Professionals
Date:	10 September 2024

Agenda item:	2024-25 Item (72)

Title of report:	Performance Brief –August 2024

Meeting:	Trust Board
Date:	4 October 2024

Presented by:	Andrea Osborne, Director of Finance and Resources					
Prepared by:	Victoria Douglas-McTurk, Head of BI Yasmin Ahmed, Deputy DoF Dan Barnett, Head of Strategy					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	This report seeks to: • Highlight escalations against the Trusts High Level Indicators (HLIs) and provide assurance to the Trust Board on progress relating to the development of the Performance Brief (as we introduce a new format report based on Statistical Process Control (SPC) charts) • Provide an update on Financial Performance and delivery of the 24/25 financial plan

Previously considered by:	HLIs- Business Committee and Quality Committee Finance Report -Business 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			
	No		Why not/what future plans are there to include this information?	N/A

Recommendation(s)	Note escalation / risks & progress on the development of.

List of Appendices:	

Performance Brief

Introduction

Following discussion at the Board Workshop on 3rd September work has now commenced to further develop and enhance and the Trusts approach to Performance reporting. This aims to put Statistical Process Control (SPC) charts at the centre of performance reporting which will improve the focus of, and narrative contained within the Performance Brief.

Noting that this is a significant change for the organisation, it was further agreed that oversight and scrutiny of performance would continue to operate at Committee level with exceptions and escalations through to Board.

Progress Update

A revised draft Performance Brief was produced in September for consideration by the Trust Leadership Team, Business Committee and Quality Committee. The data to inform this report was provided in both the original and SPC formats. Those who contribute to the narrative were asked to examine the SPCs and form their commentary based on these. Both the original data tables and SPC charts are provided as appendices to this report, a summary of the progress made in terms of representing the data in this new format is presented in the table below with over 58% of the Trusts high level indicators now reported through SPC.

	Reported via SPC	In Transition to SPC	Not suitable for SPC	**Total**
Safe	5	5	4	**14**
Effective	0	5	4	**9**
Caring	2	0	0	**2**
Responsive	17	0	1	**18**
Well, Led	8	3	1	**12**
Total	**32**	**13**	**10**	**55**

There are a number of measures included in the Performance Brief where it is not appropriate to create an SPC. This is because we do not have enough data either because numbers are very low or because we have not been measuring the indicator for long enough.

A new Executive Summary table is in development categorising the high-level indicators according to SPC methodology, of variation and assurance, highlighting whether the target was met and whether performance was improving or deteriorating. Focus was given to those measures that were deteriorating and/or failing the target. Narrative for many of these measures was available however this also drew attention to measures that are not normally commented on: CAMHS routine waits for eating disorder services, LMWS access and data quality standards in the Mental Health Data Set. Where narrative on these was not available at the time the report was produced but has been requested for inclusion in future reports.

As expected, the new summary table highlighted the issues within our responsiveness domain and that our patients are continuing to experience waiting a long time for care as well as challenges within the well-led domain relating to performance against target for statutory and mandatory training and appraisals. The presentation of the appraisal data in an SPC format has highlighted that without significant action we will not meet the target. This was discussed in Senior Operations Performance Panel and an action plan has been requested.

Learning from the first month of this new approach has highlighted:

- Opportunities to improve the supporting narrative, encouraging this to be more concise and targeted. A template is in development that will aim to support this, and it will be further discussed at the Senior Leadership Team on 9th October with a view to being used as the basis for a "draft run" of the Performance Brief through October, reviewing September's data.

- Scope to enhance the oversight of performance through the Executive Summary, including coverage of all indicators (currently it only lends itself to those measures reported via SPC) as well as highlighting the movement of measures between categories providing assurance around the impact of actions being taken.

Key Exceptions/ Escalations by Domain

Safe

- There was one Serious Incident Investigation signed off as complete in the reporting period.
- There were three incidents which met the requirement for statutory Duty of Candour in August 2024

Caring

- The Friends and Family Test responses remain consistent with previous months with 93.1% reporting "good" or "very good" experiences and 3.01% having "poor" or "very poor" experiences.

Effective

- Patients living in IMD1 are more likely to wait more than 18 weeks for care in non-consultant led LCH services.

Responsive

- Services operating RTT pathways continue to experience significant and systemic challenges to achieving waiting time standards.
- Recent performance in relation to our Urgent Community Response has been good and has been meeting the target albeit not reliably.
- The percentage of patients we are seeing in less than 6 weeks for diagnostic tests is well below target and continues to deteriorate. The service is undertaking a Waiting List Assurance Programme with two primary areas of focus: clinical review of patients and changes to referral criteria requests.
- Patients continue to wait more than 52 and more than 65 weeks in a number of service areas. A detailed summary of actions being taken, and predicted trajectories, has been provided to the Business Committee in September 2024 alongside this paper.
- There have been 6 breaches of the CAMHS ED urgent 1-week standard during the reporting period.

Well Led

- MaST performance continues to be consistent and stable reporting at 87.4%, just below the overall 90% KPI for our MaST training programme.
- Appraisal compliance remains largely static and consistent at 75%. An internal audit has been commissioned with Audit Yorkshire for September to examine overall assurance and compliance, and the challenges in meeting our 90% KPI.

Finance – August 2024

Leeds Community Healthcare NHS Trust

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

Summary Performance

I&E YTD (£'000)	Apr	May	Jun	Jul	Aug	RATING
Plan (Surplus)/Deficit	(84)	(168)	(252)	(336)	(425)	
Actual (Surplus)/Deficit	330	200	187	75	(120)	
Variance (Favourable)/Adverse	414	368	439	411	305	

Forecast outturn (£'000)	Apr	May	Jun	Jul	Aug	RATING
Plan (Surplus)/Deficit	(990)	(990)	(990)	(990)	(990)	
Forecast (Surplus)/Deficit	3,225	(990)	(990)	(990)	(990)	
Variance (Favourable)/Adverse	4,215	0	0	0	0	

At the end of August 2024, the Trust is reporting a surplus of £120k against a planned surplus of £425k. The deficit against plan of £300k is mainly due to under delivery of efficiencies of £438k and offset by a small non- pay underspend.

There has been a reduction in staff numbers by 14wte from July (3,045wte) to August (3031wte) due to grip and control measures in place. However, the rate of expenditure on staffing has remained unchanged from July due to one-off in-month nursing costs of £142k in the Adult Business Unit

Specialist Business Unit have developed a recovery plan that will be presented through the Trust governances processes, this includes actions to address the overspend in Police Custody.

A straight-line forecast of the month 5 position would be a £288k surplus, whilst this represents an improvement of £523k from the M4 extrapolated position, this would still be an adverse position of £702k against a planned surplus of £990k.

The forecast position continues to be closely monitored and as the level of savings is expected to increase in future month the Trust continues to forecast delivery of the planned surplus of £990k. Delivering on the forecasted savings outlined in the Quality & Value programme is key to achieving this position, as is the assumptions that the agenda for change pay awards will be fully funded.

Further details of risks and mitigations to the forecast out-turn are set out further in the report, with the worst-case position currently being assessed as a deficit of £3.5m.

To note the Trust's underlying budgetary deficit, as per the Board approved financial plan submission, remains at £2.6m, however, this relies on full delivery of the recurrent savings plan.

Quality & Value Programme Delivery YTD (£'000)						
	Apr	May	Jun	Jul	Aug	RATING
Plan	1,315	2,633	3,950	5,260	6,575	
Actual	538	1,931	3,140	4,845	6,137	
Variance (Favourable)/Adverse	777	702	810	415	438	

Temporary Staffing Expenditure YTD (£'000)						
	Apr	May	Jun	Jul	Aug	RATING
Agency Plan	315	630	944	1,257	1,574	
Agency Actual	260	451	661	837	955	
Variance (Favourable)/Adverse	(55)	(179)	(283)	(420)	(619)	

Year to date, £6,137k of efficiency savings have been delivered against a plan of 6,575k, an adverse variance against plan of £438k. Although still behind plan the levels of monthly savings being reported has increased significantly since the start of the year reducing to £35k behind plan during August.

The Trust continues to forecast achievement of the annual savings target, of £15.8m. At the end of August, schemes to the value of £13.7m have been identified with work continuing through the Q&V programme to identify the remaining £2.1m. This remains a static position from that reported in July.

The position remains heavily reliant on non-recurrent savings being achieved through interest receivable and vacancies. Of the total value of the schemes identified for the year, c42% are non-recurrent, £5.8m against a plan of £2.6m. Work to identify recurrent plans remains ongoing but will need to conclude within the coming months to avoid deteriorating the underlying financial position and impacting adversely on the 25/26 Q&V programme.

Further detail is presented in the Q&V deep dive section of this report rep.

The Trust continues to reduce agency expenditure compared to the financial plan. In month agency spend reduced from £176k in M4 to £118k in M5.

In August, the Trusts agency spend represented 0.9% of total pay spend. This is a reduction of 0.5% from the 1.4% of total pay spend on agency in July.

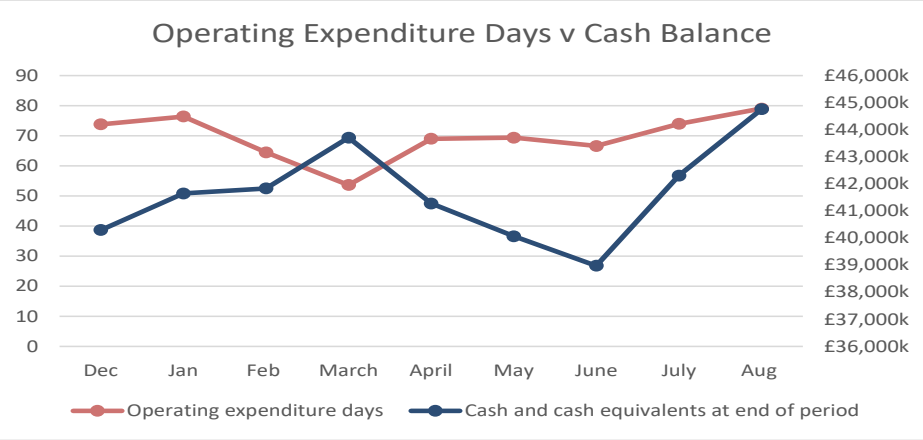
Agency expenditure reduction is mainly due to the grip and control measures in place. The reduction has been seen in all Clinical Business Units, mainly in Medical, Nursing and AHP staffing costs.

Cash Actual (£'000)						
	Apr	May	Jun	Jul	Aug	RATING
Plan	41,864	42,788	42,317	42,162	41,894	
Actual	41,279	40,066	38,976	42,308	44,761	
Variance (Favourable)/Adverse	585	2,722	3,341	(146)	(2,867)	

At the end of August 2024, the Trust is reporting a cash balance of £44,761k, above plan by £2.9k. The cash balance has improved from the previous month, due to the payment of outstanding invoices from Northpoint and Beeston PCN.

Cash is above plan year to date due to additional interest and higher than planned accruals within working capital. The cash is forecasted to be £2m higher than plan due to forecasted higher interest receivable.

The cash operating days, i.e. the Trusts ability to pay its short-term liabilities such as salaries and wages and other bills as they fall due, remains strong.



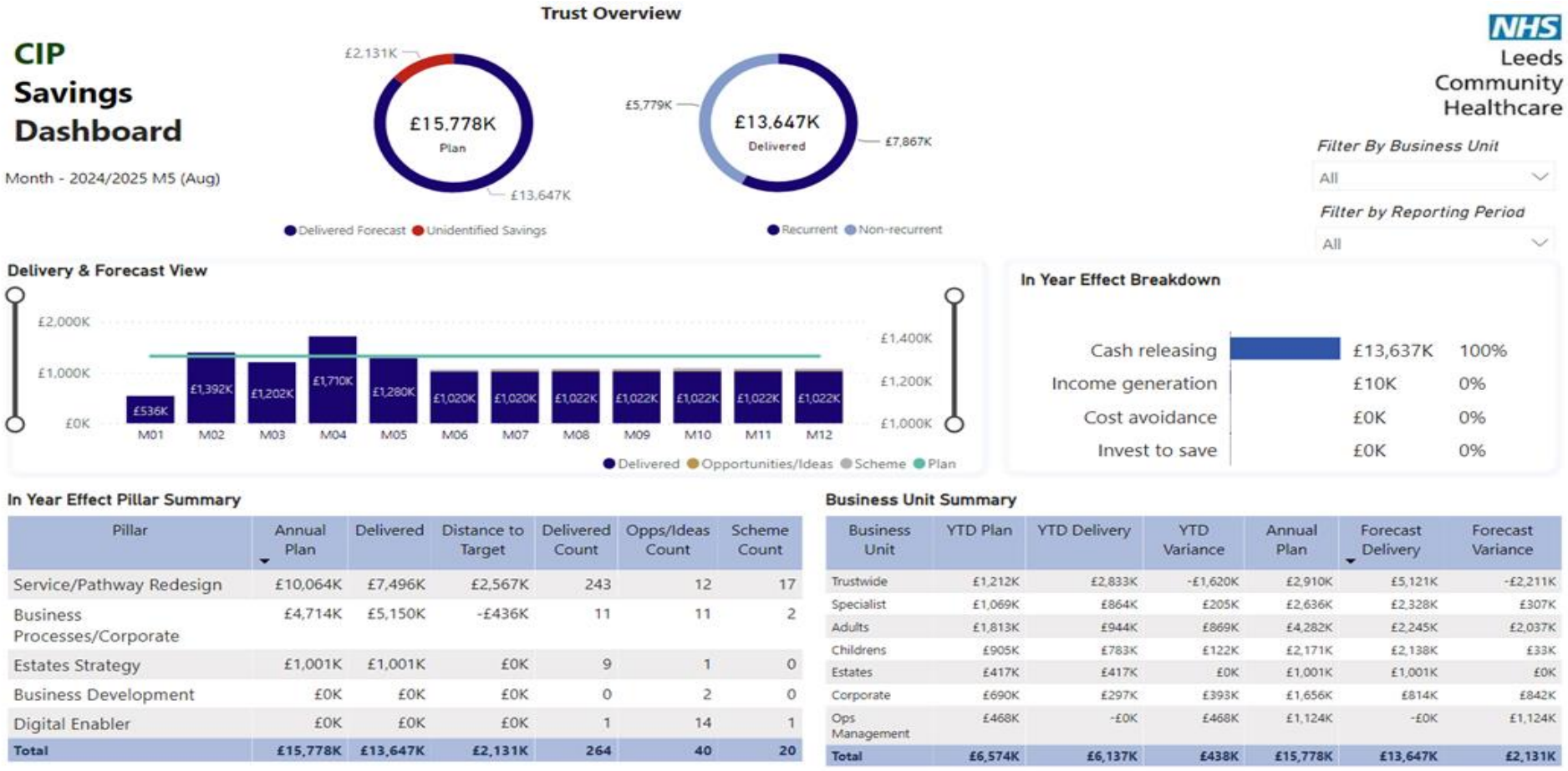
Capital Expenditure YTD (£'000)						
	Apr	May	Jun	Jul	Aug	RATING
Plan	(9,279)	(9,364)	(2,948)	(6,806)	(6,946)	
Actual	(2,783)	(2,820)	(2,887)	(3,040)	(3,135)	
Variance (Favourable)/Adverse	6,496	6,544	61	3,766	3,811	

The Trust's annual capital plan for 2024/25 is £15,020k, of which £2,605k is in respect of operational capital expenditure and the balance is to fund Right of Use Asset leases following the adoption of IFRS 16. The plan was amended by NHSE to reflect a revised profile based on year to date spend.

At the end of August 2024, the Trust has spent £3.1m compared to a plan of £6.9m. Monthly expenditure on owned assets relates to mobile phone purchases. The main year to date expenditure is on lease expenditure due to the measurement of Community Health Partnership right of use leases. A delay in the agreement of the lease at St Georges at a lower than planned rental, due to reduced occupancy is the main reason for the underspend against plan both year to date and in the forecast (YTD £3.3m FOT £2.2m. The agreement is now expected to be completed for October.

The Trust is forecasting to spend £11.5m by the end of March 2025. This is an underspend of £3.1m from the CHP remeasurement variance, due to the remeasurement figure being lower than predicted due to a change in RPI from when the initial modelling was undertaken and £0.4m from property lease additions, which are no longer forecast to commence.

Quality & Value - Deep Dive



In Year Effect Pillar Summary

Pillar	Annual Plan	Delivered	Distance to Target	Delivered Count	Opps/Ideas Count	Scheme Count
Service/Pathway Redesign	£10,064K	£7,496K	£2,567K	243	12	17
Business Processes/Corporate	£4,714K	£5,150K	-£436K	11	11	2
Estates Strategy	£1,001K	£1,001K	£0K	9	1	0
Business Development	£0K	£0K	£0K	0	2	0
Digital Enabler	£0K	£0K	£0K	1	14	1
Total	**£15,778K**	**£13,647K**	**£2,131K**	**264**	**40**	**20**

Business Unit Summary

Business Unit	YTD Plan	YTD Delivery	YTD Variance	Annual Plan	Forecast Delivery	Forecast Variance
Trustwide	£1,212K	£2,833K	-£1,620K	£2,910K	£5,121K	-£2,211K
Specialist	£1,069K	£864K	£205K	£2,636K	£2,328K	£307K
Adults	£1,813K	£944K	£869K	£4,282K	£2,245K	£2,037K
Childrens	£905K	£783K	£122K	£2,171K	£2,138K	£33K
Estates	£417K	£417K	£0K	£1,001K	£1,001K	£0K
Corporate	£690K	£297K	£393K	£1,656K	£814K	£842K
Ops Management	£468K	-£0K	£468K	£1,124K	-£0K	£1,124K
Total	**£6,574K**	**£6,137K**	**£438K**	**£15,778K**	**£13,647K**	**£2,131K**

The Trust's Savings dashboard for M05 August is presented above, the forecast position continues to improve month on month as the programme matures and now stands at £13.65m (Pay £8.7m / Non-Pay £4.95m), a £1.15m increase from last month. Plans to mitigate against the current level of unidentified savings, £2.1m, continue to be explored. There are a further 40 opportunities and ideas being explored to generate additional savings and work continues on the corporate and service transformations.

It is anticipated these will be delivered from the service transformation projects currently underway. To note that whilst schemes are in development and service leads have committed to making recurrent savings in 2024/25 through the Quality and Value programme until these have been finalised and equity and quality impact assessments have been undertaken these savings may not be delivered and there is a risk that the forecast financial outturn will not be achieved.

As at month 5 the Trust has successfully generated in-year savings from the additional grip and control measures that have been implemented to mitigate in year financial risks as the service and corporate redesigns are undertaken. However, as much of the savings are non-recurrent in nature, 42%. c£5.8m it remains essential that work to convert the savings to recurrent schemes remains a priority to avoid deteriorating the underlying financial position.

Workstream Updates

Service Transformation	**Corporate review and business processes**	**Estates Strategy**	**Business Development**	**Digital Enablers**
Whilst at different stages, 11 services are now undertaking a service redesign with at least 5 nearing implementation stage and able to quantify their expected savings. A key area of risk relates to the Children's Business Unit where fully costed proposals remain outstanding.	All corporate teams to complete a self-assessment blueprint. These are now being reviewed to gauge timelines and resource requirements. Full-year savings for the corporate reviews are unlikely until next year, however this is off-set by the over achievement of non-recurrent savings such as interest received etc. A key focus of the workstream in the early months has been to enhance reporting and controls, targeting reductions in discretionary spend and overtime. A detailed review of the position at month 5 highlights a significant reduction in spend, being on average £143k per month lower than that reported in 23/24, a significant proportion of which relates to overtime with enhanced controls put in place by individual Business Units.	The estates workstream remains in a strong position having achieved all of its savings for this year. Due to a potential long lead in time for Estate rationalisation priorities for Year 2 of the Q&V programme are now being assessed	Capacity has been directed to support a number of tenders over recent months. Constraints of the financial envelope have meant that there is little opportunity to gain any further contribution from existing business. Work with Business Units has however identified opportunities for income generation which will now start to be developed.	A number of digital innovation projects are underway following receipt of external Front Line Digitisation funding. Agreement of the Year 1 - Digital strategy business case is a key enabler to progressing the further alongside strengthening the benefits realisation model

Agenda item:	2024-25 Item (73)

Title of report:	Chair's Assurance Report: Nominations & Remuneration Committee held 16 September 2024

Meeting:	Trust Board Meeting Held in Public
Date:	4 October 2024

Presented by:	Brodie Clark, Trust Chair, Chair of the Nominations and Remuneration Committee					
Prepared by:	Laura Smith / Jenny Allen, Director of Workforce					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	This paper identifies the key issues for the Board arising from the Nominations and Remuneration Committee meeting held on 16 September 2024. Matters discussed include: • Employment Policies: • 2024 VSM pay award recommendation and bonuses • Doctors / Dentists on local T&Cs pay award recommendation • Critical Shifts Incentive (CSI) in Police Custody

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	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	x

Is Health Equity Data included in the report (for patient care	Yes		What does it tell us?	
	No		Why not/what future plans are there to	This paper is focused on the LCH workforce

and/or workforce)?			include this information?	

Recommendation(s)	The Board is recommended to note this information.

List of Appendices:	N/A

Introduction

This paper identifies the key issues for the Board arising from the Nominations and Remuneration Committee meeting held on 16 September 2024.

Please note that the previous regular quarterly meeting of the committee was held on 28 June 2024.

Items discussed:

Employment Policies:

The Committee noted that multiple Employment policies had recently been reviewed at LCH between management and staff side colleagues; with review periods ranging between 12 months and 4 years.

2024 VSM pay award recommendation and bonuses

The Committee noted that the Senior Salaries Review Body had been received by Government, recommending a universal uplift of 5% to the salaries of Very Senior Managers (VSMs) in the NHS with retrospective effect from 1 April 2024 (or employment start date if later).

The Committee agreed that the 5% uplift could be paid to VSMs at the point when the national NHS letter formally confirming the NHS acceptance of the uplift was received.

The Committee ratified the decision made by its members since the 28 June 2024 meeting, that bonuses would not be paid to the VSM Group at LCH for 2023/24. They made clear that this was not a reflection on performance but rather in consideration of the current financial pressures which are bearing down on all areas and levels across the Trust.

Doctors / Dentists on local ts&cs pay award recommendation

The Committee approved the application of a 6% pay award for LCH doctors on local terms & conditions, backdated to 1 April 2024. This award mirrors that for doctors & dentists on national pay, terms & conditions.

Critical Shifts Incentive (CSI) in Police Custody

The Committee confirmed their approval of the decision to enable the Police Custody Service to continue using the critical shift incentives for the duration of the Police operation associated with this summer's riots. The operation is currently expected to conclude on 30 September 2024.

Recommendations

The Board is recommended to note this information.

Agenda item:	2023-24 (74)

Title of report:	Annual Medical Director's report 2023-2024

Meeting:	Trust Board
Date:	4 October 2024

Presented by:	Dr Stuart Murdoch Deputy Medical Director					
Prepared by:	Dr Ruth Burnett Executive Medical Director					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	To provide Board with an update and overview regarding our responsibilities as an employer of Medical and Dental staff within the Trust, including: • Appraisal and medical revalidation • Managing concerns • Pre-employment checks. It fulfils the requirements set by NHS England in relation to: • Annual Organisational Audit • Designated Body Annual Board Report • Statement of Compliance This Executive Medical Director's report covers the period 01/04/23 to 31/03/24 and includes information and activity relating to the Trust responsibilities regarding employment of medical and dental staff; based on the four key principles identified in the handbook and guidance regarding "Effective Clinical Governance to support revalidation" published by the GMC in 2024. It is accompanied by the recommended template for the Statement of Compliance for 23/24. Whilst this template formally refers to our employment of medical professionals, for the purpose of the report it also references our employment of dentists, unless specifically noted otherwise.

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?	The Trust has a highly diverse workforce.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	The Committee is recommended to: • Note the contents of the 2023/24 Annual Executive Medical Director's Report • Note the requirements by NHS England to include the statement of compliance from the Board. • Approve the statement of compliance and submission to NHS England • Note that the 2023/24 LCH Self-Assessment regarding compliance with the NHS England Quality Framework option will not be presented in its entirety and the opportunity for Board members to view this online on request.

List of Appendices:	Appendix 1 – Professional Standards Framework for Quality Assurance and Improvement 2023-2024 Leeds Community Healthcare NHS Trust (Statement of Compliance)

Medical Directors Annual Report
(including NHSE Statement of Compliance 23-24)

1 Introduction

The report details key areas of progress and further identified work against each of the four key principles identified in the GMC document of 2024 as those that underpin effective clinical governance in this context.These are:

- **Principle 1: An effective environment**
  Organisations create an environment which delivers effective clinical governance for doctors.
- **Principle 2: Continuous Improvement**
  Clinical governance processes for doctors are managed and monitored with a view to continuous improvement.
- **Principle 3: Fairness**
  Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination.
- **Principle 4: Supporting Process**
  Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practice.

Leeds Community Healthcare NHS Trust is a Designated Body responsible for the appraisals of all doctors employed by the Trust. Regulations require that all Designated Bodies must nominate or appoint a Responsible Officer, who must be a licensed doctor. This post is held in LCH by the Executive Medical Director and is therefore represented on the Board.

The Responsible Officer is supported by a Deputy Medical Director (Professional Standards) and a Head of Medical Education and Revalidation. The Deputy Medical Director post has been held by an individual holding consultant status since Sept 2019. This individual has undergone NHSE approved Responsible Officer training.

This report covers the period of 01/04/23 - 31/03/24. During this period LCH had a prescribed connection with 40 doctors, and responsibilities to 8 dentists who undergo annual appraisal but whose regulatory body the General Dental Council (GDC) does not currently have a revalidation process.

Of the 40 doctors that were due an appraisal, 97.5% (39 doctors) completed their appraisal within 23/24. 8 dentists were due an annual appraisal for 23/24 of which 100% were completed. 9 doctors were due for revalidation in 23/24, 100% of which were successfully revalidated for five years.

The Trust has agreed to support doctors working in LCH who are self-employed or work via an agency but conduct regular work for the Trust. LCH would provide appraisal and revalidation services for doctors with no other prescribed connection who work via the bank as well as ensuring other employment checks have taken place.

LCH had two doctors in a remediation or MHPS process during 23/24. The Trust Board have been regularly updated in private session. One of these cases has

resulted in the successful return of the doctor to the full scope of their clinical practice.

2 Current position/main body of the report

Analysis of the Medical and Dental Workforce in LCH can be seen below, this includes 40 doctors with a prescribed connection to the Trust, 10 dentists, and 19 training posts.

Medical and Dental Workforce 23/24			
Ethnic Group	**Headcount**	**%**	**FTE**
White	**21**	**30.43%**	**13.84**
Ethnic Minority	**17**	**24.64%**	**12.25**
Unspecified/Not Stated	**31**	**44.93%**	**22.55**
Grand Total	**69**	**100.00%**	**48.64**

Compared to previous year there is a decrease in the percentage of staff recording their ethnic group as 'White' (26 in 23/24), and an increase in staff recording their ethnic group as 'Ethnic Minority (14 in 23/24). Staff recording their ethic group as 'Unspecified/Not Stated' has decreased from last year (32 in 23/24), the total number of staff recorded last year was 72, this has reduced this year due to vacancy factor.

Age profiles of Medical and Dental Workforce 23/24						
Age Band	**22/23 Headcount**	**22/23 %**	**22/23 FTE**	**23/24 Headcount**	**23/24 %**	**23/24 FTE**
26-30	6	8.33%	4.20	8	11.59%	6.33
31-35	7	9.72%	4.60	8	11.59%	4.55
36-40	12	16.67%	6.36	12	17.39%	7.60
41-45	9	12.50%	5.45	9	13.04%	6.75
46-50	18	25.00%	9.97	16	23.19%	9.70
51-55	8	11.11%	5.30	9	13.04%	8.63
56+	12	16.67%	6.93	7	10.14%	5.09
Grand Total	**72**	**100%**	**42.81**	**69**	**100.00%**	**48.64**

There has been a reduction in the number of staff aged 56+ due to recent retirements in ICAN. Successful recruitment has allowed the service to continue without consultant gaps, the majority of appointments had worked in the service as trainees prior to appointment.

The analysis of the workforce based on ethnicity demonstrates a highly diverse workforce.

Over the last year CLASS has supported services with staff as follows:

CLASS Data 23/24	
Service Worked for	**Total Hours worked (previous years hours)**
Community CAMHS	2306 (1984)

Leeds Sexual Health	830 (380)
ICAN Service	0 (21)
Community Gynaecology Service	147 (0)
Total Hours	**3,283 (2,692.5)**

The increase in hours from CAMHS largely reflects ongoing gaps in the doctor in training rota and the rota not having prospective cover for leave. Significant gaps remain in both the consultant and trainee rota; plans are in place to advertise for consultant posts following previous unsuccessful recruitment in a challenged labour market. Alongside this, different models of care are being explored as part of the service transformation. Leeds Sexual Health Service and Community Gynaecology Service employed a number of doctors via CLASS to support clinical activity, these doctors are GPs with extended roles and are now employed on fixed term contracts utilising the GP salary scale introduced last year for all GPs in similar roles, these doctors have subsequently been offered contracts of employment.

Education

In the year 23/24 Leeds Community Healthcare was able to offer the following educational placements:

Medical Education Undergraduate and Postgraduate Placement Figures 2023-2024		
Service	**Undergraduate****	**Postgraduate**
ICAN	380	8
LSH	150	1
Community Gynaecology	50	1
CAMHS/Psychiatry	37.5	11
Elderly Medicine/Neuro Rehabilitation	192	-
GP VTS Trainees	-	3
MSK	120	-
Total	**929.50**	**24**

*Undergraduate placements are calculated based on 6 cohorts per academic year, multiplied by number of students per cohort, multiplied by days to give a representation of 'placements' provided, the same students may have been at LCH in different services during different cohorts.

This represents an increase of 37.5% in Postgraduate training provision in CAMHS and Psychiatry from 8 placements in 22/23 to 11 in 23/24 in line with NHS England's Multi-professional Education and Training Investment Plan (METIP) for 23/24.

LCH provides clinical placements for Postgraduate and Undergraduate Medical Education working in partnership with NHS England and the University of Leeds, to oversee clinical training for all levels of medical students and doctors in training.

The Trust has a medical education governance structure, led by the Medical Director, and supported by the Associate Director for Teaching and Student Support (ADTSS) for undergraduates and Director Medical Education (DME) for postgraduates, clinical staff, trainers and a dedicated administration team focussed on delivering and supporting high quality education and training.

LCH hosts over 400 Undergraduate Medical Students with over 900 placement opportunities, and 24 Postgraduate Doctors in training across 5 different services per year. Community placements provide experience of delivering care in a wide range of settings including in people's own homes as well as in clinics, Community Centres and schools.

Teaching and training standards, and support are reviewed annually via the NHS England Self-Assessment Return (SAR), in which organisations carry out their own quality evaluation against the National Quality Framework. It is based on continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation. A copy of the SAR is available on request.

The Quality Framework identifies the standards that organisations are expected to meet to provide high quality learning environments. The NHS Education Contract (2021-24) requests providers to fulfil the obligations of its roles and responsibilities set out in the Quality Framework and to submit a return to NHS England on their compliance with the contract. The education placements offered by LCH have been reviewed by Leeds University for undergraduate placements for two years, and by NHSE for postgraduate and these reviews have been very favourable. “The NHS England team commended the trust on the excellent amount of work being undertaken” – Executive Summary NHSE Senior Leader Engagement meeting Report.

In the NHS England National Education and Training Survey (NETS) the Trust scored well across all domains and either matched or outperformed the England-wide community Trust benchmark group. NETS is a national survey of healthcare trainees’ and students’ experiences of their education and training environments, gathering the views of c.40,000 respondents nationally in 2023.

The Medical Education Team have improved resources available to Medical Students, by creating a public facing webpage with information on working in community, specific information for bases such as access to lockers, prayer facilities and parking. The page will be further developed to include important induction materials.

➢ 3 Impact

Position statement for 23/24

Principle 1: An effective environment (Organisations create an environment which delivers effective clinical governance for doctors)

Board, knowledge, skills, and competencies

The Medical Director is a board member and has received training to support oversight of the clinical governance arrangements for doctors. They ensure the board is kept up to date on changes to clinical governance processes for doctors and the impact of those changes.

There is a designated NED for doctors in an MHPS investigation. The board engages with Clinical/Medical leaders via regular meetings both virtually and face to face.

LCH has a combination of individual service and central mechanisms which hold information pertinent to effective clinical governance for medical and dental staff. Each service is responsible for meetings and discussions regarding these, and

medical and dental staff of all employment statuses are encouraged to participate and actively contribute.

When things that go wrong are reported, there are robust processes in place to investigate incidents, respond appropriately to the patient, and support the individuals involved in the incident. This response is managed by the clinical governance team with the quality leads in the business unit. This process is responsive but improved information about performance and outcome could facilitate a more proactive approach. The ability to proactively link this data to medical professional standards oversight could be improved and work is underway to facilitate this with the introduction of PSIRF.

The four Trust policies related specifically to the employment of medical and dental staff were approved by SMT in 2021 and are in place:

- Appraisal and Revalidation Policy
- Medical and Dental Job Planning Policy
- Remediation, Reskilling and Rehabilitation Policy
- Maintaining High Professional Standards (MHPS) Policy

The policies are currently being reviewed.

The Trust has robust processes in place to ensure appropriate checks are undertaken to confirm all doctors and dentists undertaking employed work in the Trust are appropriately qualified and fit for role.

The Revalidation Team coordinate with Workforce and QPD colleagues to share information in order to provide central assurance of any issues relating to medical and dental staff. Revalidation Panels were carried out as required during 22/23, linking with Trust systems to ensure that appropriate submission and reflection on incidents and complaints was included in the relevant appraisals.

The Trust has strong processes in place to support individuals who speak up and raise concerns; from the operational or clinical line manager of the individual, directly with an Executive Director or with the Freedom to Speak up Guardian.

The Board is aware of the risks associated with clinical governance systems for doctors through the reports into the Quality Committee, this report and due to the oversight of the MHPS process.

At the beginning of 2024 the Medical Directorate in collaboration with the Organisational Development and Improvement Team (ODI) engaged with the medical and dental workforce to explore the strengths and weaknesses of LCH as an employer. We are addressing the issues raised from the outcomes of this work.

Previous years priorities:

- Support the development of a system that provides information about medical and dental activity and outcomes at a service and individual level. This will align with the recommendations from the Paterson report.
- Review policies relevant to the employment of medical and dental staff prior to renewal in 2024.

- Work with QPD to explore methods of proactively linking incident and complaint/concern data with individual clinicians in a way that supports professional standards but maintains an appropriate 'human factors' approach for organisational learning.

Comments:

- Health Care Quality Improvement Partnership (HQIP) is looking at tendering for a national medical and surgical clinical outcome programme.
- Policy review is underway in 2024.
- The introduction of PSIRF will allow for easier identification of clinicians involved in incidents, who are identified in DATIX.

Identified priorities for 24/25:

- Work with Leeds Teaching Hospitals NHS Trust on Maintaining High Professional Standards (MHPS).
- Review the learning from Peer Review with Birmingham and Derbyshire.
- Continue to work with QPD to ensure high clinical professional standards are in place.
- The Medical Directorate will address the issues raised from the Medical and Dental Engagement exercise.

Principle 2: Continuous Improvement (Clinical governance processes for doctors are managed and monitored with a view to continuous improvement)

Leeds Community Healthcare meets regularly with the GMC to discuss issues regarding incidents relating to doctors, and doctors in an MHPS process. Verbal feedback at the last meeting was complimentary of the processes in place and the open nature of the discussion, also reflective of the complexity of cases seen in this environment.

The Medical Directorate explored the possibility of involving Patient Representatives in revalidation panels but was not feasible. The Trust is now partnering with two Community Trusts to provide a mutual solution of an impartial panel member.

The Trust has presented information to both the University and NHSE on the quality of education provided at both an undergraduate and postgraduate level. There has been positive feedback from both meetings. Doctors are supported in their job plan to participate in education and training.

Previous years priorities:

- Embed and utilise electronic job planning for medical and dental staff – this will allow alignment of Trust and service priorities and objectives with individual objectives.
- Development of supporting information for all medical and dental staff bringing together data on activity and performance. This will align with the response to the Paterson enquiry where we would aim to provide benchmarking data to the public on procedures (in this setting there is a need to explore non-procedure-based areas which is often more difficult).
- Ensure compliance with GIRFT recommendations applicable to our services.
- Declaration of interests for all appropriate staff.

Comments:

- Roll out of electronic job planning is being reviewed in light of the end of the current regional contract, and feedback on the system.
- It has not been possible to progress the collection of meaningful data for non-procedure-based specialties. We will continue to explore useful data for meaningful benchmarking.
- GIRFT reports are in the process of being embedded within QPD.
- LCH now has a system in place for all appropriate staff to make appropriate declarations.

Identified priorities for 24/25:

- Explore useful data for meaningful benchmarking
- The Trust will continue to explore the use of e-Job Planning for doctors and the potential to re-procure.

Principle 3: Fairness (Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination)

Revalidation Panels ensure that all revalidation recommendations are supported by a thorough consideration of all aspects of the five years of appraisal preceding the recommendation. The introduction of these panels during 18/19 has strengthened the Trust processes and reduces the possibility of bias or discrimination.

The Trust has a 'Freedom to Speak Up Guardian' (FTSUG). In 23/24 there had been one formal and two informal individual concerns/conversations from doctors, doctors in training and dentists with the FTSUG, this is on a background of 148 raised across the Trust. The number of staff raising concerns from medical and dental workforce is the same as the previous year (22/23).

Junior medical staff can also raise issues or concerns via the Guardian of Safe Working Hours (GSWH), the Guardian produces regular Board papers on issues raised.

No concerns have been raised by any doctor in relation to decisions regarding the clinical governance of doctors; decisions relating to deferral of revalidation are usually made in conjunction with the doctors and in line with GMC guidance.

During 23/24 there has been one grievance raised by a doctor or dentist employed by LCH, this has been managed appropriately. There have not been any exception reports raised by a doctor to the Guardian of Safe Working hours.

Previous years priorities:

- Recruitment of new appraisers to support the system in light of anticipated changes.
- Reintroduction of regular face to face appraisal updates following the pandemic in line with the new meeting plan

Comments:

- One appraiser was recruited and appropriately trained to undertake appraisals in year.
- A full programme of meetings is planned for the coming year, including Appraiser Updates and Medical and Dental Engagement meetings.

Priorities for 24/25:

- Further work will be required to recruit appraisers to reflect upcoming retirements in the medical workforce.
- A peer review is planned for 2024 with Birmingham and Derbyshire Community Trusts, with a view to ensuring processes are free from discrimination and bias.

Principle 4: Supporting Process (Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practice)

LCH has a longstanding history of robust clinical governance processes to support medical revalidation and has continued to perform well in this regard. Revalidation submission and recommendations are in line with the National average.

Submissions summary - GDE (gmc-uk.org)

LCH has a Responsible Officer who is appropriately trained to undertake their responsibilities having undergone the training with NHSE. The RO participates in the regular RO network activities which have recommenced this year and undertake shared learning across the region.

The duties of the RO are supported by information provided by the appraisal process and regular meetings with the GMC.

There are systems in place to respond and manage concerns related to the fitness to practice of doctors. These systems work in conjunction with the GMC and the Practitioners Performance Advice, part of NHS Resolution. This system will also address concerns related to locum doctors and doctors in training in conjunction with NHS England

Previous years priorities:

- Continue to review the appraisal model in conjunction with guidance from NHSE and the GMC, continue to ensure we follow the best practice guidance and that this is cascaded and discussed appropriately with both appraisers and appraisees.
- Audit information held by the Trust on doctors who have a responsible body other than LCH.

Comments:

- LCH proactively sought opportunity for peer review with similarly sized Community Trusts. Peer Review will be undertaken in 2024 with Birmingham and Derbyshire Community NHS Trusts.
- Doctors working for the Trust who have an alternative Responsible Officer connection to their locum agency or alternative employer are offered support for appraisal and revalidation in the form of a "Scope of Work" letter provided by their Medical or Dental lead, detailing their work within the Trust. LCH provides appraisal and revalidation support for all doctors with a designated connection to the organisation.

- The GMC updated the Good Medical Practice (GMP) guidelines which have been actively shared with all doctors and have been implemented in the appraisal system. NHSE have updated the appraisal output form which has been reflected in the SARD medical appraisal system.
- LCH are in the process of planning a Quality Assurance exercise with our Peer Review partners to provide an unbiased review of a sample of appraisals undertaken in year.

Priorities for 24/25:

- Continue to review the appraisal model in conjunction with guidance from NHSE and the GMC, continue to ensure we follow the best practice guidance and that this is cascaded and discussed appropriately with both appraisers and appraisees.
- Undertake a Quality Assurance exercise with Peer Review partners.

➢ 4 Recommendations

The Board is recommended to:

- Note the contents of the 2023/24 Annual Executive Medical Director's Report
- Note the requirements by NHS England to include the statement of compliance from the Board.
- Approve the statement of compliance and submission to NHS England
- Note that the 2023/24 LCH Self-Assessment regarding compliance with the NHS England Quality Framework option will not be presented in its entirety and the opportunity for Board members to view this online on request.

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of Leeds Community Healthcare NHS Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	No update required
Comments:	Dr Ruth Burnett is LCHs appointed Responsible Officer, with Dr Stuart Murdoch as Deputy, both are fully trained.
Action for next year:	No update required

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	No update required
Comments:	Sufficient funds, capacity and resources are available for the RO to carry out the responsibilities for the role. The Trust utilises the SARD Medical Appraisal System.
Action for next year:	No update required

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	No update required
Comments:	The SARD system is maintained to provide an accurate up to date overview of the appraisal and revalidation position within the Trust, backed up by a limited access, password protected Excel database.
Action for next year:	No update required

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Carry out a cross check with other Medical Workforce Policies.
Comments:	Medical and Dental Policies are in the process of being updated and will be shared with the Trust's Joint Negotiating Committee.
Action for next year:	No Action required

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	LCH will independently look to undertake a peer review exercise with a similar sized organisation.
Comments:	Peer Review underway with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust to share procedures, policies and best practice.
Action for next year:	Further benchmarking and collaborative work planned for 24/25 to include Quality Assurance and membership of Revalidation Panels.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Review of long-term locums in the Trust.
Comments:	LCH now offers appraisal support for Locum and Short-Term Contract Doctors. Scope of work letter completed to support doctors' full scope of work when employed elsewhere when requested. All doctors, regardless of employment status, are involved in governance processes relating to incidents and complaints. The Trust encourages them to be actively involved in any issues raised by patients, will ensure they have access to the relevant clinical record and will provide copies of documentation relating to these incidents for the purposes of appraisal. Training and development opportunities are available and will be supported as appropriate for all doctors regardless of employment status. Every member of LCH staff has access to regular support from their clinical and operational line managers, including discussion regarding development needs and opportunities, clinical supervision and

	encouragement, and opportunities to be involved in local governance and service improvement processes. Doctors working for the Trust who have an alternative Responsible Officer connection to their locum agency or alternative employer are offered support for appraisal and revalidation in the form of a "Scope of Work" letter provided by their Medical Lead, detailing their work within the Trust.
Action for next year:	No action required

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	No action required
Comments:	All doctors are supported to have a Medical Appraisal within the SARD system, where they can store supporting information and reflect. Complaints, concerns and incidents are reviewed at Revalidation stage.
Action for next year:	No action required

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	No action required
Comments:	Any doctors who have not had an appraisal have had an understandable reason for this and submitted plans to complete this within an approved timeframe.
Action for next year:	No action required

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	No action required
Comments:	The Trust has a 'Medical and Dental Appraisals and Revalidation Policy' in place, this is regularly reviewed in line with National guidelines, and is discussed at the Trust's Local Negotiating Committee, before being ratified by Trust Board.
Action for next year:	No action required

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	No actioned required
Comments:	One new appraiser trained, actively working to future proof the appraiser network
Action for next year:	Work to future proof the appraiser network

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	No actioned required
Comments:	Appraisers are all supported to attend appraisal network/development attempts and are provided with both individual feedback and anonymised Trust feedback from the quality assurance process. regular 'Trust Appraiser Updates' are held to provide an opportunity for supported peer discussion and development in the context of appraisal. Appraisees have been reminded about the need to have a whole of practice appraisal, including leadership or education roles in addition to work in other settings.
Action for next year:	No actioned required

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	Complete the 23/24 Quality Assurance process.
Comments:	Peer review partners will carry out Quality Assurance of each other's appraisals processes to ensure an unbiased review.
Action for next year:	Complete the 24/25 Quality Assurance process with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	Continue to engage with the GMC appropriately.
Comments:	Regular Revalidation panels are held as required. The Executive Medical Director, Deputy Medical Director, and Head of Medical

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

	Education and Revalidation meet with the GMC Employee Liaison Advisor quarterly.
Action for next year:	Continue to engage with the GMC appropriately.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	No update required
Comments:	The outcome of Revalidation Panels is communicated directly with the doctor, indicating their revised revalidation date. The Responsible Officer made 9 positive recommendations to the GMC during the period covered by the report, all in a timely manner and supported by a Revalidation Panel. This covers all doctors for who recommendations were due during this period.
Action for next year:	No update required

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	No update required.
Comments:	The SARD system records all Designated Body Doctors appraisal and revalidation data. LCH has robust pre-employment processes in place for all new medical staff joining the Trust on a permanent or temporary basis. Concerns raised in relation to doctors are reviewed as appropriate and escalated within the organisation. The Medical/Dental Lead role job description is updated and is in use.
Action for next year:	No update required.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Work with Quality and Professional Development Team to help to embed the LFPSE Framework and explore ways of presenting incident data for doctors.
Comments:	Work is ongoing to ensure that the LFPSE Framework is embedded alongside PSIRF. The Revalidation Team regularly liaises with the Trust's Patient Experience Team.
Action for next year:	Continue to embed LFPSE Framework is embedded alongside PSIRF.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	This is a new action for 23/24
Comments:	The SARD Medical Appraisal system is used to ensure doctors can access their appraisal information easily. SARD acts as a repository for supporting information.
Action for next year:	No action required

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	No action required
Comments:	Concerns raised in relation to doctors are reviewed as appropriate and escalated within the organisation. The Maintaining High Professional Standards (MHPS) policy and the Remediation, Reskilling and Rehabilitation policy are both current. The RO has regular meetings with the GMC ELA and PPA advisors to discuss any potential cases of concern.
Action for next year:	No action required

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	LCH will explore involving Patient Representative panel members to provide a patient voice at Revalidation Recommendation panels.
Comments:	Invite partnering community trusts from Peer Review to Revalidation panels. LCH did explore Patient Representatives, but this would be a large undertaking for a voluntary role and would require significant training.
Action for next year:	Inclusion of neutral panel member from a Partnering Trust in Revalidation Panels.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	No action required.
Comments:	The Trust can respond promptly to any request, this is signed off by the Responsible Officer prior to the transfer of information. LCH has robust processes for requesting appropriate information from partner organisations on transfer to the Trust of new Designated Body doctors, and for providing it when doctors transfer out. - Any concerns are raised with SM or RB if there are concerns, externally concerns are raised with the DBs RO.
Action for next year:	No action required.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	As stated, the Trust is exploring working collaboratively with other Trusts and involving patient representation to ensure processes are fair and free from bias.

Comments:	The Trust will invite partnering community trusts from Peer Review to Revalidation panels.
Action for next year:	Inclusion of neutral panel member from a Partnering Trust in Revalidation Panels.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	New for 23/24
Comments:	As the Trust receives outputs from National reviews, reports and enquiries they are reviewed at appropriate committees and groups and incorporated into the organisation as necessary. Recent work has focussed on 'Letby' with a paper discussed at Quality Committee and Trust Board.
Action for next year:	Continue to review guidelines as appropriate.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	New for 23/24
Comments:	Policies are in place to review professional standards for all clinical registered staff working in Leeds Community Healthcare – doctors, dentists, nurses and AHPs. Work has also been undertaken to ensure appropriate standards are in place for non-registered clinical staff. The Trust has a policy in place in relation to Professional Registration which is due for renewal in April 2025 which applies to all clinical staff required by law to hold a current and relevant professional registration. This policy sets out in a consistent way how registered staff are managed.
Action for next year:	Support the review of the Professional Registration Policy in time for renewal next year.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	New for 23/24
Comments:	The Trust has robust processes in place to ensure that appropriate checks are undertaken to confirm that all doctors and dentists undertaking employed work in the Trust are appropriately qualified and fit for role. These processes are in line with NHS mandatory pre-employment checks. The Workforce Directorate ensures that the processes undertaken with regards to bank and agency doctors and dentists is robust. These applications are reviewed by the Medical or Dental lead (or appropriate deputy) for fitness for role prior to any employment commencing and a new form has been developed that ensures additional checks are incorporated in line with best practice (e.g. Confirmation of Responsible Officer).
Action for next year:	No action required

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	New for 23/24
Comments:	The Trust strives to ensure that all staff are engaged in providing community healthcare services to the population we serve. We support our staff to develop and present opportunities to them so that they can develop in their careers and their ability to support colleagues and trainees. In the last year we have conducted an organisation learning review of the experience of our doctors working in the Trust and are exploring how we can develop all areas raised and build on the positive aspects.
Action for next year:	Action required

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	New for 23/24
Comments:	All policies within the Trust detail how adjustment should be made to ensure equality for all staff as set out in the Equality Act of 2010. The Trust pays due regard for the need to • Eliminate unlawful discrimination, harassment and victimisation • Advance equality of opportunity for all staff This includes removing or minimising disadvantages to staff and taking steps to protect people with different needs.
Action for next year:	Continue to monitor compliance with the Equality act and work with the human resources team and groups within the organisation to ensure fairness is being delivered.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	New for 23/24
Comments:	The Trust has in place a Speaking Up-Raising Concerns Policy which enables all staff to speak up at the earliest opportunity. It is authored by the Freedom to Speak up Guardian who addresses concerns from all staff groups. The Trust has a cultural approach called Speaking Up is a Practice Not a Position. This means that there are several speaking up channels at the trust. Staff are encouraged to use any of these channels to ensure their voice is heard. The mechanisms are: • Managers and colleagues • Easy Access to Senior Managers and Directors • Ask the CEO anonymous Q and A on the trust intranet • Trade Unions • Workforce Department (HR)

	• Freedom To Speak Up Guardian • Race Equality Network Speaking Up Champions In addition to this there are regular engagement meetings between all medical staff and the Medical Director, and the Resident doctors have regular meetings with the Guardian of Safe working hours, and the education team in which concerns can be raised.
Action for next year:	Continue to monitor concerns raised

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	New for 23/24
Comments:	The Trust policy on appraisal has an ability for doctor to raise a complaint or grievance from the appraisal process with the Responsible Officer or Deputy Medical Directors. If this process does not result in a satisfactory outcome the complaint can be raised with the Chief Exec of The Trust. The appraisal system utilised by the Trust allows feedback from appraisers to appraisees which is analysed and fed back. Any issues identified are addressed with individuals.
Action for next year:	Continue to monitor processes. In the last four years there have been no formal complaints and feedback is consistently good.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	New for 23/24
Comments:	The Trust is aware of differential raising of concerns, entry into MHPS processes and referral to the GMC, in relation to country of primary medical qualification and protected characteristics. The number of doctors with a connection to LCH is relatively small and the number of doctors involved in incidents is small. It would be difficult to identify any concerns about issues, but we are vigilant and continue to question our processes and decisions.
Action for next year:	Continue to monitor concerns and processes in relation to involvement by doctors and protected characteristics.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	New for 23/24
Comments:	The Trust attends the regional RO and Appraisal Leads Networks, In the last year it has begun a peer review/support programme with two other similar Trust to explore processes and procedures and ensure learning is shared. The RO regularly meets with the regional GMC liaison officer.

Action for next year:	Continue to build on relationship with other Trusts and attend appropriate meetings

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 – 31 March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	40

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	39
Total number of appraisals approved missed	1
Total number of unapproved missed	0

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	9
Total number of late recommendations	0
Total number of positive recommendations	9
Total number of deferrals made	2
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	**2**
Total number of trained case managers	**1**
Total number of new concerns registered	**0**

Total number of concerns processes completed	**1**
Longest duration of concerns process of those open on 31 March	
Median duration of concerns processes closed	
Total number of doctors excluded/suspended	**1**
Total number of doctors referred to GMC	**1**

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	0
Number of new employment checks completed before commencement of employment	0

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

Leeds Community Healthcare NHS Trust has a robust system in place for ensuring appraisal and revalidation of doctors employed by the Trust, for the appraisal of dentists and ensuring appropriate fitness to practice and fitness for role of other medical staff who work for the Trust. 39 doctors and 8 dentists have had an annual appraisal for the year April 2023 and March 2024. 9 doctors have been successfully revalidated. The Trust has continued to provide high quality appraisal, supported and developed doctors and dentists regarding both appraisal and their general wellbeing, improved engagement with medical and dental staff and continued to further improve our systems to better support our medical and dental staff.
Actions still outstanding
Work identified in the 22/23 Medical Directors report to undertake an independent peer review and quality assure the appraisal processes is underway with Derbyshire and Birmingham Community NHS Trusts, further steps are identified for progress during 23/24.

Current issues

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

At the beginning of 2024 the Medical Directorate in collaboration with the Organisational Development and Improvement Team (ODI) engaged with the medical and dental workforce to explore the strengths and weaknesses of LCH as an employer. We are addressing the issues raised from the outcomes of this work.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Further benchmarking and collaborative work planned for 24/25 to include Quality Assurance and membership of Revalidation Panels.

- Further work will be required to recruit appraisers to reflect upcoming retirements in the medical workforce.
- Complete the 24/25 Quality Assurance process with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust.
- Continue to engage with the GMC appropriately.
- Continue to embed LFPSE Framework is embedded alongside PSIRF.
- Continue to work with QPD to ensure high clinical professional standards are in place, and explore useful data for meaningful benchmarking
- Work with Leeds Teaching Hospitals NHS Trust on Maintaining High Professional Standards (MHPS).
- Inclusion of neutral panel member from a Partnering Trust in Revalidation Panels.
- Continue to review the appraisal model in conjunction with guidance from NHSE and the GMC.
- Continue to ensure we follow the best practice guidance and that this is cascaded and discussed appropriately with both appraisers and appraisees.
- Continue to attend RO and Appraisal Leads Networks.
- Review the learning from Peer Review exercise with Birmingham and Derbyshire Community Trusts and embed new ways of working.
- Continue to monitor compliance with the Equality act and work with the human resources team and groups within the organisation to ensure fairness is being delivered.
- Continue to build on relationship with other Trusts and attend appropriate meetings.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Achievements

Leeds Community Healthcare meets regularly with the GMC to discuss issues regarding incidents relating to doctors, and doctors in an MHPS process. Verbal feedback at the last meeting was complimentary of the processes in place and the open nature of the discussion, also reflective of the complexity of cases seen in this environment.

LCH has a longstanding history of robust clinical governance processes to support medical revalidation and has continued to perform well in this regard. Revalidation submission and recommendations are in line with the National average

Challenges The Medical Directorate explored the possibility of involving Patient Representatives in revalidation panels but was not feasible. The Trust is now partnering with two Community Trusts to provide a mutual solution of an impartial panel member. It has not been possible to progress the

collection of meaningful data for non-procedure-based specialties and we note the national commissioning of outcomes which we hope will reflect our work. We will continue to explore useful data for meaningful benchmarking.

The small number of medical staff in the organisation mean that remaining up to date with MHPS processes can be a challenge when looking for case investigators, as well as the familiarity with colleagues.

Aspirations A peer review is planned for 2024 with Birmingham and Derbyshire Community Trusts, with a view to ensuring processes are free from discrimination and bias.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Leeds Community Healthcare NHS Trust

Name:	
Role:	
Signed:	
Date:	

Agenda item:	2024-15 Item 75

Title of report:	**Annual Workforce Equality, Diversity, and Inclusion Report 2023/24 (Incorporating Overarching Equality, Diversity, and Inclusion Improvement plan)**					
Meeting:	Trust Board					
Date:	4 October 2024					
Presented by:	**Director of Workforce, OD, and System Development**					
Prepared by:	**E&D Facilitator (Workforce)**					
Purpose: (Please tick ONE box only)	Assurance	*	Discussion		Approval	
Executive Summary:	The Trust Board receives this annual update on progress made and future actions around Workforce Equality, Diversity, and Inclusion to meet the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract. This paper provides; *A retrospective look at the Equality, Diversity, and Inclusion highlights during 2023 *The Overarching Equality, Diversity, and Inclusion Action Plan for 2024/2025 (Includes Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES) and Gender Pay Gap (GPG) actions					
Previously considered by:	Business Committee 25 September 2024 Trust Leadership Team 18 September 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?	
Recommendation(s)	The Trust Board is recommended to: • Note the Equality, Diversity, and Inclusion highlights during 2023/24 • Agree that the continued delivery of the Overarching Equality, Diversity, and Inclusion Action Plan for 2024-25 provides assurance that the Trust meets the workforce requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract (WDES & WRES)			
List of Appendices:	Appendix A – Overarching Equality, Diversity, and Inclusion Action Plan 2024 – 2025, (*Includes GPGR, WDES and WRES actions*) Appendix B – Workforce Disability Equality Standard (WDES) Action Plan 2024/25 Appendix C – Workforce Race Equality Standard (WRES) Action Plan 2024/25 Appendix D – LCH NHS Staff Survey – Harassment, bullying or abuse at work data 2022,2023. Appendix E – WDES and WRES – Harassment, bullying or abuse 2019-2023			

Annual Workforce Equality, Diversity, and Inclusion Report

1. Introduction

1.1 This Equality, Diversity, and Inclusion (EDI) Annual Report 1 November 2023 – 31 October 2024, summarises the action taken, and highlights the progress made throughout 2023 against the NHS EDI Improvement Plan, which meets the requirements of the Public Sector Equality Duty (PSED), a requirement of the Equality Act 2010.

1.2 This year we have changed the format of the report to align with the NHS EDI Improvement Plan. A proposed Overarching Equality, Diversity, and Inclusion Action Plan for 2024/2025 can be found at Appendices A. For ease of reporting and publishing Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES) and Gender Pay Gap Actions (GPG), on the Trust website, we have lifted specific actions and attached separate Appendices. The overarching EDI action plan has been developed with input from a range of key stakeholders. The TLT are asked to consider some specific requests that have been received as part of that engagement exercise. These are highlighted in bold within the respective WDES and WRES Action plans (*Appendices B & C)*

1.3 The section below, reminds us of the range of statutory, NHS or Organisational requirements within which the Equality, Diversity, and Inclusion work, operates within.

2. Background

2.1 The Public Sector Equality Duty (PSED) sets out the main statutory duty that all public authorities must, in the exercise of their functions, have due regard to the need to:

- We eliminate unlawful discrimination, harassment and victimisation, and any other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and people who do not
- Foster good relations between people who share a protected characteristic and people who do not

2.2 The NHS Long Term Workforce NHS Long Term Workforce Plan (england.nhs.uk), plan defines the size, shape, mix and number of staff needed to deliver high quality patient care, now and into the future.

2.3 The NHS equality, diversity, and inclusion (EDI) improvement plan has been designed to improving the culture of our workplaces and the experience of our workforce, to boost staff retention and attract diverse new talent to the NHS.

2.4 The Equality Delivery System (EDS) is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS,

while meeting the requirements of the Equality Act 2010. LCH has been assessed as achieving for all three domains.

2.5 The current social unrest in the UK has yet again brought long standing issues of equality and discrimination to the forefront. As a Leeds Anchor organisation, LCH must be at the heart of the city-wide work to address inequality in the community and One Leeds workforce.

3. NHS EDI Improvement plan, high impact actions.

3.1 High Impact Action 1. *Measurable objectives on EDI for Chairs, Chief Executives and Board members.*

Current Position
The information gathered indicates that, at present, all Trust directors and the majority of Non-Executives have confirmed ED&I objectives. Work continues with support from the Company Secretary and the Chair to ensure a full suite of ED&I objectives are implemented and sustained across the full Trust Board membership.

NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).

Current Position
We are achieving the desired outcome through the regular reports provided to the Trust Board, NHS Staff Survey reports, Workforce Strategy updates and annual Trust Board EDI development workshops.

3.2 High Impact Action 2. *Overhaul recruitment processes and embed talent management processes.*

Current position
Diverse recruitment panels - In March 2024, the BME Fair Recruitment processes was introduced for a BME member of staff to be involved with the full recruitment and selection of posts at Band 7+. Sixteen members of staff have signed up to support the process. An audit of the process will be completed, and the findings and recommendations will be provided to the TLT.

Talent Management - The BME Talent Development programme is progressing well with 41 staff participating, which exemplifies a commitment to fostering talent and diversity within the Trust. This is due to be completed in December 2024, after which an evaluation of the programme will be conducted by the ODI team and reported to TLT.

Recruitment - The Applicant Tracking System has been implemented and we are excited to work through and understand how we can use the data in a more meaningful way to help us to address any disparities in the recruitment and selection process.

BME Reverse Mentoring and BME Allyship Programmes – During the 5 x cohorts of running both programmes, a total of 33 pairs of mentors and mentees, took part in the BME Reverse Mentorship programme and 54 delegates took part in the BME Allyship Programme. Following these programmes, all participants were invited to bi-monthly BME Allies Forum to continue that learning. Staff continue to benefit from attendance on the programmes as highlighted in Successful Allyship - Challenging diagnostic advice on patients with different skin colour.

Following the retirement of the lead person, these programmes were paused, and we are taking the opportunity to review with the Race Equality Network (REN) how the two programmes and allies forum, could be jointly resourced and supported in the future.

Together with other One Leeds Workforce partners we have, as one of our positive actions, actively targeted areas of Leeds with higher representation of BAME populations in hyper-local recruitment campaigns.

Currently, as part of Leeds One Workforce Programme, LCH, together with other health and social care partners are delivering a varied programme of work, in particular Project 5.2 Schools and Young People – Health & Care Careers. Further details can be found by clicking here.

3.3 High Impact Action 3. *Eliminate total pay gaps with respect to race, disability, and gender.*

Current position

We are pleased for the first time this year to be reporting on Ethnicity pay gap data, aligned with the requirements of the NHS EDI HI Actions, (further detail below), and we will shortly be reporting on Disability Pay Gap data.

Gender Pay Gap - (GPG), as previously reported to TLT and the Nominations and Remuneration Committee, as of 31 March 2024 there has been an increase in the Mean GPG from 3.5% in 2023 to 4.6% in 2024 in favour of males.

The Median GPG has increased, from -1.8% in 2023 in favour of females to 0% in 2024. This is much lower figure than the 2023 gap among UK median earners (7.7%), (*www.ons.gov.uk/employmentandlabourmarket*).

Analysis of the data suggests that these changes in the GPG are a consequence of the 1% increase in female employees and 1% decrease in male employees in the lowest paid quartile of the LCH workforce (Quartile 1).

In the UK, the difference in pay, expressed in gender pay gap terms, is 14.8% for full-time employees. *(www.ons.gov.uk/employmentandlabourmarket)*

The LCH Mean (average) Gender Bonus Pay Gap has increased from -16%, in favour of females in 2023, to 20.2% in favour of males in 2024 because of a reduction in numbers, through leaving or retiring, of women eligible for the consolidated Local Clinical Excellence Awards.

The Overarching Equality, Diversity, and Inclusion Action Plan 2024-2025 (*Appendices A) contains* actions designed to address the Gender pay gap.

Ethnicity Pay Gap – this is the first year that the Trust has conducted an Ethnicity Pay Gap. The initial finding is that there is a 5.8% mean and 13.6% median pay gap between White and BME groupings in favour of the White group. This data has been extracted from the information held on ESR system.

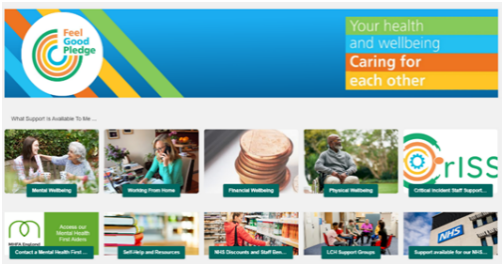
This table provides further breakdown of information and illustrates the complexities of reporting.

Further analysis will take place, and findings will be reported to the TLT towards the end of Q3 2024/25.

Disability Pay Gap – This will be a new action which will be progressed in Q4 2024/25, and subsequent findings reported to TLT.

Ethnic Origin Grouping	Avg. Hourly Rate	Median Hourly Rate
Asian	18.3230	15.3866
Black	16.7988	15.7622
Mixed	17.5499	15.2661
NULL	16.5743	14.5641
Not Stated	20.9765	20.7569
Other	16.9710	16.6034
White British	18.7284	18.1917
White Other	20.4366	18.7613
% Diff Asian - Black	9.0729	-2.3830
% Diff Asian - Mixed	4.4047	0.7891
% Diff Asian - White British	-2.1648	-15.4197
% Diff Asian - White Other	-10.3423	-17.9877
% Diff Black - Mixed	-4.2798	3.2495
% Diff Black - White British	-10.3029	-13.3549
% Diff Black - White Other	-17.8002	-15.9856
% Diff Mixed - White British	-6.2923	-16.0819
% Diff Mixed - White Other	-14.1249	-18.6297
% Diff White British - White Other	-8.3585	-3.0362

3.4 High Impact Action 4. *Health Inequalities within their workforce*



The Trust focus remains on staff's physical, mental, and financial wellbeing and provides a wide range of support identified on the MyLCH Health and Wellbeing Pages

The LCH Staff Health and Wellbeing Facebook group - caring for each other continues to flourish by providing support and information to over 900 members of staff.

The Disability, Neurodiversity and Long-Term Conditions Staff Network Group continues to thrive with over 50 members, who share their experience of living with a health condition and look at ways to raise awareness by personal stories. The DNLTC staff network group also gets involved with some key Trust work, such as

using their experience to develop a “toolkit” on reasonable adjustments, input into Wellbeing and related Policies as well as supporting with self-assessing our re-accreditation as a Disability Confident Leader Employer.

An over-arching Health and Wellbeing Action Plan and more bespoke health and wellbeing support offer for staff going through a Quality and Value Programme, has been developed and continues to flex to meet staff needs.

The Trust has a Board level Wellbeing Guardian, who continues to meet with the Director of Workforce, to ensure health and wellbeing remains in line of sight to the Trust Board.

In addition to the Trust Flexible Working Policy, LCH, and other health & social care organisations have come together as part of the Leeds Health & Social Care Academy, with the LCH DoW as the SRO, to promote the We can flex initiative, based on the NHS ‘Supporting Your Team to Work Flexibly: A Line Manager’s Guide’ document which can be found here.

3.5 High Impact Action 5. *Comprehensive Induction and onboarding programme for International recruited staff*

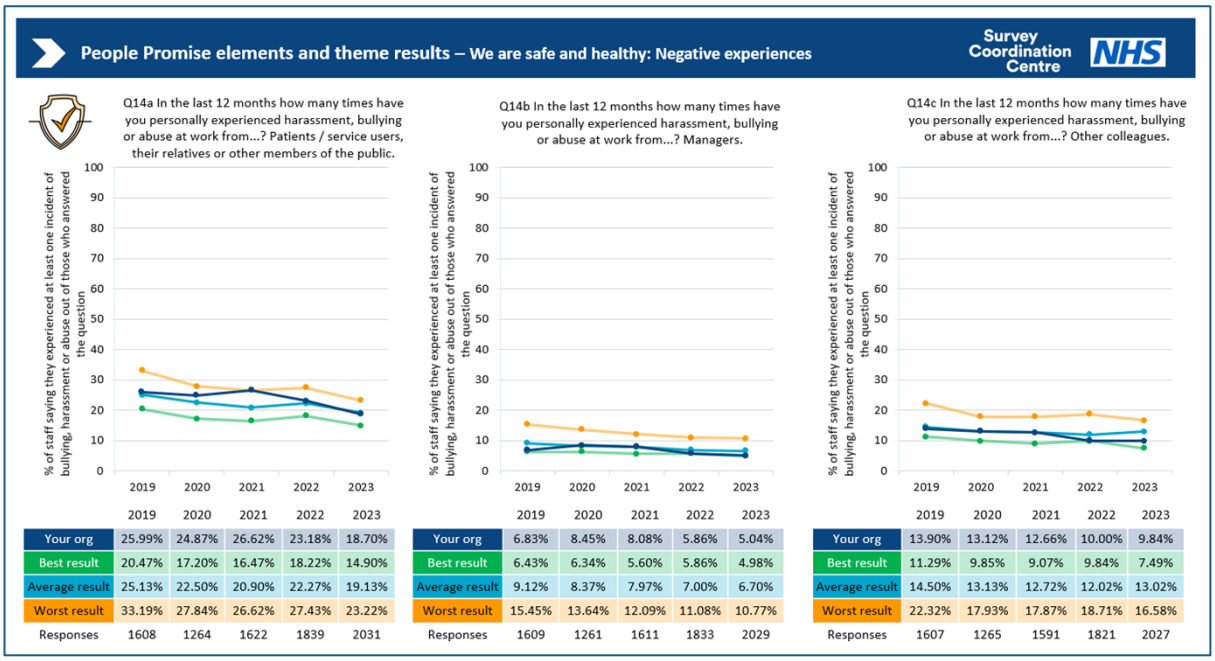
NHS England recognised the Trust for our commitment to supporting internationally educated nurses through the achievement of the NHS Pastoral Care Quality Award for providing best practice pastoral care for international nurses and midwives.

A Pastoral Lead, for International Nurses and Midwives (Registered Nurse), was appointed to provide support to existing and future internationally recruited staff. They participated in authoring an article and working with colleagues from the Queen's Nursing Institute to write an informative piece, 'Valuing internationally educated nurses and diversity in the community nursing workforce'. which has been published in the British Medical Journal and other websites.

3.6 High Impact Action 6. *Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.*

There continues to be strong internal leadership and direction to eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

As illustrated in the benchmarking table below, LCH performance is improving and fairs well in comparison to the benchmarking group.



	2019	2020	2021	2022	2023
Your org	25.99%	24.87%	26.62%	23.18%	18.70%
Best result	20.47%	17.20%	16.47%	18.22%	14.90%
Average result	25.13%	22.50%	20.90%	22.27%	19.13%
Worst result	33.19%	27.84%	26.62%	27.43%	23.22%
Responses	1608	1264	1622	1839	2031

	2019	2020	2021	2022	2023
Your org	6.83%	8.45%	8.08%	5.86%	5.04%
Best result	6.43%	6.34%	5.60%	5.86%	4.98%
Average result	9.12%	8.37%	7.97%	7.00%	6.70%
Worst result	15.45%	13.64%	12.09%	11.08%	10.77%
Responses	1609	1261	1611	1833	2029

	2019	2020	2021	2022	2023
Your org	13.90%	13.12%	12.66%	10.00%	9.84%
Best result	11.29%	9.85%	9.07%	9.84%	7.49%
Average result	14.50%	13.13%	12.72%	12.02%	13.02%
Worst result	22.32%	17.93%	17.87%	18.71%	16.58%
Responses	1607	1265	1591	1821	2027

With improved data analysis we are beginning to better understand which areas/services are experiencing challenges in this area. (*NHS Staff Survey Data 2022 & 23*). This data has been shared with Business Units, and discussions are taking place at BU leadership, service, and team levels to explore the data and reduce the disparity of experience. (*Appendices D)*.

Presently working alongside those areas highlighted as hotspots in the NHS Staff Survey, Wharfedale Hub, MSK, Community Dentistry, HCM, Kippax Neighbourhood Team and LSH. All services have been supported by FTSUG, ODI and EDI to address disparity of experience and are having Cultural Conversations within their teams, having received support from the Health Equity lead and EDI Facilitator (Workforce)

In addition to all this work taking place, there is a wide and varied range of support, resources, and initiatives in place to support services, teams, and individuals. These include;

There is a wide and varied range of support, resources, and initiatives in place to support services, teams, and individuals. These include;

- No Bystanders initiative
  *Information for managers and staff available on MyLCH
  *The No Bystanders initiative resource is available via the Cultural Conversations MyLCH page
  * Staff Networks promote the No Bystanders initiative at all meetings.

- During the reporting period 440 LCH staff attended 4 Neurodiverse Culture and Communication sessions delivered by external company Lexxic. This demonstrates a real interest in this area. The DNLTC Staff Network group are considering how to increase awareness and learning around neurodiversity

- Compassionate and courageous leadership programme in place

- A range of appropriate policies in place for support;
  Bullying and Harassment Policy
  The Prevention and Control of Violence, Aggression
  Lone Working Policy

- Freedom to Speak up Guardian support in place

- Specific bullying and harassment learning resources on the Leeds Health and Care Learning portal for managers and staff

LGBTQIA+

- Now that we have an established LGBTQIA+ staff network, we have found that many of our Rainbow Ambassadors have joined that network, which enables a rich depth of conversations to take place.

- LCH has supported Leeds Pride, for a third year now, demonstrating commitment to inclusivity.

Central resources and support are in place to assist services to facilitate two Cultural Conversations per year. With an increased focus on the Quality and Value Programme by services, teams, and individuals there has been a limited uptake of the Cultural Conversations programmes. We are therefore encouraging those services who have engaged with this, to promote their learning and experience for others to learn.

The Overarching Equality, Diversity, and Inclusion Action Plan 2024-2025 *(Appendices A*) contains actions designed to create an environment that eliminates conditions and environment in which bullying, harassment and physical harassment occurs and reduces the incidents and the disparity of experience between different protected characteristics.

4. Next steps for 2024/25

4.1 The Overarching Equality, Diversity, and Inclusion Action Plan 2024-2025 (Appendices A) provides targeted actions in core areas of recruitment, development, health, and wellbeing, harassment, bullying and aggression to achieve our equality objectives within the Workforce Strategy, to be *much more representative of our communities* and that *disparities in employee experience have substantially reduced; with any remaining disparity actively tackled* by 2025.

4.2 The NHS EDI Improvement Plan was introduced in June 2023 by NHSE with a proviso that individual Integrated Care Board (ICB) would manage Trusts performance. Presently the West Yorkshire Integrated Care Board has requested annual updates on progress. With the development of the WYICB equality strategy it is anticipated that there will be an increase in scrutiny and expectations.

4.3 In 2024/24 we will focus on improving the quality of equality data held on ESR, essential for us to foster an inclusive workplace, and improving employee experiences. Through the actions in the overarching EDI action plan, we will focus on harassment, bullying, and abuse in the workforce, essential for the well-being of our staff.

Recommendations

The Trust Board is recommended to:

- Note the Equality, Diversity, and Inclusion highlights during 2023/24
- Agree that the continued delivery of the Overarching Equality, Diversity, and Inclusion Action Plan for 2024-25 provides assurance that the Trust meets the workforce requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract (WDES & WRES)

APPENDICES A

Leeds Community Healthcare NHS Trust

Overarching Equality, Diversity, and Inclusion Action Plan 2024 - 2025.

(*Includes GPGR, WDES and WRES actions*)

Measure *NHSE require improvement no specific targets have been allocated*	Action	Lead	Review Date	Delivery Date	PSED	EDS2	WDES	WRES
Organisational priority -Staff Equality Data								
Reduce the percentage of unknown and prefer not to say categories held on ESR for the following protected characteristics, currently - Ethnicity - 16.3% (613) Disability – 19.3% (737) Religion or Belief – 29.3% (1103) Sexual Orientation – 21.5% (821)	Provide clear and accessible information ensuring that staff have easy access to information about the importance of equality declaration and how it contributes to creating an inclusive workplace.	EDI	15.10.24	31.12.24	YES	Domain 2 & 3 (Link)	YES (Link)	YES (Link)
	Regularly track and analyse equality declaration rates to identify any trends or patterns that may indicate areas for improvement. Use this data to inform targeted interventions and strategies to increase staff declaration.	EDI	N/A	Monthly	YES	Domain 2 & 3 (Link)	YES (Link)	YES (Link)
	Promote ESR Equality Data update self-service function to all staff through - - MyLCH - Corporate Induction (Staff handbook and marketplace)	EDI	N/A 15.10.24	Monthly 31.12.24	YES	Domain 2 & 3 (Link)	YES (Link)	YES (Link)
	Create a Workforce Equality Data dashboard and provide access for all LCH staff.	EDI	15.10,24	31.12.24	YES	Domain 2 & 3 (Link)	YES (Link)	YES (Link)

Measure *NHSE require improvement no specific targets have been allocated*	Action	Lead	Review Date	Delivery Date	PSED	EDS2	WDES	WRES
High impact action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.								
Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process.	The Trust Chair will record mutually agreed EDI objectives in executive directors' appraisals	Trust Board Secretary	_	31.3.24	YES	Domain 2 & 3 (Link)	YES (Link)	YES (Link)
Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025).		Trust Board Secretary	_	31.3.25	YES	Domain 2 & 3 (Link)	YES (Link)	YES (Link)
NHS boards must review relevant data to establish EDI areas of concern and prioritise actions.	Progress will be tracked and monitored via the Board Assurance Framework	Trust Board Secretary	-	31.3.25	YES	Domain 2 & 3 (Link)	YES (Link)	YES (Link)
High impact action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.								
An improvement in BME candidates experience of the recruitment process reported through the REN and FTSUG.	Audit the BME Fair Recruitment process and present the findings and recommendations to the TLT	EDI	8.10.24	31.12.24	YES	Domain 3 (Link)	_	YES (Link)
A reduction of the disparity between protected characteristics in the recruitment & selection process	Conduct an analysis of the 2024-25 recruitment process NHS Jobs data *(application, shortlisting, and appointment)* for all protected characteristics. Findings and recommendations to be reported to TLT	EDI	31.3.25	31.6.25	YES	Domain 3 (Link)	YES (Link)	YES (Link)
	All recruiting managers to attend the Trust Recruitment and Selection Managers course & refresher courses	EDI	31.12.24	31.3.25	YES	Domain 3 (Link)	YES (Link)	YES (Link)
A diverse recruitment panel can help ensure that the LCH workforce reflects the diversity of the community it serves, promoting inclusivity and representation at all levels of the Trust.	Provide an options paper to TLT to consider widening participation to staff who have declared a disability and/or identify as LGBTQIA+	EDI	31.12.24	27.2.25	YES	Domain 3 (Link)	YES (Link)	YES (Link)
Continued delivery of the BME Talent Management programme	Following an evaluation submit an options paper to TLT	ODI	31.12.24	31.3.25	YES	Domain 3 (Link)	_	YES (Link)

Measure *NHSE require improvement no specific targets have been allocated*	Action	Lead	Review Date	Delivery Date	PSED	EDS2	WDES	WRES
High impact action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.								
Consider the expansion of the current development programme to include Disability and Sexual Orientation **(Staff Networks request)**	Following the evaluation of the BME Talent Management programme consider widening participants to staff who have declared a disability and/or identify as LGBTQIA+	EDI	28.2.25	31.3.25	YES	Domain 3 (Link)	_	_
High impact action 3: Develop and implement an improvement plan to eliminate pay gaps.								
Increase the number of women in the Gender Pay Gap Reporting Quartile 4 (Highest)	Promote local, regional, and national development and networking opportunities for women – in 2023-24, 14 members of LCH took part in the Leeds Heath & Care Academy Springboard women's development programme.	EDI	31.12.24	31.3.25	YES	Domain 2&3 (Link)	_	_
Increase the use of skill-based assessment tasks in recruitment *(DWP best practice*)	Through quarterly communication with Recruitment Managers.	EDI	31.12.24	31.3.25	YES	Domain 2&3 (Link)	_	_
Ensure all LCH promotion, pay and reward processes are transparent for all	Continue adhering to the Agenda for Change Job Evaluation Process and Job Evaluation Panel, and clear and transparent processes for non-Agenda for Change staff	EDI	31.12.24	31.3.25	YES	Domain 2 (Link)	-	-
Increase the number of men who are working flexibly in accordance with the Flexible Working Policy	Promote the Trusts flexible working policy for men and women through quarterly promotion pieces and personal stories in MyLCH.	EDI	31.12.24	31.3.25	YES	Domain 2 (Link)	_	_
	This data is not currently collated and reported on ESR. EDI will work with WFI to explore how this data can be collated and reported on via ESR.	EDI	31.12.24	31.3.25	YES	Domain 2 (Link)	_	_
Increase the number of men who are taking Shared Parental Leave – currently 1.	Encourage the uptake of Shared Parental Leave - to share childcare more equally. We will continue to collaborate with the Men's Health Forum to raise awareness and increase uptake and quarterly promotion pieces and personal stories in MyLCH.	EDI	31.12.24	31.3.25	YES	Domain 2 & 3 (Link)	_	_
Reduce the Ethnicity Pay Gap	Conduct further analysis of the Ethnicity Pay Gap and report findings and recommendations to the TLT *(New action)*	EDI	8.10.24	31.12.25	YES	Domain3 (Link)	_	YES (Link)
Reduces the Disability Pay Gap	Create a Disability Pay Gap Report, and report findings to the TLT. *(New action)*	EDI	31.12.24	30.4.25	YES	Domain 3 (Link)	YES (Link)	_

Measure *NHSE require improvement no specific targets have been allocated*	Action	Lead	Review Date	Delivery Date	PSED	EDS2	WDES	WRES
High impact action 4: Develop and implement an improvement plan to address health inequalities within the workforce.								
Line managers should have regular wellbeing conversations with their teams supported by national resources, including the health and wellbeing framework	This has been included in the Trusts Compassionate and Courageous Leadership management training and Wellbeing at Work Policy.	ADoW	31.12.24	31.3.25	YES	Domain 2 (Link)	_	_
NHS organisations are encouraged to adapt NHS England's policy on menopause awareness as applicable to their local workforce. They should also adopt and implement the Supporting our NHS people through menopause: guidance for line managers and colleagues. This will ensure they fully support colleagues experiencing menopause, maximising their wellbeing, and allowing them to work for as long as they wish to contribute.	Continued promotion as a Menopause friendly Employer – highlight the range of support available from the OH provider such as, managers awareness sessions and 1-1 support	ADoW	31.10.24	31.11.24	YES	Domain 2 (Link)	_	_
Achieve reaccreditation of the Disability Confident Leaders Accreditation	Review the current Disability Confident Leaders delivery plan.	EDI	31.8.24	27.9.24	YES	Domain 2 (Link)	YES (Link)	_
	Conduct a peer assessment of performance and intentions with the Disability, Neurodiverse & Long-Term Conditions Staff Network.	EDI	10.10.24	31.10.24	YES	Domain 2 (Link)	YES (Link)	_
	Submit evidence for Disability Confident Leaders reaccreditation	EDI	-	1.11.24	YES	Domain 2 (Link)	YES (Link)	_
High impact action 5: Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff.								
Appointment of an International Recruits Pastoral Support Officer (IRPSO)	Continue to provide support to internationally recruited nurses as recognised by the International Nursing and Midwifery Pastoral Care Quality Award	IRPSO	In place and on-going	In place and on-going	YES	Domain 3 (Link)	YES (Link)	YES (Link)

Measure *NHSE require improvement no specific targets have been allocated*	Action	Lead	Review Date	Delivery Date	PSED	EDS2	WDES	WRES
High impact action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment, and physical violence at work occur.								
Disability (figures reported in 2023 NHS Staff Survey) Staff experiencing harassment, bullying or abuse from the public in the last 12 months. *(Nondisabled staff scores in brackets)* 25% (16%) Staff experiencing harassment, bullying or abuse from managers in the last 12 months. *(Nondisabled staff scores in brackets)* 10% (3%) Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months. *(Nondisabled staff scores in brackets)* 14% (9%) **Race** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months **White staff percentage in brackets.* 17.7% (18.8%) Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months **White staff percentage in brackets.* 15.2% (11.7%) In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team **White staff percentage in brackets.* 11.3% (2.7%)	Review the Too Hot to Handle report and submit recommendations for implementation in LCH to the TLT	ADoW	30.9.24	31.12.24	YES	Domain 3 (Link)	_	YES (Link)
	Review the welcome event slide deck to include No Bystanders and a link within the Welcome booklet.	EDI	30.8.24	31.10.24	YES	Domain 3 (Link)	YES (Link)	YES (Link)
	Create and publish a No Bystanders landing page on MyLCH - Projects and Campaigns section prior to the launch of the 2024 NHS Staff Survey.	EDI	30.9.24	31.10.24	YES	Domain 3 (Link)	YES (Link)	YES (Link)
	The EDI facilitator will continue to work with Business Units to support improvement in staff experience of harassment, bullying or abuse at work.	EDI	31.12.24	31.3.25	YES	Domain 3 (Link)	YES (Link)	YES (Link)
	Deliver 10 Compassionate & Courageous leadership sessions for managers as part of the Managers Development Programme	ODI	31.12.24	31.3.25	YES	Domain 3 (Link)	YES (Link)	YES (Link)
	The November 2024 Schwarz Round event will focus on bullying and harassment/No Bystanders	ODI	N/A	Nov 24	YES	Domain 3	YES (Link)	YES (Link)

Measure *NHSE require improvement no specific targets have been allocated*	Action	Lead	Review Date	Delivery Date	PSED	EDS2	WDES	WRES
						(Link)		
	Access existing forums/meetings to hear staff's views and progress positive thinking.	EDI	8.10.24	31.12.24	YES	Domain 3 (Link)	YES (Link)	YES (Link)
	Continued capture & analysis of Datix reports relating to staff experiencing harassment, bullying from patients, relatives or the public to inform #Nobystanders activity and actions.	EDI	31.12.24	31.3.25	YES	Domain 3 (Link)	YES (Link)	YES (Link)
	Consider how to hold managers to account for improvements for staff experience and provide an options paper to the TLT.	EDI	31.12.24	31.12.24	YES	Domain 3 (Link)	YES (Link)	YES (Link)
	Research how NHS staff survey data for Age, Gender, Religion & Belief, Sexual Orientation and Transgender can be presented and establish how to tackle any disparities in experience.	EDI	31.12.24	31.4.25	YES	Domain 3 (Link)	_	_
	Continued conversations with staff networks and other stakeholders to capture qualitative data that explores the underrepresentation across staff groups.	EDI	31.12.24	31.12.24	YES	Domain 3 (Link)	YES (Link)	YES (Link)
Every service in LCH takes part in two Cultural Conversations in 2024/25 (*Health equity strategy action and TLT decision*)	Offer support to service and team managers in the three business units for them to facilitate Cultural Conversations in their respective services and teams.	Health Equity/EDI	31.12.24	31.3.25	YES	Domain 3 (Link)	YES (Link)	YES (Link)
	Monthly promotion of the Cultural Conversations resources via MyLCH	Health Equity/EDI	31.12.24	31.3.25	YES	Domain 3 (Link)	YES (Link)	YES (Link)

*The delivery of work within the timescales outlined is based on the EDI team being appropriately resourced – currently carrying 2 vacancies.

Appendices B

Leeds Community Healthcare NHS Trust

Workforce Disability Equality Standard (WDES) Action Plan 2024/25

WDES Metrics	Description	Action	Measures	Timescale	Lead
1	The percentage of staff in each of the AfC Bands1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce	Promote the equality self-service function on ESR and promote the case to declare/update equality data to reduce the percentage of not stated on ESR.	A decrease the percentage of "Not stated" staff disability data held on ESR below *20*%.	31.3.2025	**EDI**
		Continue to work with, as part of the Leeds One Workforce (LOW) partnership, the Employer and Partnership Team (Disability Confident and Health Model) Dept for Work and Pensions to explore development for local unemployed Disabled people to gain work experience in the Trust.	Contribute to an overall increased number of applications and appointments from people with disabilities. Improvement on the 2023/24 WDES Metric score of 1.6. A relative likelihood below 1 indicates that non-disabled applicants are less likely to be appointed from shortlisting compared to Disabled applicants *(WDES Technical guidance)*	31.3.2025	**Recruitment and Resourcing**
		Share Business Unit staff with disabilities representation with General Managers to raise awareness of the disparity of representation	Annual reporting Increase awareness of staff with disabilities representation at Business Unit level	31.3.2025	**EDI**
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	Equality analysis of the recruitment process 2024/25 The findings and recommendations will be reported to the TLT	A relative likelihood below 1 indicates that non-disabled applicants are less likely to be appointed from shortlisting compared to Disabled applicants *(WDES Technical guidance)* The WDES Metric score in 2023 was 1.6.	By the end of Q1 2025.	**EDI**

WDES Metrics	Description	Action	Measures	Timescale	Lead
		Continued conversations with staff networks and other stakeholders to capture qualitative data that explores the underrepresentation across staff groups.	Two engagement sessions with both the Disability, Neurodiverse and Long-Term Conditions network and staff side reps to provide updates on this indicators performance and identify solutions for improvements	31.12.24 & 31.3.25	**EDI**
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	All recruiting managers to attend the Trust Recruitment and Selection Managers course & refresher courses	All recruitment panels comprise of at least one panel members who has attended the Trust Recruitment and Selection Managers course.	Ongoing Review 31.12.24	**EDI**
		Continue the facilitation of the Cultural conversations programme and the West Yorkshire Health & Care Partnership Cultural Competency and Humility training.	Increased likelihood of disabled staff being appointed across all posts. Each service to have two cultural conversations per year (Health Equity Strategy action)	Ongoing Review 31.12.24	**Health Equity and EDI**
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process	Promotion of Leeds Health & Care Academy (LHCA) Disability Awareness resources for staff development, these include but are not restricted to, - Unconscious Bias awareness - Disability Confident - Disability Etiquette - Disabled adventures in work and recruitment - Neurodiversity, an introduction - Mental Health in the workplace, managing stress. - Mental Health in the workplace, doing the right thing.	Increased access and completion of LCHA hosted Disability awareness learning. The WDES Metric score in 2023 was 0, a relative likelihood below 1 indicates that Disabled staff are less likely to enter formal capability processes compared to non-disabled staff: *(WDES Technical Guidance*)	Ongoing Review 31.12.24 31.3.25	**EDI**
	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process	Provide Wellbeing at Work Policy advice and guidance for Managers.	Improved NHS Staff Survey results	Ongoing Review 31.12.24 31.3.25	**Human Resources**
		Review number of formal ER cases twice per year and take corrective action as appropriate.	Reduction in number of formal ER cases	Ongoing (Review Sept & Mar each year)	**Human Resources**
4a(i)	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse, from the public in the last 12 months.	Ensure that advice & guidance on how to report bullying and harassment from patients, relatives, staff & managers is clear, concise, published and promoted to staff throughout the year. Promote importance of reporting any issues to Line managers and/or the Freedom to Speak Up Guardian.	A reduction of the percentage of staff experiencing harassment, bullying or abuse, from the public in the last 12 months, below the NHS Staff Survey results of 25.2% for disabled staff and 16.2% for non-disabled staff.	31.3.25 31.3.25	**EDI** **EDI**

WDES Metrics	Description	Action	Measures	Timescale	Lead
		Ensure that advice & guidance on how to report bullying and harassment from patients, relatives, staff & managers is clear, concise, published and promoted to staff throughout the year. Delivery of the Cultural conversations programme and the West Yorkshire Health & Care Partnership Cultural Competency and Humility training.		30.9.24 31.3.25	**EDI** **Health Equity and EDI**
4a(ii)	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from their managers in the last 12 months.	Ensure that advice & guidance on how to report bullying and harassment from patients, relatives, staff & managers is clear, concise, published and promoted to staff throughout the year. Promote importance of reporting any issues to Line managers and/or the Freedom to Speak Up Guardian. Ensure that advice & guidance on how to report bullying and harassment from patients, relatives, staff & managers is clear, concise, published and promoted to staff throughout the year. Delivery of the Cultural conversations programme and the West Yorkshire Health & Care Partnership Cultural Competency and Humility training.	A reduction of the percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from their managers in the last 12 months below the NHS Staff Survey results of 9.7% for disabled staff and 3.2% for non-disabled staff.	31.3.25 31.3.25 30.9.24 31.3.25	**EDI** **EDI** **EDI** **Health Equity and EDI**
4a(iii)	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.	Ensure that advice & guidance on how to report bullying and harassment from patients, relatives, staff & managers is clear, concise, published and promoted to staff throughout the year. Promote importance of reporting any issues to Line managers and/or the Freedom to Speak Up Guardian. Delivery of the Cultural conversations programme and the West Yorkshire Health & Care Partnership Cultural Competency and Humility training.	A reduction of the percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months below that of the 2023 NHS Staff survey of 13.6% for disabled staff and 8.5% for non-disabled staff. .	30.9.2025 30.9.24 31.3.25	**EDI** **EDI** **Health Equity and EDI**
4a(iv)	Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse. Saying last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months.	Promote importance of reporting any issues to Line managers and/or the Freedom to Speak Up Guardian. Continued development and implementation of No Bystanders initiative actions. Ensure that advice & guidance on how to report bullying and harassment from patients, relatives, staff	An increase in the percentage of staff saying last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months, from the 2023 NHS Staff Survey results of 53.6% for disabled staff and 60.6% for non-disabled staff.	30.9.24 31.3.25 30.9.24	**EDI** **EDI** **EDI**

WDES Metrics	Description	Action	Measures	Timescale	Lead
		& managers is clear, concise, published and promoted to staff throughout the year. Promote importance of reporting any issues to Line managers and/or the Freedom to Speak Up Guardian. Delivery of the Cultural conversations programme and the West Yorkshire Health & Care Partnership Cultural Competency and Humility training. Ensure that advice & guidance on how to report bullying and harassment from patients, relatives, staff & managers is clear, concise, published and promoted to staff throughout the year.		30.9.24 (Ongoing) 31.3.25 30.9.24	**FTSUG** **Health Equity and EDI** **EDI**
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Following the evaluation of the BME Talent Management Programme, explore the development and delivery of an Organisational Approach to Improving Talent Management (*Disability Development Programme)*	Increased representation across the banding hierarchy and leadership structure. Elimination unequal experiences at work, where some employees experience or perceive their career progression is limited by their protected characteristics.	End of Q4 24/25	**EDI/ODI**
6	Percentage of Disabled staff compared to nondisabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (presenteeism)	Provide Wellbeing at Work Policy advice and guidance to Managers.	A decrease in percentage of both disabled and non- disabled staff saying that they have felt pressure from their Manager to come to work, despite not feeling well enough to perform their duties (presenteeism) below that of the 2023 NHS staff survey results of 19.2% for disabled staff and 10.7% for non-disabled staff.	31.3.2025	**Human Resources**
7	Percentage of Disabled staff compared to nondisabled staff saying that they are satisfied with the extent to which the organisation values their work.	Promotion and release of staff to attend and actively participate in the *Disability, Neurodiversity and Long-Term Conditions staff network*.	An increase in the percentage of disabled staff and nondisabled staff saying that they are satisfied with the extent to which the organisation values their work of the 2023 NHS Staff Survey results of 50.4% for disabled staff and 57.2% for non-disabled staff.	31.3.2025	**EDI**
		Continue to provide an administrative resource and budget to the Disability, Neurodiversity and Long-Term Conditions staff network.		31.3.2025	**EDI**

WDES Metrics	Description	Action	Measures	Timescale	Lead
		Continued promotion of Mindful Employer status achieved and positive support around mental health. Continued promotion as a Menopause friendly Employer – highlighting the range of support available, managers awareness sessions and 1-1 support provided through OH provider.		31.3.2025 31.3.2025	**EDI** **EDI**
		Continued promotion that LCH is an Endometriosis Friendly Employer highlighting the condition and support available.		31.3.2025	**EDI**
		Achieve revalidation of the Disability Confident Leaders Accreditation		31.12.24	**EDI**
8	Percentage of staff with a long-lasting health condition or illness, saying that their employer has made adequate adjustments(s) to enable them to conduct their work	Wellbeing at Work Policy advice and guidance s for Managers Promote supporting guidance and Toolkit alongside the Policy	Improved NHS Staff Survey results 80% by 31/3/25 83% by 31/3/26	31.3.2025 Ongoing	**Human Resources** **Human Resources**
		(Action #23 -24/25) Achieve revalidation of the Disability Confident Leaders Accreditation		31.12.24	**EDI**
		Explore how Neurodiversity awareness training for all staff can be implemented		31.3.25	**EDI**
		Explore how Mandatory disability training for managers and staff can be implemented		31.3.25	**EDI**

APPENDICES C

Leeds Community Healthcare NHS Trust

Workforce Race Equality Standard (WRES) Action Plan 2024/25

WRES Indicators	Description	Action	Measures	Timescale	Lead
1	The percentage of staff in each of the AfC Bands1-9 and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce	Promote the equality self-service function on ESR and promote the case to declare/update equality data to reduce the percentage of unknown/not declared on ESR.	14.5% of LCH workforce identify as BME. 18% of LCH workforce identify as BME	31.3.2025 31.3. 2028	**EDI**
		Continue to work with, as part of the Leeds One Workforce (LOW) partnership, the Employer and Partnership Team (Disability Confident and Health Model) Dept for Work and Pensions to explore development for local unemployed people from minority ethnic groups to gain work experience in the Trust.	Contribute to an overall increased number of applications and appointments from people who identify as BME. Improvement on the 2023/24 WRES Metric score of 0.6. A figure below "1" would indicate that white candidates are less likely than BME candidates to be appointed from shortlisting. *(WRES Technical guidance)*	Ongoing – Update on progress 31.12.2024 31.3.2025	**Recruitment and resourcing**
		Share Business Unit BME representation with General Managers to raise awareness of the disparity of representation.	Annually Increase awareness of BME representation at Business Unit level	31.3.2025	**EDI**
		Continued conversations with staff networks and other stakeholders to capture qualitative data that explores the underrepresentation across staff groups and actions to improve indicator performance.	Two engagement sessions with both the Race Equality Network and staff side reps to provide updates and seek actions to improve this indicators performance.	31.12.2024 & 31.3.2025	**EDI**

APPENDICES C

WRES Indicators	Description	Action	Measures	Timescale	Lead
2	Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.	All recruiting managers to attend the Trust Recruitment and Selection Managers course & refresher courses	All recruitment panels comprise of at least one panel members who has attended the Trust Recruitment and Selection Managers course.	31.3.2025	**Recruitment and resourcing**
		Diverse recruitment panels – continue to promote and oversee the requirement for staff from across the Trust to be an equal panel member for recruitment of Band 7+ posts.	Increased BME representation at Band 7 and above.	31.3.2025	**EDI**
		Audit the BME Fair Recruitment process and present the findings and recommendations to the TLT.		27.2.25	**EDI**
2	Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts.	Promotion of Leeds Health & Care Academy (LHCA) learning resources for staff development, these include but are not restricted to, - Allyship - An Introduction to Intersectionality - Creating an environment based on Respect. - Cultural awareness in the workplace - Inclusion essentials - Inclusive language and communication - Inclusive leadership - Tackling race bias at work – a manager's guide - The effective bystander - The impact of micro behaviours in the workplace - Understanding race bias at work - Understanding unconscious bias	Increased access and completion of LCHA hosted learning resources related to race and ethnicity.	31.3.2025	**EDI**
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process. What is baseline starting from?	Continue the delivery of the Cultural conversations programme and the West Yorkshire Health & Care Partnership Cultural Competency and Humility training.	Increased likelihood of BME staff being appointed across all posts. Each service to have two cultural conversations per year (*Health Equity Strategy - TLT action)*	Ongoing Review 31.12.2024. 31.3.2025	**Health Equity and EDI**

APPENDICES C

Leeds Community Healthcare NHS Trust

WRES Indicators	Description	Action	Measures	Timescale	Lead
		Review number of formal ER cases twice per year and take corrective action as appropriate.	Reduction in number of formal ER cases	Ongoing, collate in Oct & Mar each year.	**Human Resources**
4	Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff.	Continued delivery of the BME Talent Development Programme.	Increased representation across the banding hierarchy and leadership structure. Elimination unequal experiences at work, where some employees experience or perceive their career progression is limited by their protected characteristics.	31.12.2024	**ODI**
		Continue to provide support to internationally recruited nurses as recognised by the International Nursing and Midwifery Pastoral Care Quality Award		31.3.25	**IRPSO**
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months	Continued capture of Datix reports relating to staff experiencing harassment, bullying from patients, relatives or the public to inform #Nobystanders activity and actions.	A reduction in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months as reported in the NHS Staff Survey 2023. *(17.7% BME, 18.8% White)*	31.12.2024 & 31.3.2025	**EDI**
		Ensure that advice & guidance on how to report bullying and harassment from patients, relatives, staff & managers is clear, concise and is published and promoted to staff throughout the year.		30.9.24	**EDI**
		Explore how Staff networks can be part of the process and be provided with training and support to better support and advise staff.		31.3.24	**EDI**
		Continue to provide support to internationally recruited nurses as recognised by the International Nursing and Midwifery Pastoral Care Quality Award		31.3.25	**IRPSO**

APPENDICES C

WRES Indicators	Description	Action	Measures	Timescale	Lead
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Continued delivery of the No Bystanders initiative actions	A reduction in the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months as reported in the NHS Staff Survey 2023. (*15.2% BME, 11.7% White)*	31.3.25	**EDI**
		Continued promotion of international, national, regional cultural awareness days & events.			**EDI**
		Continue to provide support to internationally recruited nurses as recognised by the International Nursing and Midwifery Pastoral Care Quality Award		31.3.25	**IRPSO**
7	Percentage believing that trust provides equal opportunities for career progression or promotion.	Diverse recruitment panels – continue to promote and oversee the requirement for staff from across the Trust to be an equal panel member for recruitment of Band 7+ posts.	Increased BME representation at Band 7 and above.	31.3.2025	**EDI**
		Audit the BME Fair Recruitment process and present the findings and recommendations to the TLT.		27.2.25	**EDI**
		Conduct an analysis of the 2024-25 recruitment process NHS Jobs data (application, shortlisting, and appointment) for all protected characteristics. Findings and recommendations to be reported to TLT.		31.6.25	**EDI**
8	In the last 12 months have you personally experienced discrimination at work from a manager or team	Continued delivery of the No Bystanders initiative actions	A reduction in the percentage of staff personally experiencing discrimination at work from a manager or team as reported in the NHS Staff Survey 2023. *(11.3% BME, 2.7% White)*	31.3.2025	**EDI**
			Number of patient and staff engagement messaging about #NoBystanders	31.3.2025	**EDI**

APPENDICES C

WRES Indicators	Description	Action	Measures	Timescale	Lead
8	In the last 12 months have you personally experienced discrimination at work from a manager or team	Delivery of Compassionate & Courageous leadership sessions for managers as part of the Managers Development Programme	Delivery of 10 session in 2024/25 Percentage of staff (including international staff) accessing. wellbeing support, counselling, FTSUG, PTSD support due to Racism	31.12.2025	**ODI**
9	BME board membership	Target BME organisations, recruiters, and community groups to publicise & promote NED roles opportunities.	Increased applications from BME candidates for NED role vacancies	31.3.2025	**EDI & Trust Board Secretary**

APPENDICES D

Leeds Community Healthcare NHS Trust

LCH NHS Staff Survey – Harassment, bullying or abuse at work data 2022,2023.

Red = more than 10% lower than the organisational percentage.

14a in the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives, or other members of the public (Never).				
Base Size			Score	
2022	2023		2022	2023
1,839	2,031	Organisation	76.60%	81.20%
22	23	Woodsley Neighbourhood Services	50.00%	60.90%
-	51	Wharfedale Recovery Hub	-	60.80%
19	22	Chapeltown Neighbourhood Services	73.70%	59.10%
11	12	Liaison & Diversion Humber	63.60%	58.30%
14	24	Yeadon Neighbourhood Services	64.30%	58.30%
23	34	Seacroft Neighbourhood Services	65.20%	52.90%
10	10	Children's Nursing Team	70.00%	50.00%
-	19	Admin Estates North & West	-	42.10%
11	10	HH Custody Suite	9.10%	40.00%
11	14	WY Custody Suite	36.40%	35.70%
-	15	Admin Estates Area 1	-	33.30%
14	13	SY Custody Suite	7.10%	23.10%

14b in the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers (Never).				
Base Size			Score	
2022	2023	Team	2022	2023
1,833	2,029	Organisation	94.20%	95.00%
45	37	LMWS	86.70%	86.50%
14	13	SY Custody Suite	85.70%	84.60%
11	12	QPD Practice & Prof Development	100.00%	83.30%
-	12	Community Discharge Assessment Team	-	83.30%
-	12	Facilities Management and Safety	-	83.30%
-	16	HR, CLaSS, and Recruitment	-	81.30%
19	18	Kippax Neighbourhood Services	89.50%	77.80%
21	13	Ican West	95.20%	76.90%
-	13	Ican Occupational Therapy	-	76.90%
11	12	Liaison & Diversion Humber	90.90%	75.00%
12	12	Wetherby Neighbourhood Services	100.00%	75.00%
17	17	Sexual Health Service	94.10%	70.60%

14c in the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues (Never).				
Base Size			Score	
2022	2023	Team	2022	2023
1,821	2,027	Organisation	90.10%	90.20%
-	10	CSLT Yellow Team	-	80.00%
18	18	Kippax Neighbourhood Services	83.30%	77.80%
22	18	Diabetes Service	90.90%	77.80%
-	22	NT Triage Hubs	-	77.30%
-	12	Community Discharge Assessment Team	-	75.00%
11	11	Liaison & Diversion Humber	72.70%	72.70%
21	29	Dental Services	95.20%	72.40%
21	21	Child CCare and Core Respite	90.50%	66.70%
11	10	HH Custody Suite	63.60%	60.00%
17	17	Sexual Health Service	70.60%	58.80%
14	12	SY Custody Suite	64.30%	58.30%
11	14	WY Custody Suite	90.90%	57.10%

Leeds Community Healthcare NHS Trust

		In the last 12 months how, many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives, or other members of the public?					In the last 12 months how, many times have you personally experience harassment, bullying or abuse at work from other colleagues?					In the last 12 months have you personally experienced discrimination at work from manager / team leader?				
		2019	2020	2021	2022	2023	2019	2020	2021	2022	2023	2019	2020	2021	2022	2023
National	Staff with one or more long lasting health conditions or illnesses	34.0%	31.6%	33.0%	33.1%	30.0%	26.4%	25.7%	25.3%	25.0%	23.8%	18.5%	18.6%	17.2%	16.4%	14.6%
	Staff without a long-lasting health condition or illness	27.1%	25.2%	25.8%	25.9%	23.3%	17.2%	16.8%	16.6%	16.6%	15.4%	10.8%	10.7%	9.8%	9.4%	8.2%
LCHT	Staff with one or more long lasting health conditions or illnesses	34.0%	31.0%	34.0%	34.0%	14.1%	19.0%	20.0%	20.0%	14.1%	13.6%	12.0%	15.0%	12.0%	8.8%	9.7%
	Staff without a long-lasting health condition or illness	22.0%	24.0%	22.0%	24.0%	8.6%	12.0%	11.0%	10.0%	8.6%	8.5%	5.0%	7.0%	7.0%	4.8%	3.2%

		In the last 12 months how, many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives, or other members of the public?					In the last 12 months how, many times have you personally experience harassment, bullying or abuse at work from colleagues?					In the last 12 months have you personally experienced discrimination at work from manager / team leader?				
		2019	2020	2021	2022	2023	2019	2020	2021	2022	2023	2019	2020	2021	2022	2023
National	Staff from all other ethnic groups combined	30.3%	28.9%	29.2%	30.4%	27.8%	28.4%	28.8%	27.6%	27.7%	24.9%	14.5%	16.7%	17.0%	16.6%	15.5%
	White staff	27.9%	25.9%	27.0%	26.8%	24.1%	23.6%	23.2%	22.5%	22.0%	20.7%	6.0%	6.2%	6.8%	6.7%	6.7%
LCHT	Staff from all other ethnic groups combined	21.0%	21.0%	23.8%	16.3%	17.7%	24.1%	24.8%	19.3%	12.9%	15.2%	17.9%	15.3%	13.7%	12.1%	11.3%
	White staff	26.5%	24.0%	26.4%	23.9%	18.8%	16.7%	16.4%	16.0%	12.8%	11.7%	4.3%	4.3%	4.3%	4.2%	2.7%

Agenda item:	2024-2025 (76)

Title of report:	**Significant Risks and Risk Assurance Report**

Meeting:	Trust Board
Date:	4 October 2024

Presented by:	Sam Prince, Deputy 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 is one risk on the Trust risk register that has a score of 15 or more (extreme). There are a total of 13 risks scoring 12 (very high).

Previously considered by:	Trust Leadership Team 25 September 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 (September 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 (September)
Total Open Risks	70	60
Risks Scoring 15 or above	1	2
New Risks	13	13
Closed Risks	3	4
Risk Score Increasing	1	3
Risk Score Decreasing	3	7
Risk Score Static > 3 months	18	18

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 (July 2024)
1048: Mind Mate Single Point of Access (SPA) increasing backlog of referrals (system-wide risk).	**15**	**15**
The risk score continues to be 15, the rationale being: Impact of 5 (catastrophic) due to the volume of children and young people on the waiting list for SPA (approximately 4000). There is a reliance on the referral information to triage priority and need and further reliance on families and other professionals to expedite referrals when circumstances change.		

Risk	Current Score	Previous Score (July 2024)
Likelihood of 3 (possible) as there is an increase of children and young people presenting elsewhere in the system (e.g. A&E) to respond to deteriorating conditions. Actions to manage/reduce the risk: The ICB acknowledge that phase 2 of the review has to be brought forward and urgent decisions need to be made to redesign the SPA to ensure it is fit for purpose with the capacity it has. The Quality and value work underway for CAMHS would need to be kept in mind as they are interdependent. The need to communicate the current position within SPA to families and the wider system has been agreed and an expedited phase 2 redesign process is due to commence. Of note, the current position will be discussed at population board level in July and in a joint ICB and LCH steering group. It is expected that further communications will be needed to families and the wider system as plans are agreed and changes take place. The aim is to reduce the risk to 12 by 31/3/25.		
1187 **Insufficient IT Resilience leading to the risk of extended outages of the infrastructure**	**12**	**16**
Risk reviewed in light of further digital risks added to the risk register and made consistent with these. Risk score reduced from 16 to 12. Rationale for reducing the likelihood from likely to possible is that there is evidence that the risk (major outage) does not occur weekly, but probably does occur more frequently than at least annually. Some of the simpler recommendations from the external resilience review are starting to be implemented and whilst they have not yet had an impact they will be re-reviewed to identify if these have impacted the consequence score.		

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	12	Unchanged
1042	Provision of equipment from Leeds Community Equipment Services (LCES)	12	12	Unchanged
1139	General risk of non-concordance with the overarching organisational process for medical devices	12	12	Unchanged

ID	Description	Rating (current)	Rating (previous)	Status
1169	Hoist, couch and slide sheet risk of non-compliance	9	12	Reduced
1171	Patient safety concerns in Yeadon Neighbourhood Team	12	12	Unchanged
1179	Impact/Management of Neurodevelopmental Assessment Waiting List	12	12	Unchanged
1187	Insufficient IT Resilience leading to the risk of extended outages of the infrastructure	12	16	Reduced
1198	Impact of ADHD medication waiting list	12	12	Unchanged
1199	The impact and management of the CYPMHS Therapies waiting list	12	12	Unchanged
1226	Quality and Value - financial balance not achieved	12	12	Unchanged
1230	Non-compliance with NHSE EPRR Annual Assurance process	12	12	Unchanged
1217	Digital and BI teams have insufficient capacity	12		New
1218	Lack of capacity in services to engage with digital transformation projects	12		New
1220	A large proportion of the population are digitally excluded	12		New

Nine 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 70. Of these there are 26 open clinical risks and 44 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	7	6	0	0	13
3 - Moderate	1	9	25	7	0	42
2 - Minor	0	3	8	1	1	13
1 - Negligible	0	0	1	0	0	1
Total	1	19	41	8	1	70

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, fifteen 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 health and safety, compliance with information governance and cyber security, and business continuity and emergency planning.	The BAF strategic risks directly linked to compliance with standards / legislation is: BAF Risk 4 Failure to be compliant with legislation and regulatory requirements BAF Risk 7 Failure to maintain business continuity (including response to cyber security)
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
Theme Five: Digital Transformation	

[1] Risks: 772, 913, 954, 957, 984, 994, 1015, 1042, 1043, 1048, 1112, 1179, 1198, 1199, 1211
[2] Risks: 877, 981, 1070, 1109, 1139, 1168, 1171, 1187, 1196, 1231
[3] Risks: 902, 1089, 1206, 1230
[4] 1226, 1227, 1228, 1229

Four risks relate to digital transformation, including capacity to deliver transformation[5]	The BAF strategic risk directly linked to digital transformation are: BAF Risk 3 Failure to implement the digital strategy BAF Risk 6 Failure to have sufficient resource for transformation programmes

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 6th December 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: 11 September 2024

[5] Risks: 1217, 1220, 1224, 1218

Agenda item:	2024-2025 (77)

Title of report:	Board Assurance Framework Quarterly Update

Meeting:	Trust Board
Date:	4 October 2024

Presented by:	Sam Prince, Deputy Chief Executive Officer					
Prepared by:	Helen Robinson, Company Secretary					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	It is a requirement for all Trust Boards to ensure there is an effective process in place to identify, understand, address, and monitor risks. This includes the requirement to have a Board Assurance Framework (BAF) that sets out the risks to the strategic plan by bringing together in a single place all the relevant information on the risks to the Board being able to deliver the organisation's objectives. As previously noted, following the agreement of the Trust's strategic objectives and priorities for 2024/25, the BAF will now be reviewed on a quarterly basis and the outcome shared with the Board. The updated BAF is attached at Appendix 1. The changes in red reflect the output of the first quarterly review which has taken place during August/September with the support of the Executive Directors and the Trust Leadership Team. Each strategic risk has been reviewed in terms of the following: o Operation of the current controls / whether any additional or gaps in controls need to be added o Progress against the actions o Impact of the actions on the score o Any further actions identified to reduce the risk to target o Whether there are any missing sources of assurance that need to be added. During Q2 a new cover sheet template for Committee and Board meetings has also been rolled out to include the reference to the appropriate strategic risks within the contents of the paper. The Board is reminded that the BAF is presented here for assurance on its completeness as of September 2024.

Previously considered by:	Trust Leadership Team 25 September 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)	The Board is asked to: • Receive the BAF and to be assured of the appropriateness of updates, including risk scoring and mitigating actions.

List of Appendices:	Appendix 1 – 2024_25_BAF_September2024

Board Assurance Framework (BAF) 2024/2025

Introduction

The Board Assurance Framework (BAF) provides the Board with a register of strategic risks that have the potential to impact on the achievement of the Trust's strategic objectives and gives assurances that the risks are being managed effectively. The Framework aligns strategic risks with the strategic objectives and highlights key controls and assurances.

Where gaps are identified, or key controls and assurances are insufficient to reduce the risk to acceptable levels (within the Trust risk appetite), action needs to be taken. Planned actions will enable the Board to monitor progress in addressing gaps or weaknesses and to ensure that resources are allocated appropriately.

Assurance

The Board receives the BAF quarterly. The risks aligned to the Board Committees are also reported to the relevant Committee bi-monthly, where the relevant Committee agrees a level of assurance for each risk.

The BAF provides the basis for the preparation of a fair and representative Annual Governance Statement. It is the subject of annual review by both Internal and External Audit.

Trust Objectives (Strategic Goals) with the underpinning 2024/25 Trust Priorities

Strategic Goal - Work with communities to deliver personalised care

- *Trust Priority: We will provide proactive and timely care that is person centred by ensuring the right service delivers the right care at the right time by the right practitioner.*

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

- *Trust Priority: To have a well led, supported, inclusive and valued workforce*

Strategic Goal – Collaborating with partners to enable people to live better lives

- *Trust Priority: We will develop a Leeds Community Collaborative in partnership to amplify the community voice and facilitate care closer to home.*

Strategic Goal - To embed equity in all that we do

- *Trust Priority –To ensure that the Quality and Value Programme has the least negative impact on those with the most need and positively impacts where possible.*

Strategic Goal - Use our resources wisely and efficiently both in the short and longer term

- *Trust Priority: To achieve the 2024/25 Trust's financial efficiency target through delivery of an effective Quality and Value Programme*

Risk Scoring

Each strategic risk is assessed (measured) in terms of consequence (how bad could it be) and likelihood (how likely is it to happen). The risk score is calculated by multiplying the consequence by the likelihood.

To maintain an objective and consistent approach across the organisation, the Trust's risk assessment matrix is used to 'score' each risk, see below:

LIKELIHOOD / CONSEQUENCE	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Catastrophic (5)	5	10	15	20	25
Major (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Minor (2)	2	4	6	8	10
Negligible (1)	1	2	3	4	5

Strategic Goals	1. Work with communities to deliver personalised care	2. Use our resources wisely and efficiently both in the short and longer term	3. Enable our workforce to thrive and deliver the best possible care	4. Collaborating with partners to enable people to live better lives
	5. To embed equity in all that we do			
Strategic Risks	**Risk 1 Failure to deliver quality of care and improvements:** If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm. **Quality Committee** (Exec Director of Nursing and AHPs)	**Risk 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)	**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)	**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)
	Risk 2 Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage. **Quality Committee and Business Committee** (Exec Director of Operations)	**Risk 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)		
	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)			
		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)		
	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)			
	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)			

Summary of Strategic Risks as of 09 September 2024

Ref	Strategic Risk	Lead Director(s)	Current Score (Sept 2024)	Target Score (2024/25)	Key changes since last review (Changes are highlighted in red on the individual strategic risk templates)
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.	Exec Director of Nursing and AHPs	16	12	The risk score remains at 16 until the outcomes of the Quality and Value programme are clearer. The target score has been reassessed and increased to account for Q&V being a 3-year programme. Two actions have been completed and moved into the controls, review of EQIA process and establishment of the Service Redesign Steering Group. Two new actions have been added relating to the CQC single assessment regime and development of statistical process controls.
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.	Exec Director of Operations	16	12	The risk score remains at 16 due to the size of the waiting lists and the need for Q&V actions to take effect. All actions are progressing. Q & V is a key action to mitigate this 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.	Exec Director of Finance and Resources	12	8	The risk score remains at 12, the actions are not progressed sufficiently to reduce the score at this point in the year. Actions due to complete in the next quarter following the approval of the digital strategy, are the development of a strategy implementation plan and business case for year 1 of the strategy.
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.	TLT	6	3	The risk score has reduced to 6, the Likelihood has reduced to 2 (unlikely) as the TLT considered that whilst the CQC single assessment framework implementation was in progress and a well-led review has been commissioned but not yet complete, the Trust has a CQC rating of Good and internal audit assurance has been provided in a number of areas of compliance.
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.	Executive Director of Finance and Resources	16	12	The risk score remains at 16 until the actions take effect. All actions are progressing. Q & V is a key action to mitigate this risk. It is not expected for the risk to reduce until the end of 2024/25.
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.	Exec Director of Operations	9	6	In-year transformation resources have been funded and the Quality and Value programme is underway. The risk score remains at 9 until the financial target has been reached. One new action has been added relating to a business case for recurrent transformation resource.
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.	Exec Director of Operations and Executive Director of Finance and Resources	12	8	There is no change to the score at this point in the year – working towards compliance with the NHSE Emergency Preparedness Resilience and Response (EPRR) annual assurance process and implementation of the actions arising from the IT resilience review.
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.	Director(s) of Workforce	12	9	There is no change to the score at this point in the year, progress of Q&V has not resulted in an increased score at this stage – assurance has been provided on the programme by Internal Audit who surveyed the staff, staff opinion was broadly positive. An action has been added to implement additional regular information on the programme.
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.	Medical Director	12	9	There is no change to the score at this point in the year – actions are ongoing in relation to embedding equity in the Q & V programme and strengthening governance and process for EQIA. Progress has been made in developing equity data and dashboards.
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.	Chief Executive	8	3	The risk score remains at 8 as the actions are in progress. Frameworks for collaboration are being explored. The Social Care Alliance Board is being established.

Board Assurance Framework Levels of Assurance

Details of strategic risks (description, ownership, scores)								Level of Assurance				
Risk		Risk ownership		Current risk score				Committee agreed level of assurance				
Strategic Goal(s)	Risk	Responsible Director(s)	Responsible Committee(s)	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	Additional Information
Work with communities to deliver personalised care	Risk 1 Failure to deliver quality of care and improvements: If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm.	DoN	QC	4	4	16			✓	✓		May 24 Quality Committee: There had been a lack of assurance drawn from the update from QAIG. Discussions on the output of QAIG to continue. July 24 Quality Committee: Assurance around waiting lists remained limited but otherwise reasonable assurance gained re: quality of services. Work regarding the info received from QAIG now in progress.
Work with communities to deliver personalised care	Risk 2 Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage.	DoO	QC/BC	4	4	16			✓	✓		April 24 Business Committee: This was deemed as reasonable assurance on this occasion as no information on waiting list data was reviewed in the meeting, however the Committee is mindful of the Board's concerns in this specific area. May 24 Quality Committee: Limited assurance due to the waiting lists situation. July 24 Quality Committee: Still lacking assurance around waiting lists and the risks associated with those waiting for various services. Would welcome a position statement in September 2024. July 24 Business Committee: 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.
Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do	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.	DoF	QC/BC	3	4	12			✓	✓		
Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do	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.	TLT	QC/BC/TB	2	3	6				✓		

Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do	**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.	DoF	BC	4	4	**16**			✓			April 24 Business Committee: Due to the Internal Audit 'Limited' assurance report on the Management of Non-Healthcare Contracts. June 24 Business Committee: Due to the position on procurement, in particular, the lack of assurance around active contract management and areas of the business not being sighted on renewal dates/penalties etc
Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do	**Risk 6 Failure to have sufficient resource for transformation programmes:** If there is insufficient resource across the Trust to deliver the Trust's priorities and targeted major change programmes and their associated projects then it will fail to effectively transform services and the positive impact on quality and financial benefit may not be realised.	DoO	BC	3	3	**9**				✓		April 24 Business Committee: The challenge of having sufficient resource to deliver the Quality & Value Programme was noted.
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 7 Failure to maintain business continuity (including response to cyber security):** If the Trust is unable to maintain business continuity in the event of significant disruption then essential services will not be able to operate, leading to patient harm, reputational damage and financial loss.	DoO/DoF	BC/AC	3	4	**12**				✓		
Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do	**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.	DoW	BC	3	4	**12**				✓		
Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do	**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.	MD	QC/TB	4	3	**12**				✓		July 24 Quality Committee: Reasonable assurance overall but Committee agreed it was limited assurance for the data presented in the QAIG Mortality Reports.
Collaborating with partners to enable people to live better lives / To embed equity in all that we do	**Risk 10 Failure to collaborate:** If the Trust does not work in partnership with other organisations, then systems will not provide a single offer for patients or achieve the best outcomes for all.	CEO	TB	2	4	**8**						

Strategic 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.

Strategic Objective: Work with communities to deliver personalised care / To embed equity in all that we do

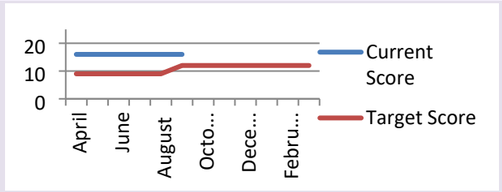
Risk Appetite: Minimal (low) to **cautious (moderate)** appetite to risk that could compromise the delivery of high quality, safe services.

Lead Director/risk owner: Executive Director of Nursing and Allied Health Professionals

Committee with oversight: Quality Committee

Date last reviewed: 6 September 2024

Risk Rating
(likelihood x consequence)
Current score:
4 x 4 = 16
Target score (end of 2024/25):
3 x 4 =12



Rationale for current risk score:
With the current Quality and Value (Q&V) programme and the need to deliver a significant financial saving alongside capacity and demand issues the delivery of quality care and improvement in an equitable way will be very challenging. This could mean decreases in quality of care and potential increases in patient harm.
Risk score remains at 16 until the outcomes of Q&V are clearer.
Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
This risk is currently very high as we embark on the Quality and Value programme as we do not yet understand exactly what changes will be made to patient pathways and the potential impact of this in relation to quality. As the programme develops this risk should decrease but it is possible it will take longer than 12 months. In accordance with this the target has been increased from 9 to 12 to account for Q&V being a 3-year programme.

Controls *(what are we currently doing about the risk?)*:

- Learning and Development Strategy
- Annual Clinical Audit Programme
- Performance Monitoring
- Health Equity Strategy
- Clinical Risk Management
- Infection Prevention and Control (IPC) Strategy
- Patient Safety Incident Response Framework (PSIRF)
- Research and Development Strategy
- CQC preparedness and single assessment framework processes
- Patient Safety Partners playing active part in Trust safety
- Service re-design steering group
- Additional short-term resource to develop and embed EQIA processes
- Trust movement to Statistical Process Controls (SPC) reporting including safety domains
- Clinical Supervision
- Quality Challenge & Process
- Quality Strategy
- Engagement Principles
- EQIA process
- Safeguarding Strategy

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
Need to establish and embed the newly formed Service Redesign Steering Group of which the Director of Nursing and AHP's is the chair.	Director of Nursing and AHP's.	31/8/2024 – Completed
Review the current EQIA process to ensure it is robust and captures the additional risks associated with service redesign and the Quality and Value Programme.	Director of Nursing and AHP's.	31/7/2024 – Completed
Development and embedding of Statistical Process Controls (SPC)	Director of Finance and Resources	End 2024/25
Implementation of the new CQC single assessment regime	Director of Nursing and AHP's.	March 2026

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
• IPC Board Assurance Framework • Clinical Governance report • Health Equity report • (Patient) Engagement report • Service spotlights at Committee • Business cases for new service or service transformation (quality scrutiny) • Patient safety (including patient safety incident investigations) update report • Safeguarding annual report • Learning and development report • IPC Annual report • Quality Account • Patient Group Directions • Children's strategy	• Performance Brief (safe, caring effective) • Mortality report • QAIG assurance report, flash report and minutes • Risk report • Safeguarding Committee minutes	• Internal audit report • PLACE inspection report • Patient experience report: complaints, concerns, and feedback

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
Ensuring feedback from EQIA process – needs to be included in the Clinical Governance report routinely in the future.	Director of Nursing and AHP's.	30/6/2024.- completed – in July QC report onwards
EQIA – develop clear oversight by clinical Directors and appropriate escalation through corporate governance processes	Director of Nursing and AHP's.	31/12/24

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1139: General risk of non-concordance with the overarching process for medical devices (12)
Risk 1042: Provision of equipment from Leeds Community Equipment Services (12)
Risk 1125: National supply issues with enteral feeding supplies (9)
Risk 1128: Quality and Value – negative impact on the patient (9)

Strategic 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.

Strategic Objective: Work with communities to deliver personalised care / To embed equity in all that we do

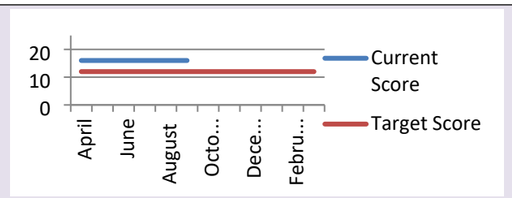
Risk Appetite: Minimal (low) to **cautious (moderate)** appetite to risk that could compromise the delivery of high quality, safe services.

Lead Director/risk owner: Executive Director of Operations

Committee with oversight: Quality and Business Committees

Date last reviewed: 28 August 2024

Risk Rating
(likelihood x consequence)
Current score:
4 x 4 = 16
Target score (end of 2024/25):
3 x 4 = 12



Rationale for current risk score:
Waiting lists have backed up during covid and there is increased demand for most services. The Trust has been unable to make significant impact on waiting lists. NHSE has mandated that there should be no 52-week waiters which increases the risk in relation to financial consequences and reputational damage.
Risk score remains at 16 due to the size of the waiting lists and the need for Q&V actions to take effect.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Ultimately the risk appetite is 3 – the identified mitigations will begin to reduce the waiting lists however tactical actions to improve financial position may have consequence on waiting lists.

Controls *(what are we currently doing about the risk?)*:

- Waiting list management and clinical triage within each service
- Communication with patients
- Incident monitoring and analysis
- Demand and capacity planning tool
- Continued support of 'harder to engage' populations through existing services
- Cancelled and rescheduled visits monitoring and action
- Commissioner involvement at Contract Management Board
- Performance panels
- Business continuity plans
- Winter plan 2024/25
- Review of capacity in Neighbourhood teams
- Front of House training for awareness of hearing and sight impediments – 4 sessions / year
- Neurodiversity assessments waiting list – right to choose offered to parents

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
Waiting list audit action plan (2023)	Executive Director of Operations	2024/25
Implementation of e-allocate – delayed due to compatibility issues with SystmOne	Executive Director of Operations	Testing end May Roll out delayed to March 2025
Transformation programme: improving prioritisation and flow (part of Q&V)	Executive Director of Operations	2024/25
Service review as part of Quality and Value Programme, review of access criteria and ways of providing services, in particular in Neighbourhood Teams and CYPMHS.	Executive Director of Operations	~~2027/28~~ 2024/26
MindMate Single Point of Access – joint work with third sector re alternative single point of access	Executive Director of Operations	31 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
• Service spotlight/focus (QC/BC) • Business cases (BC) • Change programme report (BC) • Performance panel (BC) – Sept 2024 BC position statement on waiting lists	• Risk register report (QC/BC) • Patient Safety (including patient safety incident investigations) update report (QC) • Performance Brief (Responsive: waitlists) (QC/BC) • Cancelled and rescheduled visits report (QC) • Mortality report (QC) • Safe staffing report (QC/BC) • Significant contracts performance (BC) • Health Equity report (QC/BC)	• Patient Experience report (complaints, concerns, claims) (QC) • Internal audit (BC)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
Accessibility data (diversity) – internal audit report	Executive Director of Operations	2024/25

Link to Risk Register (material operational risks scoring 9 or above):

Risk 1048: Mind Mate SPA increasing backlog of referrals (system-wide risk) (15)
Risk 877: Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand (12)
Risk 1171: Patient safety concerns in Yeadon Neighbourhood Team (12)
Risk 1179: Impact/Management of Neurodevelopmental Assessment Waiting List (12)
Risk 1199: The impact and management of the CYPMHS therapies waiting list (12)
Risk 1198: Impact of ADHD medication waiting list (12)
Risk 984: Long-term six-week waiting list breach risk in children's audiology as a result of capacity v's demand non-alignment (10)
Risk 913: Increasing numbers of referrals for complex communication assessments in ICAN service risks breaching waiting time target. (9)
Risk 957: Increase in demand for the adult speech and language therapy service. (9)
Risk 1211: Leeds Mental Wellbeing Service – Significant delays in service responding to referrals (9)
Risk 954: Diabetes service waiting times (9)
Risk 994: Waiting times for community dental services (9)
Risk 1015: Delays in treatment for podiatry patients due to demand outstripping capacity (9)
Risk 1043: Service delivery risk for CAMHS Transitions service (9)
Risk 1112: Looked after children offer (9)

Strategic Risk 3:
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.

Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do

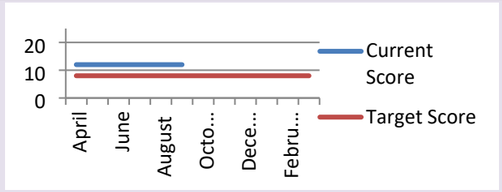
Risk Appetite: Open (high) risk appetite in pursuing innovation and challenging current working practices without compromising the quality of patient care. In the implementation of changes, the Trust has a **cautious (moderate)** risk appetite.

Lead Director/risk owner: Executive Director of Finance and Resources

Committee with oversight: Quality and Business Committees

Date last reviewed: 3 September 2024

Risk Rating
(likelihood x consequence)
Current score:
3 x 4 = 12
Target score (end of 2024/25):
2 x 4 = 8



Rationale for current risk score:
3-year digital strategy is in development with first draft expected May 2024. Outputs from externally commissioned reviews will influence priorities and implementation plan Timescales for implementation plan will be subject to affordability and will need to be considered alongside other competing priorities.
Actions not progressed sufficiently to reduce the score at this stage.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Target score assumes mitigating actions are completed within the timelines identified below and implementation of the strategy is progressing against agreed milestones.

Controls *(what are we currently doing about the risk?)*:

- Developing a refreshed Digital strategy and delivery plan.
- Established a new Digital Programme Board with links to Quality and Value Programme Data
- Secured Frontline digitisation investment to support implementation of a number of key priorities
- Commissioned external reviews to inform strategy refresh.
- Digital maturity assessment/ What good looks like assessment
- Independent IT resilience review completed
- IT Contracts register

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
Refreshed Board approved digital strategy Presented to the Board for approval – October 2024	Executive Director of Finance and Resources	Q1 2024 Oct Board
Board approved refreshed Strategy Implementation Plan and Outcome Measures Strategy implementation plan and Business Case (year 1) to be developed following approval of the strategy in October 2024.	Executive Director of Finance and Resources	~~Q2 2024~~ Dec Committee / Board
IT Contracts register & robust arrangements for the contract management of systems and services Contracts register is complete, contract management arrangements being developed.	Executive Director of Finance and Resources	~~Q1 2024~~ Q4 2024
Medium Term Financial Plan (to assess affordability of digital strategy beyond) – due date aligned to WY ICS process	Executive Director of Finance and Resources	~~Q2~~Q3 2024
Developed outline cases for investment in readiness for bids against national funding streams	Executive Director of Finance and Resources	Q3 2024

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
• Digital strategy progress report (BC / QC)	• Risk register (BC/QC) • Performance Brief (use of data to provide meaningful information) (BC/QC) • Digital maturity assessment analysis	• Internal audit (BC/QC)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
CCIO reports to Quality Committee and Business Committee, to be agreed and developed as part of the outcome measures for the Strategy Implementation Plan. Strategy implementation plan to be developed following approval of the strategy in October 2024.	Executive Director of Finance and Resources & Executive Medical Director	~~Q2~~ ~~2024/25~~ Q3
Leeds City Digital Board and links to the Programme Executive Group for visibility and priority sharing.	Executive Director of Finance and Resources	Q3 2024

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1217: Digital and BI teams have insufficient capacity (12)
Risk 1218: Lack of capacity in services to engage with digital transformation projects (12)
Risk 1220: A large proportion of the population are digitally excluded (12)
Risk 1223: Inadequate wide area network infrastructure (9)
Risk 1224: Lack of permanent third line IT support (9)

Strategic 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.

Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

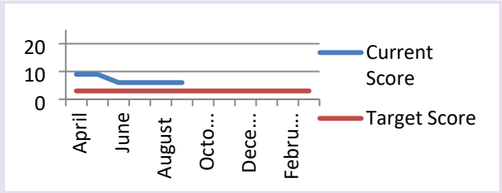
Risk Appetite: Minimal (low) to **cautious (moderate)** appetite to risk that could result in non-compliance and reputational damage. The Trust has no appetite for non-compliance with NHS Employers standards, fraud or financial loss.

Lead Director/risk owner: Trust Leadership Team

Committee with oversight: Quality and Business Committees

Date last reviewed: 4 September 2024

Risk Rating
(likelihood x consequence)
Current score:
2 x 3 = 6
Target score (end of 2024/25):
1 x 3 = 3



Rationale for current risk score:
Until the new CQC single assessment framework has been implemented and embedded, and an external well-led review undertaken, it is difficult to state how compliant the Trust currently is for 2024/25.
The Likelihood has reduced to 2 (unlikely) as the TLT considered that whilst the CQC single assessment framework implementation was in progress and a well-led review has been commissioned but not yet complete, the Trust has a CQC rating of Good and internal audit assurance has been provided in a number of areas of compliance. The overall score has therefore reduced to 6.
Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
By the end of the financial year, it is anticipated that better oversight will have been achieved and any recommendations actioned, so the likelihood of non-compliance will have reduced.

Controls *(what are we currently doing about the risk?)*:

- Quality Challenge+ (action plans)
- Quality Account
- Premises Assurance Model
- Medical staff appraisal process
- Professional registration procedures
- Mortality review process
- Safeguarding Strategy
- Duty of candour monitoring process
- Information Governance compliance
- Care Act compliance
- Health and Safety management system
- Quality Improvement Plans - in response to external reviews
- Statutory & Mandatory Training compliance
- Compliance with Civil Contingency Act 2004 (EPRR arrangements)
- Seeking legal advice and acting upon it where needed
- People policies are compliant with employment law
- NICE guidance monitoring
- Recruitment and selection procedures
- Membership of collaboratives with system partners
- Code of Governance/Provider licence compliance
- Emergency Preparedness, Resilience and Response (EPRR) framework
- Patient safety incident response framework (PSIRF)
- Environment Act Compliance (Sustainability plan)
- HR conferences to review new case law impact on policies

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
To commission an external well-led review Procurement complete – review to take place Oct/Nov	Chief Executive Officer	End of ~~Q2~~Q3
Implementation of the new CQC single assessment regime	Executive Director of Nursing and Allied Health Professionals	March ~~2025~~ 2026 – to operationalise the new regime

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
• Clinical Governance report • Patient safety and serious incident report • Safeguarding report/minutes • Quality Strategy report • Premises Assurance Model update • Health and Safety compliance report • CEO report to Board • Sustainability report • Employee relations report (Board) • Workforce report • IPC BAF Report • Information Governance Reporting • Code of Governance compliance report	• Performance brief (statutory compliance) • MHLDA Committees in Common minutes and report • NICE guidance compliance • Mortality report • Emergency Planning quarterly updates and annual report • Medical Director's Report (appraisals info) • Annual report to Board	• CQC system assessment reports • Internal audit

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
Determine the types and frequency of reports from ICB and Leeds Committee. Included in the CEO report to Board	Chief Executive Officer	Complete

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1089: Children Looked After – Initial Health Needs Assessment (9)

Strategic Risk 5:
There is a risk that the Trust will not be financially sustainable which will jeopardise delivery of all our strategic goals and priorities

Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do

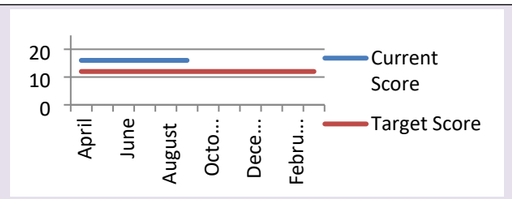
Risk Appetite: Open (high) appetite to the financial risk associated with new expenditure plans for existing services as the benefits for patient care may justify the investment. For investment in new services, the Trust's risk appetite is **cautious (moderate)** if the benefits to existing patients cannot convincingly be demonstrated.

Lead Director/risk owner: Executive Director of Finance and Resources

Committee with oversight: Business Committee

Date last reviewed: 3 September 2024

Risk Rating
(likelihood x consequence)
Current score:
4 x 4 = 16
Target score (end of 2024/25):
3 x 4 = 12



Rationale for current risk score:
The scale of financial challenge for 2024/25 is significant, the Quality and Value programme is still relatively immature and schemes to release efficiency savings are not yet developed. Whilst redesign of key systems and processes to support delivery of the financial plan is underway this is a considerable organisational change programme and will take time to embed.
Score remains at 16 until actions take effect – end of 2024/25

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months)
By the end of the financial year the Q&V programme will be more mature, and we will have a medium-term financial plan (MTFP) that will set out the likely scale of financial challenge over the next 3-5 years. Development of the MTFP will be reliant upon clarity of Trust, Place and ICS Strategies.

Controls *(what are we currently doing about the risk?)*:

- Board Approved Annual Plan, revenue, and capital
- Financial controls including budgetary controls are in place with routine performance monitoring and assessment of financial risk/mitigations to inform achievement of the financial plan
- Staff Cost Controls including ECF Process, agency, and temporary staffing controls in place
- Financial Policies (incl. but not limited to SFIs/ Scheme of Delegation / Investment Policy)
- Training programme for Non-Finance Managers commissioned and being rolled out
- Quality & Value Programme Established
- Budget Setting Process & Procedures clearly defined.

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
The Quality & Value Programme needs to mature and clear plans for the delivery of savings needs to be in place.	EDO	End Q2
Achievement of HFMA Level 4 Financial Sustainability Awaiting national guidance on MTFP assumptions, embedding culture and training and embedding Q&V to identify recurrent savings and establishing a rolling programme for year2 and year 3 savings.	EDFR	~~Q2 2024~~ Q3 2024
Leeds ICB co-ordinated system transformation and commissioner disinvestment plans are required to inform the MTFP aligned with West Yorkshire timescales	CEO	Q3 2024
Development of a LCH Medium-Term Financial Plan (Capital & Revenue) to inform 3-year Q&V programme – timing linked to requirement of Q&V programme to mature – due date changed to Q3	EDFR	Q2~~3~~ 2024
Investment policy requires review – completion delayed to Q4 2024/25	EFDR	~~Sept 24~~ Jan 25
Refresh of Performance & Accountability Framework required - work has commenced and changes have been implemented. Further work includes the Well Led review, Board workshop in November. Action not expected to complete until the end of the financial year.	EFDR	~~Q2 24~~ End 24/25

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
• Procurement Strategy update report • Performance Panel process • Quality & Value Programme Board reporting	• In Year Financial reporting (performance against plan and forecast out-turn) • Financial performance summary report on formal partnerships • Risk register report • Audit Committee – Reporting of compliance with policies and self-assessment arrangements for financial sustainability	• Internal audit – incl. annual assessment of Key Financial Controls • External Audit – Value for Money Assessment • Benchmarking information e.g. Reference Costs, Corporate Benchmarking • ICS system oversight

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
Review and strengthening of sources of assurance required:		
Enhanced financial performance reporting including progress against the Q&V programme, risk based forecasting and underlying financial position to support oversight assurance Partly completed – more on risk based forecasting and underlying financial position needed.	EDFR	~~July 2024~~ End Q3
Refreshed strategic implementation plan for Procurement to support service level assurance	EDFR	~~July 2024~~ Q3
Improve service level assurance based on the refresh of the Performance and accountability framework. Due date amended to align with the action to refresh the framework.	EDFR/COO	~~Q2 2024~~ End 24/25

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1226: Quality and Value – financial balance not achieved (12)

Strategic 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.

Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do

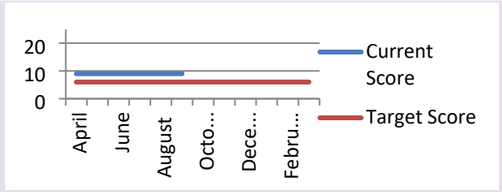
Risk Appetite: Open (high) appetite to the financial risk associated with new expenditure plans for existing services as the benefits for patient care may justify the investment. For investment in new services, the Trust's risk appetite is **cautious (moderate)** if the benefits to existing patients cannot convincingly be demonstrated.

Lead Director/risk owner: Executive Director of Operations

Committee with oversight: Business Committee

Date last reviewed: 28 August 2024

Risk Rating
(likelihood x consequence)
Current score:
3 x 3 = 9
Target score (end of 2024/25):
2 x 3 = 6



Rationale for current risk score:
We are yet to finalise the required resource against the required programmes (transformation).
Programme is underway, not yet reached the financial target – the score remains at 9

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Resourcing will be prioritised during 2024/25.

Controls *(what are we currently doing about the risk?)*:

- Estate Strategy
- Quality Improvement Strategy
- Third sector strategy work
- Quality & Value Programme and timeframes
- Change Board oversight of major change programmes
- Business Development and Change Service
- Environmental impact assessments
- Systems working – intermediate care redesign
- Alliance Board – LCH and Leeds City Council
- Review process for response to tenders (includes opportunities for transformation resource)
- Quality & Value Vacancy Control Panel
- Funded establishment for transformation resources (in year)
- Digital strategy
- Greener plan
- Partnership arrangements

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
Not nailed down prioritisation of Q&V over other projects – prioritisation of projects	Executive Director of Operations	Complete
TLT has agreed additional resource where expertise is required – completion of recruitment	Executive Director of Operations	Complete
Business case for recurrent transformation resource	Executive Director of Operations	November 2024

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
• Estates Strategy update reports (BC) • Digital strategy update reports (BC) • New business cases (QC/BC) • Major change programme updates on individual programmes (BC) • Priorities report (Board) • Business development report (BC) • Sustainability reports (BC)	• Consolidated reports on all major projects (Change Board) (BC)	• Internal audit report (BC) • IA review of Q&V programme (significant assurance) (BC)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1229: Quality and Value – impact on corporate staff (9)

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

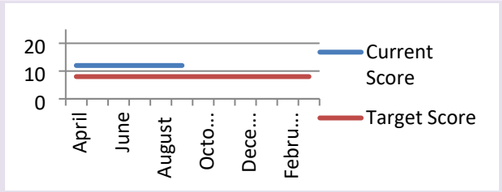
Risk Appetite: Cautious (moderate) appetite for risks relating to its reputation, the Trust's appetite is to ***avoid* risk *(*zero appetite*)*** of financial loss and **minimal (low)** to **cautious (moderate)** appetite to risk that could compromise the delivery of high quality, safe services.

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: 28 August 2024 (Executive Director of Operations) 3 September 2024 (Executive Director of Finance and Resources)

Risk Rating
(likelihood x consequence)
Current score:
3 x 4 = 12
Target score (end of 2024/25):
2 x 4 = 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).
No change to the score at this point in the year – working towards compliance with the NHSE EPRR annual assurance process and implementation of the actions arising from the IT resilience review.

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
- Trust command structure (Gold, Silver, Bronze)
- Business Continuity Plans (and IT disaster recovery plans)
- Information Governance Approval Group
- Data back-up systems
- Technical controls: Software patching regime, smooth walls and firewalls, NHS Digital Advance Threat Protection Service, Multi Factor Authentication
- 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
- On-call rota and on-call escalation procedure

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	Complete
EPRR compliance level -risk added to Risk Register in relation to non-compliance with NHSE EPRR annual assurance process. IA assurance on the workplan to achieve compliance by 2025/26	Executive Director of Operations	Q3 ~~2024/25~~ 2025/26
Limited internal "specialist cyber" capacity unable to meet demand Re-procurement for cyber incident response retainer completed. Awaiting decision from Q&V (discretionary spend) panel due 09/09/24, before placing contract through G-Cloud 13 Framework contract	Executive Director of Finance and Resources	~~August~~ September 2024
Implement recommendations of latest Penetration Test. All high recommendations have been completed by Head of IT. Penetration test is repeated 6-monthly (see controls)	Executive Director of Finance and Resources	Complete
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)	Dec 2024
Updated Cyber Incident Response Plan Plan has been updated – pending approval	Executive Director of Finance and Resources	~~June 2024~~ Dec 2024
Engagement with contractor "Dark Armour" to provide assurance around cyber security / resilience	Executive Director of Finance and Resources	Mar 2025

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1187: Insufficient IT Resilience leading to the risk of extended outages of the infrastructure (16)
Risk 1230: Non-compliance with NHSE EPRR Annual Assurance process (12)
Risk 1240: Adverse weather – continuity of service delivery (9)

Strategic 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.

Strategic Objective: Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

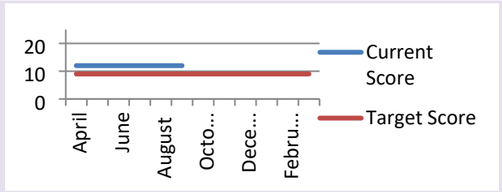
Risk Appetite: Avoid (zero risk appetite) noncompliance with NHS Employers Standards, employment fraud or lapses in professional qualifications. The Trust has an **open (high)** risk appetite to for learning and development opportunities which allows it scope to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work. **Minimal (low)** appetite to risks to staff safety and non-compliance with statutory and mandatory training requirements.

Lead Director/risk owner:
Director(s) of Workforce (DoW)

Committee with oversight: Business Committee

Date last reviewed: 9 September 2024

Risk Rating
(likelihood x consequence)
Current score:
3 x 4 = 12
Target score (end of 2024/25):
3 x 3 = 9



Rationale for current risk score:
There is currently uncertainty about the outcome of service reviews that will deliver from the Quality and Value programme.
Score remains the same, progress of Q&V has not resulted in increased risk.at this stage

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
By the end of 2024/25 we will have more certainty of the progress of the Quality and Value programme and controls will have had the opportunity to take effect.

Controls *(what are we currently doing about the risk?)*:

- Workforce strategy – implementation and monitoring
- Workforce planning, including the maintenance of long-term talent pipelines, including BME programme
- Enhanced Vacancy control process – safeguards clinically essential roles
- Business unit workforce plans
- Apprenticeship scheme
- Guardian for safe working hour's role
- Digital tools for efficiency: e-rostering, e-Allocate
- Performance panel scrutiny and case conferences for longest standing/highest complexity absence cases
- Workforce and staffside expertise on Q&V programme board and relevant workstreams
- Staffside engagement through JNCF and JNC
- Engagement with staff networks
- Ask Selina – online questions to CEO
- Series of health and well-being initiatives
- Freedom to Speak Up Guardian and Champions
- WRES and WDES action plans
- Staff survey locally owned action plan and corporate actions
- Coaching and mentorship schemes
- Leaders Network
- Approach to leadership development
- Approach to Talent Management
- Organisational change policy

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
Q&V measures to monitor the human factors associated with change (Q&V). Audit of staff opinions carried out by Internal Audit – broadly positive, staff wanted additional regular information – regular bitesize Q&V updates being implemented – due by end Oct 2024	Head of Strategy, Change and Development	~~June 2024~~ Complete End Oct 2024
Contingency planning for workforce	DoW	
Refresh of organisational change policy	DoW	July 2024 Complete

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
• Workforce report (3 x per year) • Q&V assurance report • Annual Equality and Inclusion Report • Employee relations activity report • Freedom to Speak Up Guardian reports • CEO report to Board • Service spotlight/focus	• Performance Brief (staff turnover figures, recruitment timescales, sickness absence, appraisal rate) • Safe staffing report • Guardian for safe working hours report • Priorities Quarterly Report • Quarterly and annual staff survey results • Business Committee workforce workshops	• Internal audit • Staff survey results report – leadership • Internal Audit of Q&V programme

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by

Link to Risk Register (material operational risks scoring 9 or above):
Risk 981: Insufficient awareness and application of constant supervision at WYOI (9)
Risk 1070: Capacity pressures in Neighbourhood Teams impacting ability to deliver full range of clinical supervision, statutory/mandatory and clinically essential training, and annual appraisals (9)
Risk 1227: Quality and Value – negative impact on staff (9)

Strategic 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.

Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

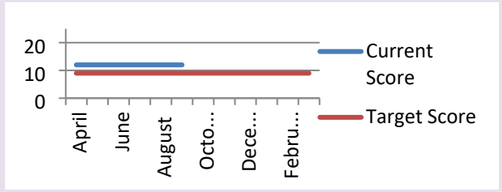
Risk Appetite: open (high) risk appetite for collaboration with people and communities to ensure their experience influences equitable approaches to change, such as for the Quality and Value Programme. Priority will be given to changes that protect equity and the Trust has a **cautious (moderate)** risk appetite for risk that may compromise the delivery of outcomes but are inclusive of an equity focus.

Lead Director/risk owner: Medical Director

Committee with oversight: Quality Committee / Trust Board

Date last reviewed: 5 September 2024

Risk Rating
(likelihood x consequence)
Current score:
4 x 3 = 12
Target score (end of 2024/25):
3 x 3 = 9



Rationale for current risk score:
- Likely as inequity is (inadvertently) embedded within existing systems and processes and therefore continuation of business as usual is likely to create inequity.
- We have identified some areas where inequality exists in our current services and processes but do not yet have a full understanding of all areas and therefore cannot yet take action to reduce inequality in these areas.
- Consequence is both outcomes for population at risk of inequity and consequence for the Trust (e.g. for failure to comply with statutory duties relating to equity)
- Work has begun to embed action to address inequity, but change is slow for such a pervasive issue

No change to the score at this stage – actions ongoing

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
- With financial factors at play it will take concerted effort to maintain the current risk score, but we should be aiming to reduce the likelihood of inequity.

Controls *(what are we currently doing about the risk?)*:
- Elevation of the equity agenda to a Trust strategic objective
- We have a strategy and action plan and links with Quality and Value programme
- Programmes of work delivering on statutory duties
- Development of measurement framework for equity

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
Further embedding equity in Quality and Value Programme	Health Equity Lead	Ongoing
Strengthen governance and process for EQIA	Head of Clinical Governance, Director of Nursing / Medical Director	~~Q2~~ Ongoing
All-level sign-up to implement action plans around statutory duties (Equality Delivery System, Armed Forces Covenant, NHSE statement on inequalities, Patient and Carer Race Equality Framework (PCREF)) We have achieved the Armed Forces Covenant accreditation and continue to work on Equality Delivery System and EQIA. We are working with partners to develop and deliver a plan to implement the PCREF and a paper is going to TLT with a proposal for the additional resource needed to deliver on the Reasonable Adjustments and a more coordinated approach to Accessible Information Standards.	Medical Director	~~Q2~~ Ongoing
Consistency in availability, analysis, and use of data: Board and Committee reporting include equity analysis and mitigating action; revised equity data dashboard/provision, to meet the requirements of the NHSE statement on inequalities. Progress is being made – dashboard measures agreed, committee / board data recorded	Chairs of relevant Committees Head of Business Intelligence	2024/25
Co-ordination of the programme and associated activity to address inequity and deliver statutory duties needs to be sufficiently resourced	TLT	Ongoing

Assurances *(how do we know if the things we are doing are having an impact?)*:

4. Service Level Assurance	5. Specialist Support / Oversight Assurance	6. Independent Assurance
• Equity report (statutory duties) to QAIG • Service/Business Unit performance reporting including focus on equitable approaches to waiting lists	• Report to Board including equity measurement framework	• Internal audit • External reporting on statutory duties • CQC

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
Analysis of EQIA and identification of gaps	Head of Clinical Governance / Medical Director and Director of Nursing	~~Q2~~ Ongoing
Meaningful assurance requires availability and analysis of high-quality data	Head of Business Intelligence	2024/25

Link to Risk Register (material operational risks scoring 9 or above):
None

Strategic 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.

Strategic Objective: Collaborating with partners to enable people to live better lives / To embed equity in all that we do

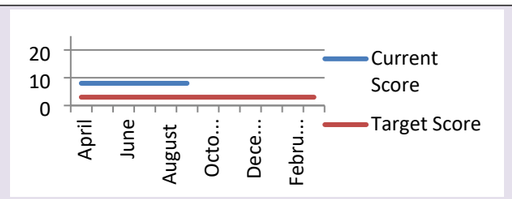
Risk Appetite: Open (high) risk appetite for developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with its statutory duties.
The Trust is supportive of innovation and has an ***open* (high)** risk appetite in pursuing innovation and challenging current working practices without compromising the quality of patient care. In the implementation of changes, the Trust has a ***cautious* (moderate)** risk appetite.

Lead Director/risk owner: Chief Executive

Committee with oversight: Trust Board

Date last reviewed: 5 September 2024

Risk Rating
(likelihood x consequence)
Current score:
2 x 4 = 8
Target score (end of 2024/25):
1 x 3 = 3



Rationale for current risk score:
Current financial planning for 2024/25 suggests a possible impact on the Trust's ability to collaborate with others.
The risk score remains at 8 as actions are in progress.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Once due diligence has been undertaken and the best frameworks for collaboration established, both the consequence and likelihood are anticipated to reduce.

Controls *(what are we currently doing about the risk?)*:

- Work with Local Care Partnerships
- Involvement in Leeds Clinical Senate
- Integrated nursing programme
- Leeds One Workforce Strategic Board
- NHS Oversight framework
- Third Sector Strategy
- PCN offer
- Involvement in projects for WY ICS
- MHLDA collaborative (and CiC)
- Leeds Committee of the ICB member
- Register of partnerships/contracts
- Community Services Collaborative
- Attendance at Primary Care Partnership, which oversees joint working in City
- Leading response to intermediate care procurement model
- TOR and MOU for major partnership arrangements
- Standards for Partnership Governance (framework)
- Social Care Alliance Board – chaired by LCH CEO and Social Services
- Leeds MWB alliance

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
Establish the Trust's role in collaborations with other organisations	Chief Executive Officer	End of 2024/25
Further work on the Social Care Alliance Board and legal framework Workshop to discuss further on 24 Sept	Chief Executive Officer	~~End of Q2~~ Ongoing

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
• CEO report to Board (TB) • 6 monthly financial performance summary report on formal partnerships (part of Performance Brief) (BC/TB) • Third Sector Strategy update reports (BC/TB)	• Minutes and updates from Mental Health Committees in Common (TB) • Reports from ICB (when available) • Reports from Leeds Committee of ICB (when available) • Risk register (QC/BC/TB) • Scrutiny of new partnerships arrangements at committees (QC/BC)	• Minutes from Scrutiny Board (TB) • CQC system assessment reports (QC/TB)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by

Link to Risk Register (material operational risks scoring 9 or above):
None

NHS
Leeds Community Healthcare
NHS Trust

Board Member Service Visits

June/July/August 2024

Service visited	Board Member	Key Themes
Child and Adolescent Mental Health Service (CAMHS)	Brodie Clark	The impact of the waiting lists on: - staff support arrangements and managing the ongoing pressure - communication with families - risk assessing and monitoring/managing the risk to patients
Community Intravenous Antibiotics Service (CIVAS)	Brodie Clark	IT remains an issue for the team and was costing frontline staff time. Inclusive management style Positive feedback regarding Quality & Value Programme objectives and communication. Potential benefit of a broader leadership development programme were discussed. Amount of admin to be undertaken on a home visit was surprising.
Infection Prevention and Control Team	Selina Douglas	This is a unique team nationally, developed as part of a collaboration agreement with Leeds City Council Public Health. Breadth of knowledge in the team is expansive, with the sepsis role being one of a few nationally. Also focus on wider public prevention issues as well as outbreaks. Flu vac – seasonal uptake has reduced across LCH –How can the board/LCH support the team this winter? Auditing of schools facilities can put the team in a difficult position. Team is part funded by LCC so this is a concern.

Service visited	Board Member	Key Themes
Community Falls Service	Laura Smith	The team were feeling positive about the move to SBU on 1 July. Positives - high levels of support and positive teamwork; and the opportunities for specialist professional development & training. Challenges - IT/network access issues leading to wasted clinical time. Unsure of potential impact of Quality & Value Programme. Plea for more/continued engagement with clinical staff as part of the admin review, as well as admin staff so all are involved in decisions to support the staff, services and patients; taking into account the diversity of the services LCH offers and their different administrative needs.
West Yorkshire Custody Suites	Brodie Clark	Clarification/consistency needed regarding signing off 'fit to release' forms. Shift systems sometimes restrictive and lacking flexibility. Little LCH management visibility, more would be welcomed/valued.
C0-19, Public Health Integrated Nursing Service (South Team)	Brodie Clark	IT issues represented a major area of risk, disruption, and delay to the delivery of the team's work. Long and lengthening waiting lists played a strong part in the focus and the concerns of the team, with them often being the 'front line' for family concerns and emotions at the delays. Noted a strong team spirit; there was a commitment and energy amongst staff.

Service visited	Board Member	Key Themes
Homeless health inclusion team	Selina Douglas	Positives: Team work in partnership with adult social care, housing and GP's alongside the hospital team which helps individuals have joined up care in the community. Team are working with some of the most vulnerable in society. High levels of compassion and dedication from the team. Challenges: Sometimes the representation from social care is patchy and the level of housing support needs to be reviewed. Hospital packs from the charity have been helpful and an ask to provide more through the charity.
MindMate	Selina Douglas	Positives: Great teamwork and ethos in developing services for children, young people and families. They have expanded and are seen as keeping to the validity of the model. They get a lot of positive feedback from families . Having a clinical psychologist as part of the team Would like to do some innovative marketing. Challenges: Gap between Children and Young People's Mental Health Service and MindMate might get wider. Neurodiversity pathway and how they can support it further. Expansion has been positive but how do they keep that team spirit. Innovation: Working with alternative settings to support a wide range of services.

Service visited	Board Member	Key Themes
Speech and Language Therapy/Swallowing Team	Selina Douglas	Positives: Small dedicated team but seen as experts across Leeds Compassion for patients Challenges: Reach could be wider across Leeds if they had a bigger team People on the waiting list would benefit from being seen sooner Risk appetite from professionals can have an impact on the service Innovation: Working across LTHT and LCH helps with understanding different pathways
Learning Disabilities Children and Young People Team	Selina Douglas	Positives: Having a dedicated resource is positive Real focus on the needs of children and young people/families Challenges: Size of team Availability of respite care
Wetherby Young Offenders Institute	Sam Prince	Positives: High standard of service offered by all members of the team to the young people, and a collective understanding of young people with particularly complex needs. Challenges: The upcoming tender process and an appetite for LCH to continue providing the healthcare service

Service visited	Board Member	Key Themes
Meanwood Neighbourhood Team	Ian Lewis	The whole team understands and has bought into the need for the Quality and Value programme and was displaying a very mature approach to trying to identify areas for improvement alongside savings. Inadequacy of IT systems, limiting the ability to identify effectiveness and demonstrate clear clinical/service outcomes.

Agenda item:	2024-25 (80)

Title of report:	Infection Prevention and Control (IPC) Board Assurance Framework (BAF)

Meeting:	Trust Board Held in Public
Date:	Friday 4 October 2024

Presented by:	Sheila Sorby Interim Director of Nursing, Allied Health Professionals and Quality, DIPC					
Prepared by:	Liz Grogan Head of Infection prevention and Control, Deputy DIPC					
Purpose: (Please tick ONE box only)	Assurance	☒	Discussion	☐	Approval	☐

Executive Summary:	The Infection Prevention and Control BAF provides assurance that Leeds Community Healthcare (LCH) is compliant or partially compliant with the criterion as outlined in the revised Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022). The purpose of the document is to ensure that patients who use Leeds Community Healthcare NHS Trust services receive safe and effective care. It is paramount that effective prevention of infection must be part of everyday practice within LCH and be applied consistently by everyone. The paper has been approved by Quality Committee ahead of Trust Board.

Previously considered by:	Quality Committee, Monday 23 September 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	Yes	☒	What does it tell us?	Equity is embedded into a large proportion of the work delivered by the IPC Team in accordance with

and/or workforce)?				the Health and social care Act. For example: 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?	

Recommendation(s)	Quality Committee is recommended to note the contents of the IPC BAF.

List of Appendices:	Appendix 1: Key line of enquiry (partial compliance)

Infection Prevention and Control – Board Assurance Framework

1 Introduction

'Good infection prevention and control (IPC), including cleanliness, is essential to ensure that people who use health and adult social care services receive safe and effective care.' This updated version of the infection prevention control board assurance framework (BAF) is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The purpose of the framework is to provide assurance to the board on the compliance with the updated version of the Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022).

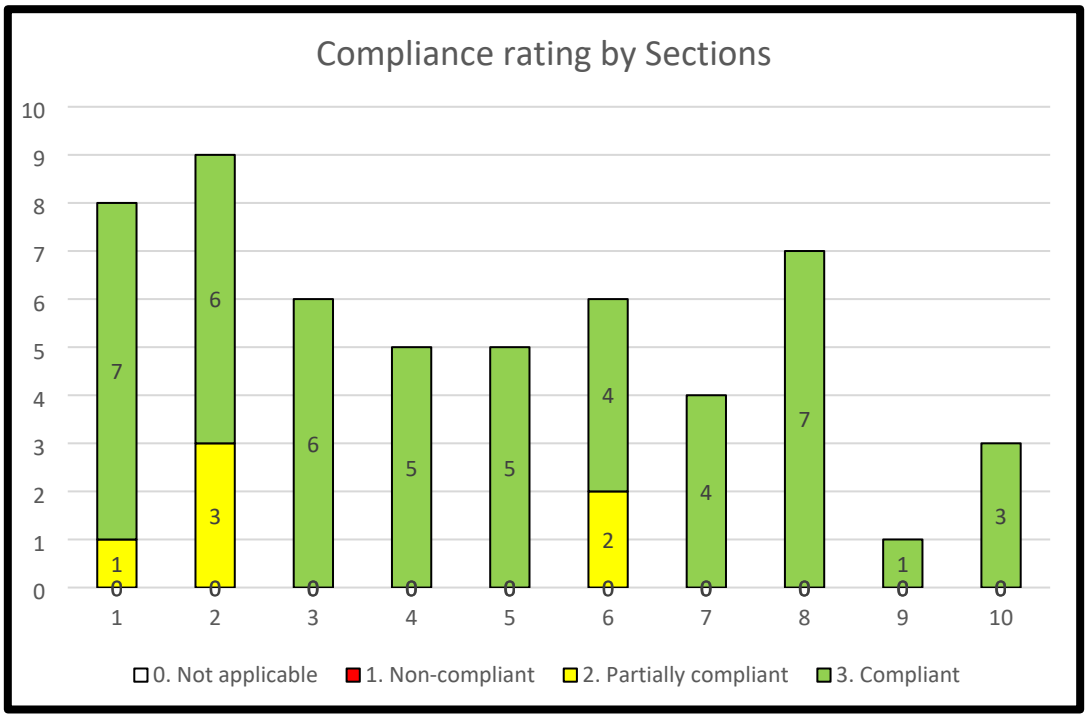
2 Current position

The document provides information on the identified Key Lines of Enquiry (KLOE) and provides assurance of the specific measures that LCH have in place to control the spread of infection.

3 Impact

- **Quality**

The majority of elements are fully compliant. There are some areas highlighted as '*partial compliance'* however there are mitigating plans in place and progress has been made since this document was reviewed in March 2024.



- **Risk and assurance**

Identified elements of partial compliance are highlighted in the document and are as follows;

- They implement, monitor, and report adherence to the NIPCM – process in place to update all relevant policies that link to the NIPCM as and when policies and guidelines are due for review.
- There is evidence of compliance with National cleanliness standards – assurance required from external providers e.g. Leeds City Council, Ministry of Justice etc. This continues to be an area of non-compliance and a short life working group is in place led by LCH estates and facilities to seek further assurance from external providers in relation to cleaning. Previously escalated to HSG, IPCG and QAIG.
- That all identified staff are fit-tested as per Health and Safety Executive (HSE) requirements and that a record is kept – provision in place to continue fit testing relevant clinical staff in line with A-Z of pathogens, locally held excel document in IPC however more robust mechanism being sought e.g. PIP for greater assurance and data metrics.
- If clinical staff undertake procedures that require additional clinical skills there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records – this requires further collaborative work with the Clinical Education Team / Clinical Leads. An example of this would be assurance around aseptic technique, monitoring of patient observations and catheterisation.

➢ 4 Next steps

Review the IPC BAF on a quarterly basis and for the contents of the document to be highlighted at the IPCG. Escalations to be raised at QAIG and for Quality Committee to receive this document on a six-monthly basis.

➢ 5 Recommendations

Quality Committee is recommended to: note the contents of the IPC Board Assurance Framework and the areas of partial compliance.

Liz Grogan
Head of IPC and Deputy DIPC
September 2024

Appendix 1: Key line of enquiry (partial compliance)

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. This continues to be escalated to the IPCG and QAIG.
2.5 There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	The risk being that we are unaware of some of the planned maintenance with external partners, which may impact compliance with HTM in the Built Environment as well as provision of services.	This is now in place for LCH premises and is listed on the agenda for the IPCG. Audits are shared by IPC to Estates and Facilities – non-compliant areas reaudited 3 monthly.
2.7 The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	The Waste Policy is in place and LCH are in the process of moving to a new tender for the Waste Contract. We are compliant with the majority of this KLOE apart from the correct waste streams being in place. We have a legal responsibility to ensure compliance with this standard.	There is a planned timescale on adopting the new waste streams with a Waste Manager in post within LCH.
6.5 That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	A rolling training programme is made available for staff who require fit testing for FFP3. Inaccuracy in the detail of the fit testing record due to it being	A locally held excel document is stored within IPC, however it does not provide individuals or teams the ownership.

	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.	
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. Further scoping work is being undertaken within LCH to develop an app to record staff competencies.

National Infection Prevention and Control Board Assurance Framework

Version 1.0 March 2023

Publication approval reference:

Introduction

The National Infection Prevention and Control board assurance framework ('the framework') is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. This framework is not compulsory but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place).

The purpose of the framework is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

The framework should be used to assure the executive board or equivalent, directors of infection prevention and control, medical directors, and directors of nursing of the assessment of the measures taken in line with the evidence based recommendations of the NIPCM (or whilst the NIPCM is being implemented) including the relevant criterion outlined in the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The outcomes can be used to provide evidence to support improvement and patient safety. The adoption and implementation of this framework remains the responsibility of the **organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined.

If the criterion is not applicable within an organisation or setting for example, ambulance services then select not applicable option.

Links

NHS England » National infection prevention and control manual (NIPCM) for England

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

Legislative framework

The legislative framework required to protect patients, service users, staff and others from avoidable harm in a healthcare setting is detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections, the duty of care and responsibilities are set out in the Health and Safety at Work Act 1974, and associated regulations for employers and employees.

Local risk assessment processes are central to protecting the health, safety and welfare of patients, service users, staff and others under relevant legislation. This risk assessment process (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings) has been designed to support services in identifying hazards and risks, and includes guidance on measures that should be maintained to improve and provide safer ways of working by balancing risks appropriately. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work using the risk assessment process and the organisation's governance processes.

Links

Health and Social Care Act 2008: code of practice on the prevention

Health and Safety at Work etc. Act 1974

Primary care, community care and outpatient settings

Acute Inpatient areas

Primary and community care dental settings

Instructions for use

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains **the responsibility of the organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined in the Act.

The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop down list. Specifically: not applicable, non-compliant, partially compliant, compliant.

Once options have been selected a summary plot for each criteria is generated automatically, which are displayed in the corresponding worksheet. The overall RAG status for an organisation/provider across all ten criteria is shown in plots under the summary worksheet.

N.B. Use of the framework **is not compulsory** but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place). In addition, not all of the criteria outlined in the framework will be relevant or applicable to all organisations or settings.

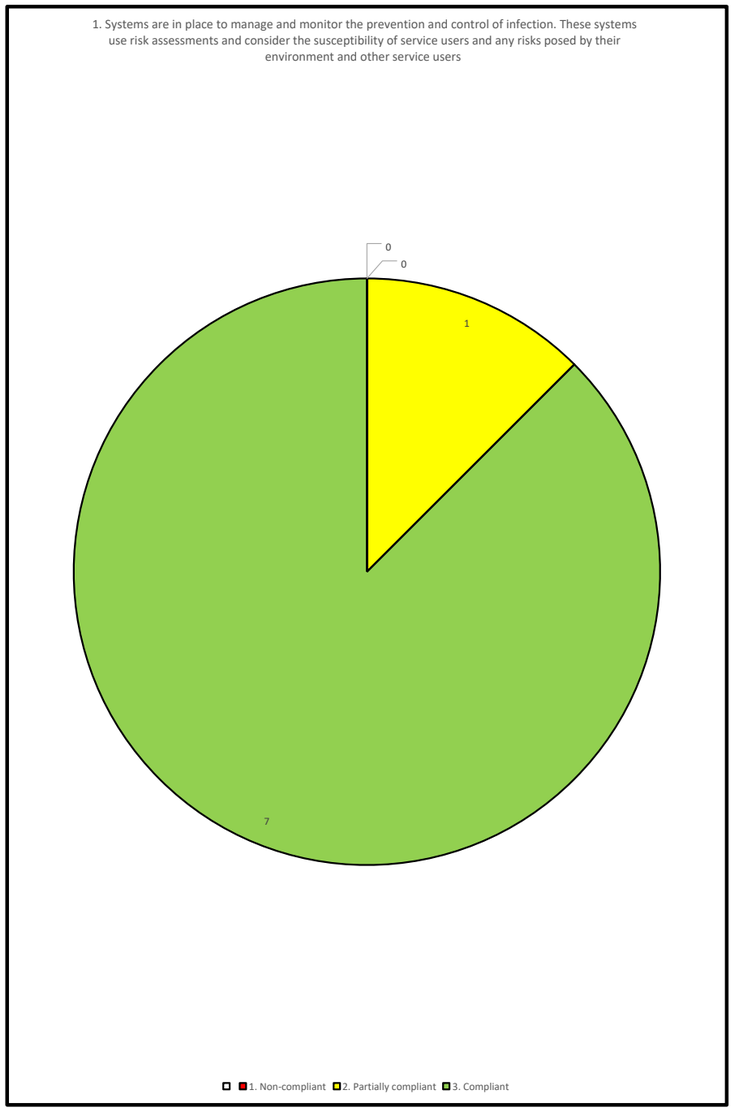
Please note: Specific URL's referred to in the document can be accessed via the ' Hyperlinks included in the BAF' tab. Or alternatively, can be accessed by clicking here.

Links

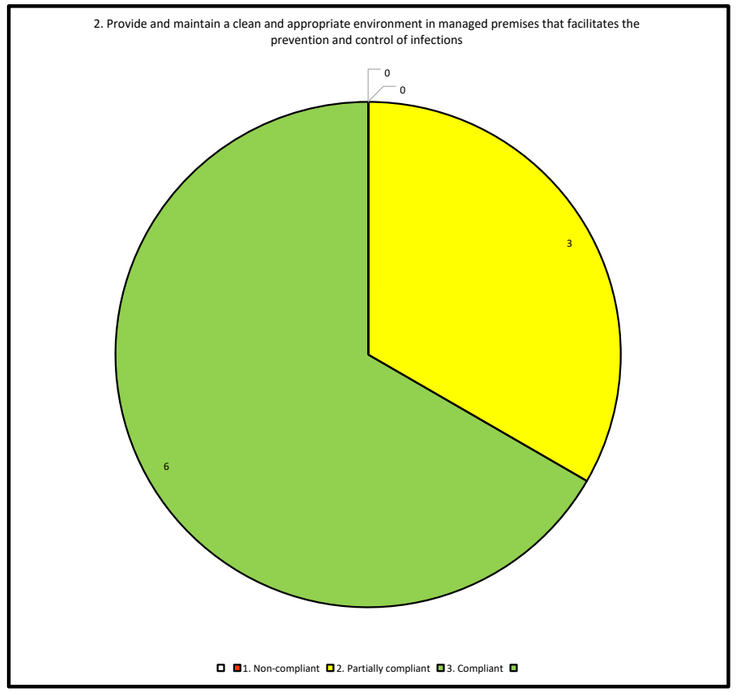
Section 1	
1.4	NIPCM
1.6	NICPM
	Primary care, community care and outpatient settings,
1.8	Acute inpatient areas
	Primary and community care dental settings
Section 2	
2.1	National cleanliness standards
2.2	Patient-Led Assessments of the Care Environment (PLACE)
2.4.1	HTM:03-01.
2.4.2	HTM:04-01
2.5	HBN:00-09
2.6	HTM:01-04
	NIPCM
2.7	HTM:07:01
	HTM:01-01
2.8	HTM:01-05
	HTM:01-06
Section 3	
3.2	UK AMR National Action Plan
3.3	UK AMR National Action Plan.
	NICE Guideline NG15
3.4	TARGET
	Start Smart, Then Focus
Section 5	
5	NIPCM
Section 6	
6.2	Roles and responsibilities
Section 7	
7	NIPCM
Section 9	
	UKHSA
9	A to Z Pathogen
	NIPCM

Infection Prevention and Control board assurance framework v0.1

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	There is a robust governance structure where a quarterly IPCG is held, escalations from this meeting feed into QAIG, upwards to Quality committee and then the board. The DIPC is the Executive Director of Nursing and AHPS and the Deputy DIPC is the Head of IPC. Terms of Reference are in place and this is reviewed annually. The Infection Prevention and Control (IPC) programme for 2023/24 to be disseminated in Quarter (Q) 1 discussed and updated quarterly at the IPC group (IPCG) outlining collective responsibility for keeping to a minimum the risks of infection and general means by which it will prevent and control such risks Programmed actions to involve all staff members and services within the Trust not solely members of the IPC team. There is an Overarching Policy in place detailing the roles and responsibilities of the organisation inline with the Health and Social Care Act code of practice (2022) and has been updated in February 2024.				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	PPM+ provides monitoring intelligence for community IPC. Relevant policies in place for the Management of Outbreaks in the Community Setting. 7 day provision of IPC to provide SME advice. Engagment with UKHSA for specific infection outbreaks. Escalation process outlined in the IPC Overarching Policy. Communicable				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Use of Datix is embedded across the organisation, with specific entry points to capture IPC incidents such as sharps incidents and environmental issues. IPC have a process in place to monitor datix on a daily basis and a flow chart that coincides with the policy around sharps management. IPC education events and champion sessions promotes use of Datix and there is an organisational culture of promoting reporting of incidents. Plans in place across the organisation to implement PSIRF, there is an identified patient safety specialist for IPC. Deputy DIPC chairing improvement group for sepsis and deterioration.				3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	Current policy pack in place that incorporate the detail of the NIPCM and references the content across LCH IPC Policy suite. The current policy manual outlines all relevant criteria as detailed in the Health and Social care Act. Overarchin Policy references NIPCM (2022) and H&SC Act (2022).	Embedding of Transmission based precautions throughout education and training.	Staff undertake Level 1 and Level 2 ESR Training. We are looking to develop some seasonal communications to appropriately risk assess for TBP's.	Update September 2024: To be implemented as part of Annual Plan for 2023-24 / 24-25.	2. Partially compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	PPM+ provides surveillance of MRSA, CDI, GNBSI data, a process is in place for IPC to complete appropriate Post Infection Reviews of specific HCAI's. All outbreaks in inpatient areas such as Wharfdale would be escalated to the DIPC and the Managagement of Outbreakspolicy would be followed, including reporting to UKHSA. Further detail outlined in the Overarching Policy. Escalation and reporting via the IPCG and quarterly to QAIG.			PPM+ platform under review as to how effective this infratructure is. LTHT have moved to a new platform: ICNet and this will be reviewed internally as to whether it can be considered as an effective surveillance system for the community.	3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Hand hygiene, environmental, mattress and cleaning audits are completed throughout LCH. MEG is the electronic auditing platform that captures the relevant information and provides assurance of compliance. This is recorded as part of the quarterly IPCG and escalations are made to QAIG where there are notable concerns. Goverance process detailed in the Overarching Policy.			New Hand hygiene Audit tool rolled out in October 2023. Results from teams across LCH consistently record at 100% which does question the validity of assurance. Further consideration to be given to an AI method of measuring compliance.	3. Compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Staff receive training as part of induction programme which covers the core fundamental basics of IPC. All staff then undertake statutory and mandatory training as part of E-Learning for Health and the attendance figures for locations are monitored and recorded as part of IPCG and HSG. any concerns escalated to Clinical leads Via Clinical Leads Meeting and QAIG.				3. Compliant

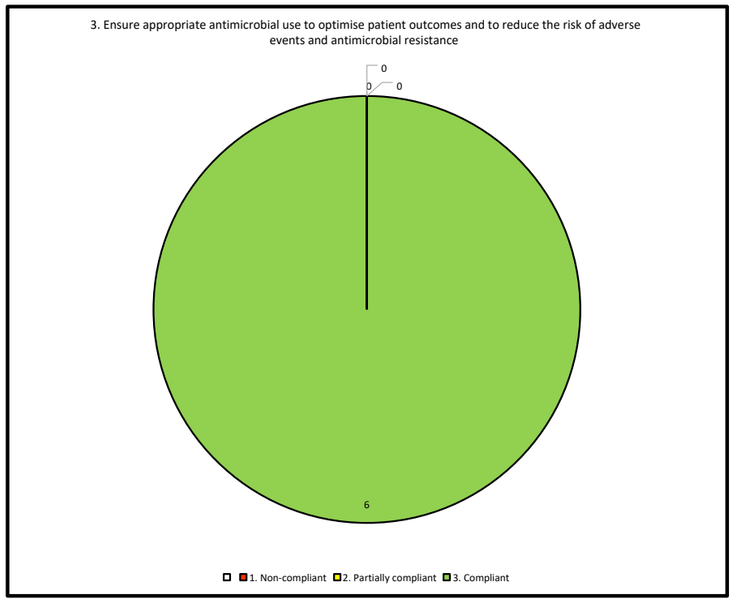


1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	IPC support teams with risk assessments where required for example for specific infections e.g. CPE in an inpatient setting. Specific risks discussed via IPCG where an action log is in place.	This KLOE is compliant however to note the following to improve assurance: Formal logging of risk assessments needs to be captured with a more robust system in place.		IPC team have supported with localised training at Wharfdale on localised issues.	3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	The National Cleaning Standards were implemented in November 2022. Monitoring of standards is in place and this is led by the Domestic Services manager. 'Scores on the door' in place and escalation of concerns is identified through IPCG and HSG, with an action log in place. Reports to come via IPCG from Domestic Services Manager. Environmental audits capture areas of non compliance. Working group in place for implementation of standards.	Assurance required from external partners such as WYOI, LCC, Adel Beck, Custody Suits etc. Cleaning Policy to be ratified - currently being completed by LCH Estates and Facilities Team.	Continuation of short life working group to be in place with Estates to discuss assurance from external partners and areas of concern that are escalated from IPC Environmental and Cleaning Audits.	Update September 2024:This continues to be escalated to QAIG around the lack of assurance from external partners.	2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE inspections are undertaken every September. Inspection team in place and external inspectors have been recruited. Action plans and report shared Q1 of fiscal year and shared with DIPC. Escalations taken to QAIG and the Board. Anecdotal feedback to be provided to QAIG prior to national report being recieved.			Currently fully led by IPC, however more of a Facilities and Estates ownership is required. Further discussion required with LTHT / national PLACE team re completion of Wharfdale Inspections	3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	S shape cleaning in place and labelling of patient equipment. Policy in place for reusable materials and a contract is in lace for external decontamination of reusable pieces for dental and podiatry. The IPC Policy manual outlines clearly roles and responsibilities across the trust. A bespoke video has been made by IPC with a voiceover to support the methods of cleaning as outlined in cleaning policy.		National Cleaning Standards in place across the organisation and each area has been accessed and provided with a risk category.	Cleaning Policy has been to the CCPG in March 2024 and is near completion for ratification. It is acknowledged that some elements of the policy will not be in place for example assurance from external landlords e.g. Leeds City Council	3. Compliant
2.4 updat	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01	Water Safety Group in place with external provision provided by a qualified water expert. Regular legionella sampling from mains taps, as well as dental waterline testing is in place and assurance audit completion for HTM 01-05 from dental.			Update September 2024: there is now a robust system in place for the maintenance of water coolers and this is monitored via the Water Safety Group.	3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	Non compliant enivironmental concerns identified through annual IPC audit completed. The audits are shared with the estates team and non compliance is re audited within three months	To capture as part of separate piece of work to identify quarterly maintenace required and for this to be discussed with HSG. Some additional premises that are used by LCH to be audited annually e.g. Daniel Bever premise at LTHT (SJUH site).	Audits are shared by IPC to Estates and Facilities - non compliant areas reaudited 3 monthly.	To discuss with Diane Allison how non compliant elements are captured by Estates and Facilities. Update September 2024: Continues to be captured at IPCG, however the reporting mechanism need strengthening	2. Partially compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	All linen within inpatient areas such as Wharfdale is managed by LTHT. Linen policy in place and NIPCM followed. For areas such as Hannah House a process is in place and there is a Management of Linen Policy in place that details the safe processing of laundry.	Assurance required from LTHT of provision and care of linen.		Policy updated March 2024.	3. Compliant
2.7 updat	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Procedure recently fully reviewed and updated. Awaiting ratification of management of Waste Policy. A 'Waste Manager' is in place that is part of the Estates and Facilities Team, with SME provided from IPC. Waste captured as part of the environmental audit. Concerns or escalations of non compliance via the IPCG and QAIG	We have existing waste streams in place that separate clinical and non clinical waste, with appropriate signage to direct staff. The streams however do not meet the new standards as outlined in the Waste management Policy.	Tender to new waste provider from April 24, when new streams will be in place.	Update September 2024: New Waste Policy implemented, recognise that a number of elements in the policy are currently not being followed. New tender process in place for waste disposal company, additional colour coding and a waste manual / guide to be implemented. Shared work with IPC / Waste Manager in Estates.	2. Partially compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	External decontamination process in place for dental and podiatry. Annual assurance and monitoring visit made to Tameside by IPC, dental and podiatry. All other equipment is single use and disposed of. Datix in place for instruments returned to Tameside with sharps still attached.			Tender process to be reviewed - discussed with Andrew Davies and Jo-ann Watson - awaiting update. Annual assurance visits made to the provider in Tameside, with dental and podiatry - due to be performed in April 2024.	3. Compliant

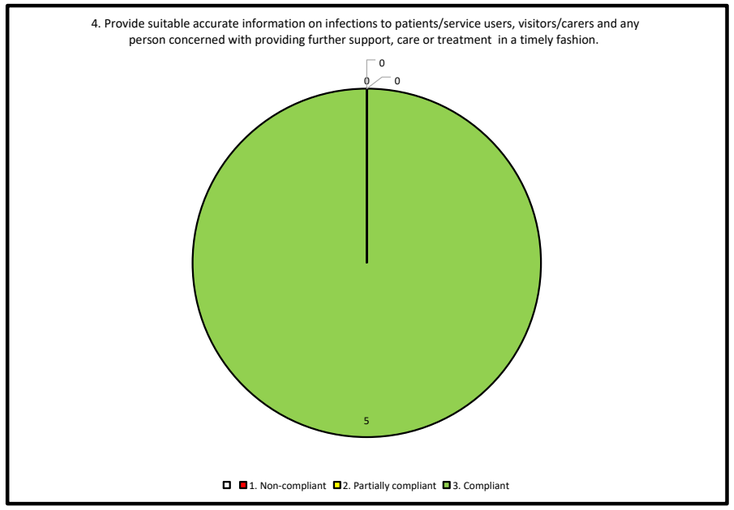


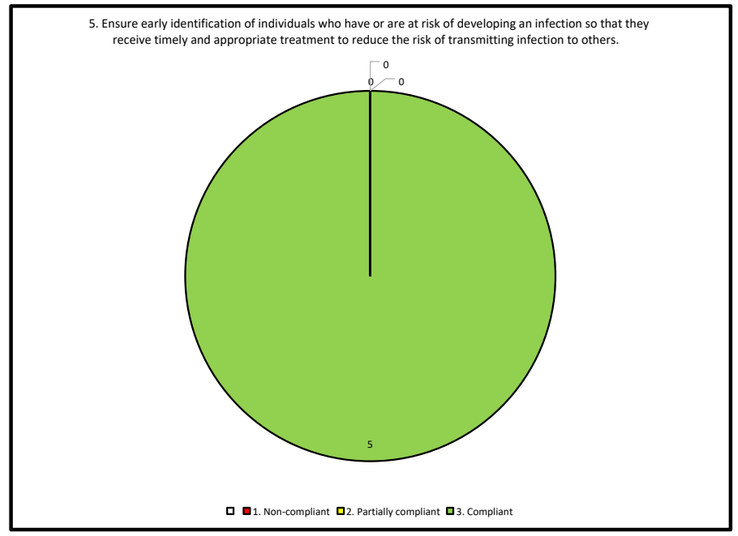
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations	Food safety compliance in place for Wharfdale in patient area and Hannah House. Training monitorted via ESR. Compulsary training for relevant staff members. Assurance detailed through PLACE inspections and Environemtnal Audits.				3. Compliant

3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	Guidelines for antimicrobial use are developed in line with Leeds health Pathways processes, with microbiology input & peer review prior to approval via the LTHT antimicrobial governance route. AMS identified lead Head of IPC and head of Medicines Management				3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	The IPC Annual Report dtails activitiy on AMS and AMR is captured in the IPC Annual Plan as well as the IPC Overarching Policy.				3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	The Executive Director of Nursing and AHP's as DIPC has overal responsibility for AMR throughout LCH.				3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: •to optimise patient outcomes. •to minimise inappropriate prescribing. •to ensure the principles of Start Smart, Then Focus are followed.	LCH IPC is part of the WY ICB AMR Collaborative Working Group, as well as the place based AMR group established by LCC. Resouces and tool are shared across the system and used as part of our approach throughout LCH. It is recognised that there is a small amount of prescribing throughout the trust. A flash report will be produced from Oct 23 jointly by Medicines Management and IPC on the systems in place as well as the audit processes to ensure that prescribing is inline with trust guidance. IPC week every November captures AMR as a health promotion day, information and links are available on the Oak and IPC are part of the NHS Futures platform for sharing resources, good working practice and bench marking.			Discussions with MEG about an electronic AMR audit that can be put in place. Considerations given around joint working with LTHT for the paediatric CVAS service.	3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: •total antimicrobial prescribing. •broad-spectrum prescribing. •intravenous route prescribing. •treatment course length.	IPC support teams with risk assessments where required for example for specific infections e.g. CPE in an inpatient setting. Specific risks discussed via IPCG where an action log is in place.				3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	There are resources available on the Oak highlighting AMR and AMS. LCH IPC are engaged with system work in relation to QI for AMR, due to relatively low prescribing rates internally there are plans in place to undertake deep dive audits/QI approach into services such as podiatry for px, LSH and WYOI.			To engage with ODI re QI for AMR.	3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	There are leaflets and information made available for specific infections. LCH IPC collaborate with PH at LCC to ensure that the information available meets the needs of the population group of Leeds and that alternative materials in multiple languages is available via UKHSA.			To add to relevant policies the different language options for information sharing.	3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	All policies and leaflets are revised every three years. Information is available on the internal and external internet as well as the Leeds Healthcare Pathways.			Consider QR codes on patient letters, texts to share information about specific infections. Start to share NHS Choices link to specific infections e.g. MRSA, CDI which are reviewed on a national level and available online.	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	All leaflets include the general principles of IPC, including importance of hand hygiene. Other control measures might include cleaning, washing of personal items, cough etiquette etc. as well as the principles of AMR - this would be dependant on the infection.				3. Compliant

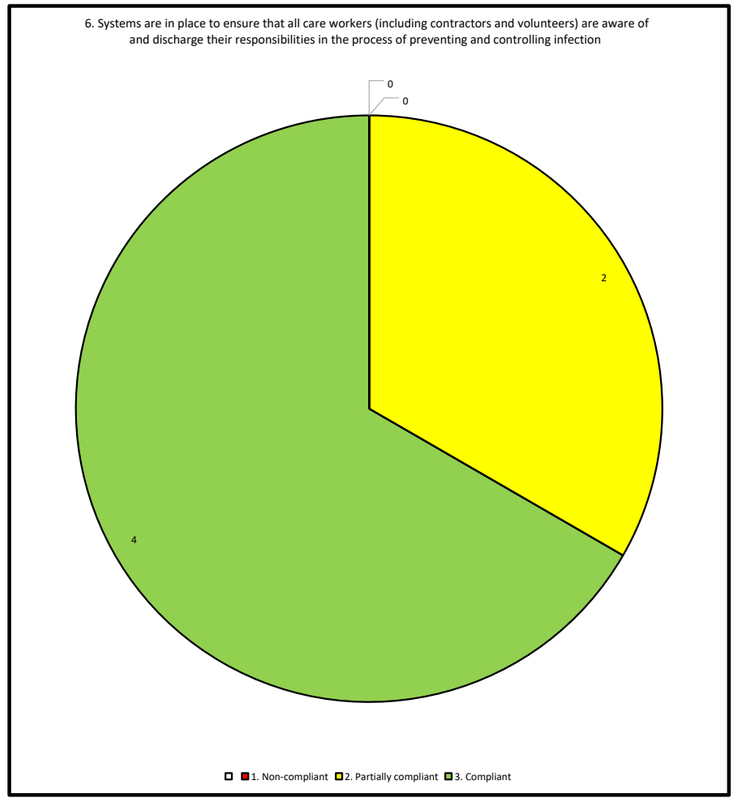


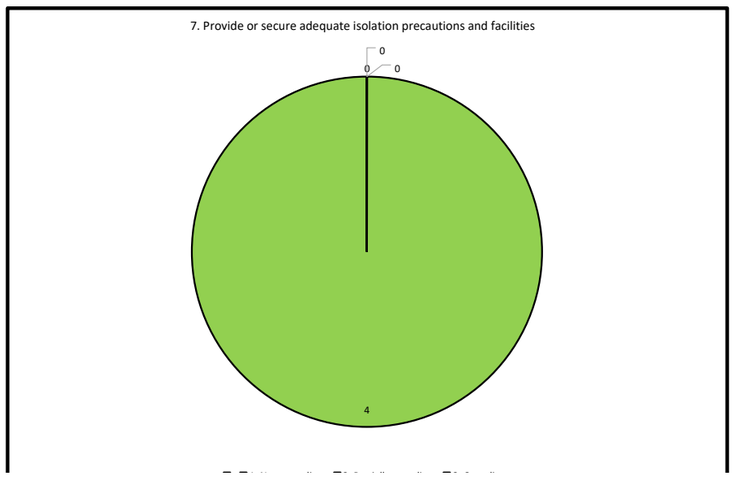
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	In patient areas have an infection control board that highlights the important key control measures. As part of national campaigns information shared with colleagues and individuals visiting our inpatient areas and health centres. Stall provide information and we hold external events to promote IPC at venues such as Kirkgate Market, use the display screen at Milllenium Sqaure etc. We use social media means by sharing information on 'X@ and the LCH Facebook page. Campaign material for winter vaccination campaigns is ordered from central DH and is shared to proote oublic health messaging.				3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Patient passports are in place for catheters, a localised passport is used through the acute and community setting. We have a lead within the IPC Team for Devices related products and they sit on the IPS DRIPP Events.			Previous discussions have been had with CUCS around the auditing and usuage of Catheter Passports. Do CVAS use passports for DRIPP?	3. Compliant
5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	Patients admitted to inpatient areas are not routinely tested for MRSA unless there is clinical rationale to do so. If patients do have clinical symptoms, swabs/smples are taken and transferred to the laboratry as per SOP. Results are then shared with inpatient area and via PPM+. Policy Manual available on the Oak outlining requirements. Stools assessment and chart in place to ensure prompt samplingfor potential CDI cases.				3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Patients in inpatient areas have infection status regularly reviewed. Medical provision in place and escalations via GP or 111/999 should this be required. Patients have NEWS2assessment as per clinical need / policy and concerns around deterioration should be promptly escalated. IPC support with risk assessments for in patient areas.			**Education and bitesize training in place for sepsis and deteriotion.**	3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Patient transfer form in place as per policy, for when patients are discharged from inpatient areas to care home or back to acute provison, detailing specific pathogens e.g. MRSA, CDI, CPE etc.			To audit transfer forms from Wharfdale to ensure completion and accuracy of detail. This is a 6 monthly audit on a sample of 20 patients.	3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage displayed on external ward area should an outbreak be in place, as well as specfic restrictions for bays if patients are being cohorted to reduce onwards tranmission.				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreaks of two or more for either staff or patient sreas are reported to UKHSA. Outbreak toolkit in place and monitoring / surveillance completed. IPC is a 7 day service and daily checkin of outbreak location are completed where SME is provided.			Point of care testing has been made available to the recovery hubs and wharfdale for potential respiratory infections, which can help detect and provide confirmation of an infection.	3. Compliant





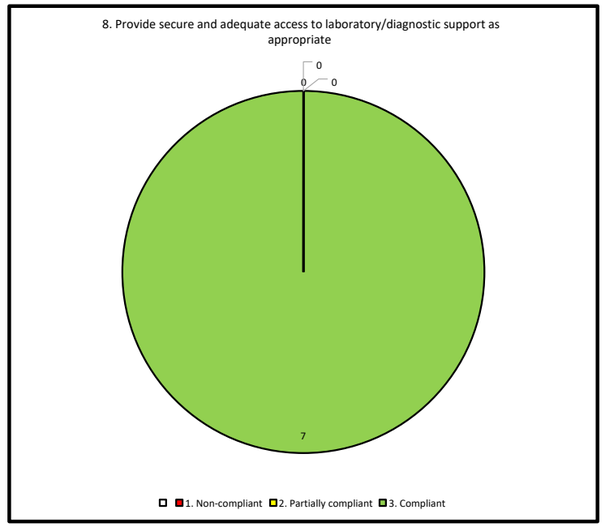
6.Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	Face to face induction training is provided to new starters. This is a 15 minute presentation that captures the basic requires for IPC. All staff are then required to complete either level 1 or level 2 E-Learning for Health Training via ESR.	Induction is not mandated for all staff, as it is only for 15 minutes it does not cover the entirity f IPC that the staff members must be made aware of.	The staff member must complete their ELFH IPC training within a two period of starting.	On average we are >90% compliant with IPC training, however we identify quarterly poor uptake cares and these are escalated to QAIG.	3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Roles and responsibilities are outlined in the IPC Overarching Policy as well as other IPC Policies e.g. Standard Precautions. They are discussed as part of the Induction Training.				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Training compliance figures captured at IPCG and HSG. Escalations of non compliance captured at QAIG via flash report. Average >90% compliance for level 1 and 2 training.				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	Staff receive training via E-Learning for Health. Information and videos on donning and doffing is available on the Oak. Staff undertake a PPE and Hand Hygiene Audit. Audit of system one notes for PPE/HH in place.			NIPCM referenced in IPC related policies.	3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff are re fit tested every two years as outlind by the HSE. Staff that are fit tested are recorded on a locally held (IPC) excel document.	A more robust mechanism e.g. ESR / PIP to record competency is required.	A locally held excel document is stored within IPC, however it does not provide individuals or teams the ownership.	Consideration around co procured PPE within the system for future pandemic prepardness, as well as sustainability approach. Update September 2024: this continues to be escalated to QAIG. A proporation of staff from each service to be fit tested however this needs to be co led between health and safety and IPC will the competency lying with the responsibility of the employee.	2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Registered staff should not be carrying out a task if they believe they are not competent. The ABU provides training to clinical and non clinical staff. Non qualified are currently undertaking new competency frameworks delivered by the Neighbourhood Team Clinical Skills and Competency Educators. All of the training provided in ABU has been peer reviewed and assessed by the relevant specialists and there are regular (3-6 monthly) meetings with those specialist services to review training materials and update training as and when there are changes to policies or practice. There are lesson plans and guides in place for all of our training sessions so that if anyone else had to cover a session there is a guide to follow.	To explore further around what is exactly in place for all clinical staff that undertake a procedure. For some clinical competencies staff self declare compliance, however there are gaps around refreshers and where this information is appropriately stored.	Staff self declare competencies and work in an autonomous manner under their relevant codes of practuce. Bespoke training can be provided by specific teams such as CUCS, CVAS and IPC.	Understand gaps for business units and how this could be accurartly recorded on staff profiles on ESR. Update September 2024: an app has been identified by WFI and there is currently a scoping exercise being undertaken. This sits outside of IPC.	2. Partially compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Risk assessments are undertaken for inpatient areas for specific infections such as CPE. These are suprted by the IPC Team and coincide with the relevant policy and the NIPCM.	A formal logging system to be in place for risk assessments ? Added to patient notes.		Further education has been provided via the IPC team on completion of risk assessments.	3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •single rooms are in short supply and if there are two or more patients with the same confirmed infection. •there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	In patient areas have specific isolation (side room) facilities. Hannah House is all single side rooms. Wharfdale has a number of side rooms that can be used if a patient has a specific infection e.g. CPE or CDI. Risk assessments are completed in collaboration with the IPC team, to ensure the correct positioning of the patient, including standard precaution principles and tranmission based precautions. If in the event a side room could not be a sourced a Datix would be completed and a hierachy of control measures to reduce onwards transmission would be in place. Isolation Policy available on the Oak and Level 2 IPC training covers isolation principles.				3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	NIPCM added to policy suite and standard precautions policy reflects TBP's. Staff education and comms in place.			Education system in place to update staff on TBP's. The new HH audit tool captures this.	3. Compliant

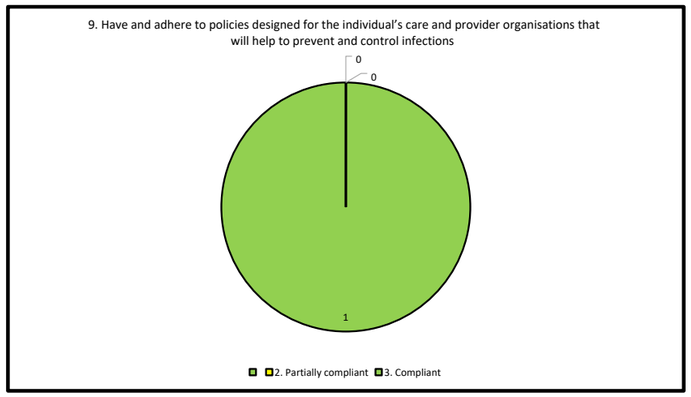




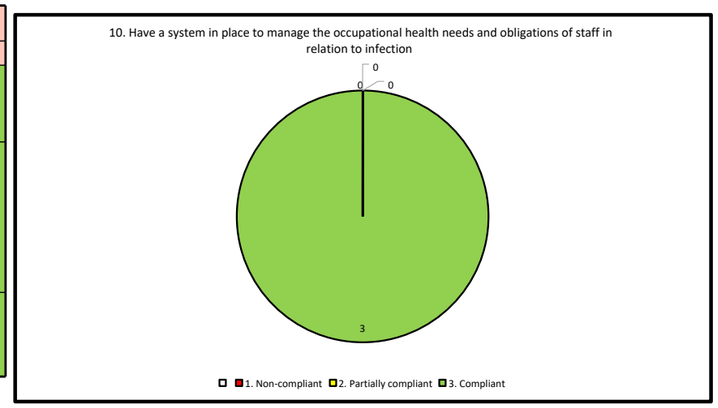
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Policies in place to reflect this, patients withhin our inpatient areas would have a risk assessment in place if they were to be transferred. If this were to occur it would be as a result of deterioration.			Transfer form in place at Wharfdale - discussed with Kirsty Jones.	3. Compliant

8.Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Contractual arrangements / SOP in place for the processing of laboratry samples with LTHT.				3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	The IPC team is a 7 day service, details are shared across the trust on how to reach out should additonal support / SME advice be required for specific pathogens / risk assessments. On call manager overnight / weekend / BH should escaltion be required. UKHSA have on call manager details should an ncident management meeting be required for a specific outbreak. Contact details for the IPC team available on the Oak. Champions are dispersed across the organisation to support teams, regular champion days are held to educate and they are a point of contact within				3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	SOP is in place for the testing of samples via LTHT laboratry. Microbiology provision provided via a SOP through LTHT. PPM+ platform shares results to the IPC team and a SOP is in place for the details of specific pathogens e.g. MRSA, CDI, E.Coli to be added onto the front page of Ssys1 notes. This is to add an additional layer of assurance as laboratry notes should be shared directly with the teams. Advice is provided on Sys 1 around decolonisation, standard precautions, tranmission based precautions etc.				3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Patients on discharge from LTHT should be provided with a transfer form highlighting any specific HCAI's e.g. MRSA, CDI, CPE. If these patients are admitted into one of our inpatient areas e.g. Wharfdale then a risk assessment with IPC will be undertaken. If patients are transferred from one of our inpatient areas to the acute setting or a care home a transfer form will detail any specific pathogens.			Audit of transfer forms to be undertaken. Liasised with Wharfdale re transfer form back into LTHT should patient have a specific pathogen.	3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Policies are in place for testing of patients should there be a clinical concern of infection. IPC training level 2 provides education on this. Staff undertake NEWS2 clinical assessment and should the patient require a specific swab or sputum sample.				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	SOP is in place with LTHT for laboratory services. This incorporates agreements with other external providers e.g. Collindale (UKHSA) and other providers for specific testing of pathogens e.g. MPX.				3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance	SOP is in place with LTHT for laboratory services. This incorporates agreements with other external providers e.g. Collindale (UKHSA) and other providers for specific testing of pathogens e.g. MPX.				3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Specific infection policy is in place that details and references the A-Z of Pathogens. All policies available on the Oak and Leeds Healthcare Pathways. Outbreaks are monitored by the IPC team - which provides as 7 day provision as part of the cooperation agreement with LCC. Tams can contact IPC for support and SOP is in place on how to monitor an outbreak. As per policy all outbreaks are reported UKHSA and an ILOG number is provided to detail on samples. IPC attend any specific IMT's with UKHSA. Bitesize training provided to staff virtually on specific infections, accessed via the Oak. Staff attend online virtual ELFH IPC training Level 1 and Level 2 - attendance rates monitored via IPCG/HSG from BI reports. Onaverage compliance 90-92%			Gap analysis against current policies to identify potential gaps and further fit testing to be completed by IPC.	3. Compliant

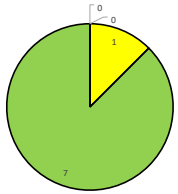




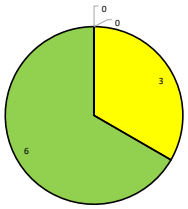
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Pregnancy risk assessment completed by line manager. IPC contacted if in the event of a concern that is escalated.	IPC do not have assurance of risk assessment s that are being undertaken for individual staff members as this is service specific.	Locally held by line managers.		3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Process in place and contract with SWYFT occupational health service. Flow chart for staff to follow in the event of a sharps incident. Lanyard card provided to staff members, posters are displayed, screen savers in place and policy outlines procedure. IPC support staff member by contacting them within 24 hours of datix to support the individual and ensure process followed.				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Contract in place with SWYFT for Occupational Health Provision and staff upon employment complete medical questionnaire via Recruitment and HR.	We do not receive any data from SWYFT outlining OH provision for IPC related activity, for example immunisation, occupational irritant dermatitus, needle stick injury response.		Escalated to Ann Hobson to discuss KPI's in place with SWYFT.	3. Compliant



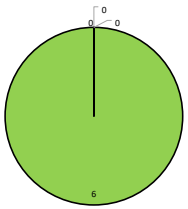
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users



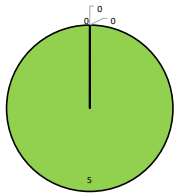
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections



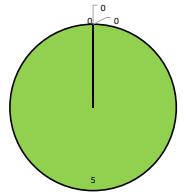
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance



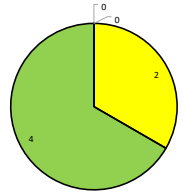
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.



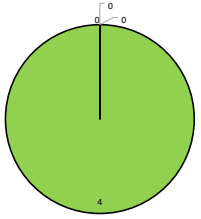
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.



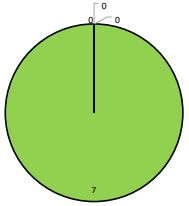
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection



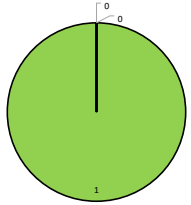
7. Provide or secure adequate isolation precautions and facilities



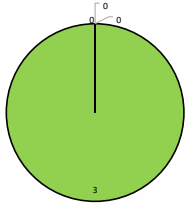
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate

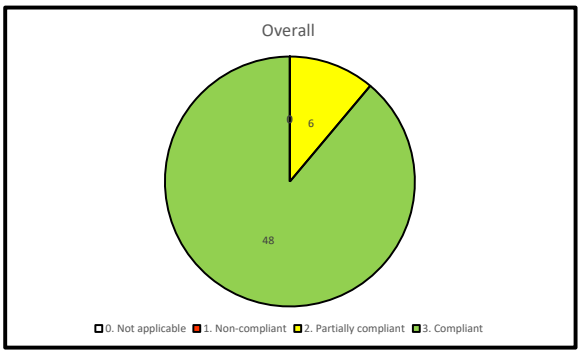


9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections



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




Overall
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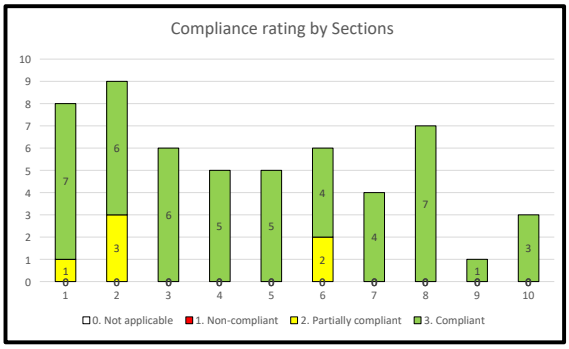
6
48
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant


Compliance rating by Sections
10
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10
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant

Leeds Community Healthcare NHS Trust

Agenda item:	2024-25 (81)

Title of report:	Patient safety including patient safety incident investigations update report March 2024-August 2024

Meeting:	Trust Board Held in Public
Date:	Friday 4 October 2024

Presented by:	Sheila Sorby - Interim Director of Nursing, Allied Health Professionals and Quality					
Prepared by:	Sarah Yeomans – Patient Safety Manager					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	In this report incidents which occurred before 01 January 2024 are managed under the Serious Incident Framework, 2015 and reported on the Strategic Executive Information System (StEIS). Incidents which occurred on or after 01 January 2024 are managed under the Patient Safety Incident Response Framework and are not externally reported to the Integrated Care Board (ICB). There was a total of 2807 LCH Patient Incidents reported between 01 March 2024 and 31 August 2024. Pressure ulcers, Self-Harm, Medication and Falls were the four most reported incident categories. Seven Patient Safety Incident Investigations (PSII) were recorded in the reporting period. Three Serious Incident Investigations and one Patient Safety Incident Investigation concluded in the reporting period. Themes of learning are outlined in the appendices of the report. Learning themes from Pressure Ulcers, Falls and Deteriorating Patient are held on Trust Wide Improvement Plans and improvement activity will be monitored by the relevant improvement group to ensure learning is embedded. Themes of learning related to these areas are held in the six-monthly reports as an output of the improvement groups.

Previously considered by:	Quality Committee, Monday 23 September 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	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 will be reviewed using the Patient Safety Dashboard, when available

Recommendation(s)	•Receive and note the contents of this paper. •Provide any feedback required.

List of Appendices:	Appendix 1 - LCH patient incidents by month and year – 01/06/2023:31/08/2024 Appendix 2 - Themes of learning from pressure ulcer incidents Appendix 3 - Themes of learning from falls incidents Appendix 4 - Learning from closed Serious Incident Investigations

BACKGROUND/ INTRODUCTION

A report on Patient Safety, Serious Incidents and Patient Safety Incident Investigations is produced bi-annually to provide the Board of Directors with the assurance that patient safety is well managed, that incidents are appropriately investigated, and that learning is acted upon to improve patient care.

Following a period of transition, the Trust fully adopted the Patient Safety Incident Response Framework (PSIRF) and enacted the Trust Patient Safety Incident Response Plan (PSIRP) on 1 April 2024. Reflective of this transition, this report will include data from incidents occurring in 2023 which have been managed under the Serious Incidents Framework (2015) and incidents from 2024 which have been managed under the Patient Safety Incident Response Framework (PSIRF).

Key Opportunities Risks and Successes for consideration.

Opportunities

Insight

- Learning from Patient Safety Events (LFPSE) has now been implemented in LCH which replaces the previous National Reporting and Learnings System (NRLS), and work remains ongoing to redesign the Trust Incident Reporting System for reporting, investigating, and learning from incidents whilst ensuring the system is accessible and user friendly.

Improvement

- Bi-monthly meetings are now established for the three Trust Improvement Groups linked to the local priorities identified in the PSIRP- falls, pressure ulcers and deteriorating patient.
- Organisational improvement plans have been developed for each of these areas where system-based improvement activity is held, ensuring that all known themes have been addressed, using appropriate data to measure progress. There is Organisational Development and Improvement membership across all three groups to further develop the improvement plans to ensure consistency and aligning with the Model for Improvement and use of PDSA cycles. Consideration is being given as to how we report for assurance from these groups.
- Six of the Trust's nine Patient Safety Specialists are progressing with the Level 3 and 4 national patient safety syllabus which is due to complete in December 2024. Following completion of this national curriculum a review of the internal training will take place.
- In addition, fifteen staff across the three business units have been identified as Patient Safety Incident Investigators and are currently undergoing training delivered by the Health Services Safety Investigation Body (HSSIB) which will equip them with skills in investigation and engagement in line with PSIRF.

Involvement

- We have engaged with our Patient Safety Partners to revise the Duty of Candour Letters and a guide for staff.

- A patient information leaflet for people involved in a patient safety incident has been produced with our Patient Safety Partners.
- A patient feedback survey is also in development to gather experiences of those affected by patient safety incidents.

Risks

- The Trust timescale of 48 working hours to undertake an initial review of a patient safety incident is not being met. This is a theme across all Business Units and work is underway to improve this position. We know some of this is administrative functions that need tightening and intend to develop a vlog for all incident handlers to understand their responsibility in updating the Datix system.
  Equally there are delays in achieving the subsequent review of the incident within 15 working days for low harm, and 30 days for moderate and severe harm.
- Adult Business Unit, as the highest reporting Business Unit, have the greatest delays, a small number of which are at 6 months, and are being prioritised. A meeting was held on 9 September 2024 with the Interim Director of Nursing and AHPs and the Business Unit leadership team. A plan is in progress to clear approximately 50 reviews which equates to the backlog from which point it is expected all reviews would be conducted within the stipulated 30 days.
- A meeting is scheduled on 17 September 2024 with the Specialist Business Unit to discuss the overdue incidents and plans to progress this work to clear the back log.
- The Patient Safety Team continue to undertake a 6 monthly audit of SI/PSII action completions. The 2023/24 audit has identified further improvements are required to provide robust assurance in relation to the completion of SI / PSII improvement actions and work is underway to address this. This is shared with Business Units through the quality reports.

Successes

- The Trust has successfully implemented the changes to adopt PSIRF within national timescales and within this reporting period.
- The Patient Safety Partners are influencing changes in Trust process and documents to improve our engagement with people within safety processes.
- The Patient Safety Team have established a forum to support supervision and development of the 15 patient safety incident investigators
- The Patient Safety Team are continuing to advance relationships and processes to support system wide learning opportunities with neighbouring organisations. This includes the invitation of partner organisations to LCH investigation review meetings and building a more collaborative system approach to our learning and improvements.

PATIENT SAFETY INCIDENTS OVERVIEW

The data for this report focusses on the period 1 March 2024 – 31 August 2024. As the data is taken from a live system there is some variation in the reported numbers over time. The data included in this report is accurate as of the 16/09/2024.

There were 2807 LCH patient incidents which occurred in the reporting period. Appendix One shows LCH patient incidents reported over a two-year period for all Trust incidents, then further split into business units. The decreasing trend of incidents in ABU from May 2024 coincides with the ceasing of reporting Moisture Associated Skin Damage (MASD) incidents. The increasing trend

in SBU is noted to be self-harm incidents and this is being monitored via the monthly BU reports. We will continue to work towards SPC reporting.

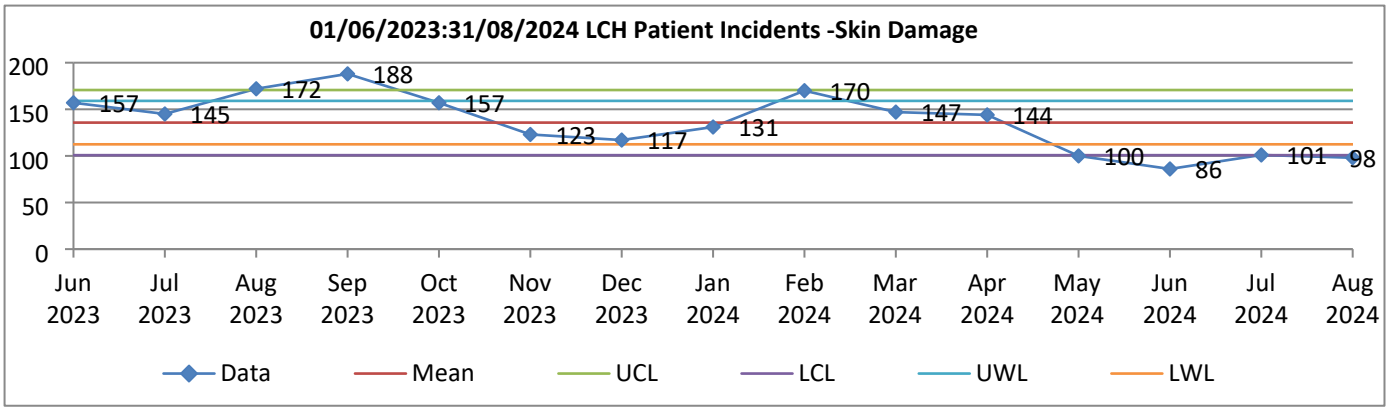
Of the 2807 incidents, 1546 (55%) were reported as causing harm; ABU (973), SBU (548), CBU (20), Corporate Business Unit – Infection Prevention Control Team (5)

The top four reported incident categories were:

- Skin Damage
- Abusive, Violent, Abusive, or self-harming behaviour
- Medication
- Patient accident that may result in an injury

All incidents are reviewed in the monthly Business Unit reports for themes and learning and shared via the Quality Assurance and Improvement Group (QAIG).

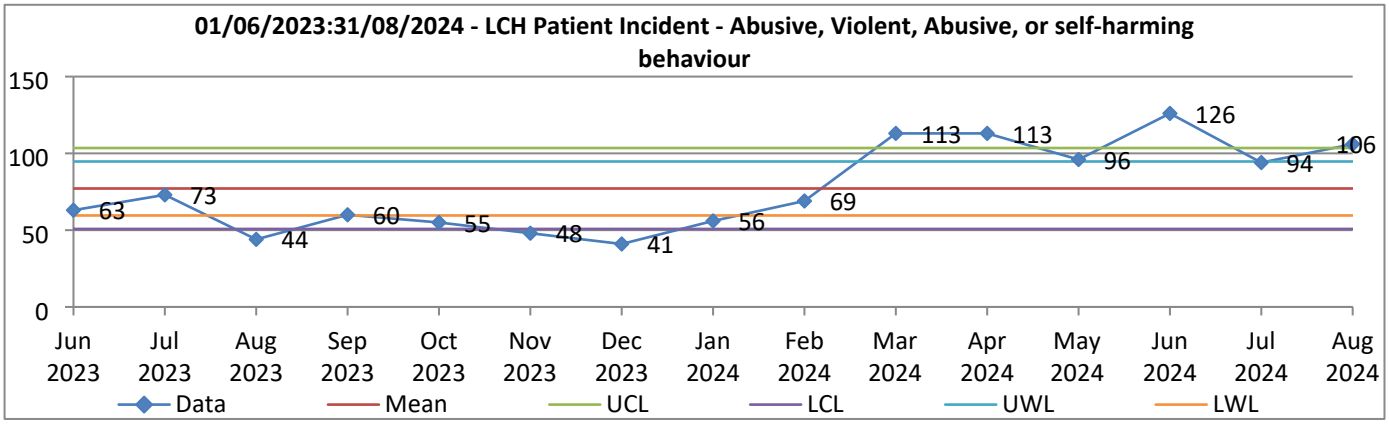
Skin damage



Of the skin damage incidents, the highest sub-category was pressure ulcers and remains in normal variation.

The top themes of learning from pressure ulcer incidents are included in Appendix Two and improvement activity linked to these themes is held within the trust wide pressure ulcer improvement plan and overseen by the pressure ulcer improvement group.
Full details of LCH pressure ulcer incidents and learning are held in the six-monthly pressure ulcer report reviewed by the pressure ulcer improvement group and sent to QAIG for noting.

Abusive, Violent, Abusive, or self-harming behaviour Incidents



The highest sub-category was self-harm during 24-hour and relates to multiple self-harm incidents for the same young people in Secure Estates, with ninety-six incidents being reported for one person.
Successive minimal harm, self-harm incidents for children and young people within the trust secure estates is one of the local patient safety priorities in the PSIRP. These incidents are discussed at the weekly Secure Estate Patient Safety panel for review and were assessed as cumulative and / or increasing harm are brought to an LCH Rapid Review.

Medication Incidents
There were two moderate and one near miss, high risk incident recorded. Medication incidents overall are showing within normal variation.

Full details of LCH medication incidents and learning is held in the Medicines report, presented quarterly to QAIG.

Patient accident that may result in an injury
The highest subcategory of this was slips, trips, falls and collisions and these remain within normal variation and are reviewed / investigated in line with the PSIRP.

Two incidents are currently being investigated as these were deaths subsequent to a fall.

The top themes of learning from falls incidents are included in Appendix Three and improvement activity linked to these themes is held within the trust wide falls improvement plan and overseen by the falls improvement group.

Full details of LCH falls incidents and learning are held in the six monthly falls report reviewed by the falls improvement group and sent to QAIG for noting.

SERIOUS INCIDENTS AND PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

There were seven Patient Safety Incident Investigations recorded, these were all incidents after 01 January 2024 and are managed under the Patient Safety Incident Response Framework, all remain in process.

There were three Serious Incident Investigations, and one Patient Safety Incident Investigation that concluded in the reporting period, learning identified is included in Appendix Four.

The Trust had no Never Events in this reporting period.

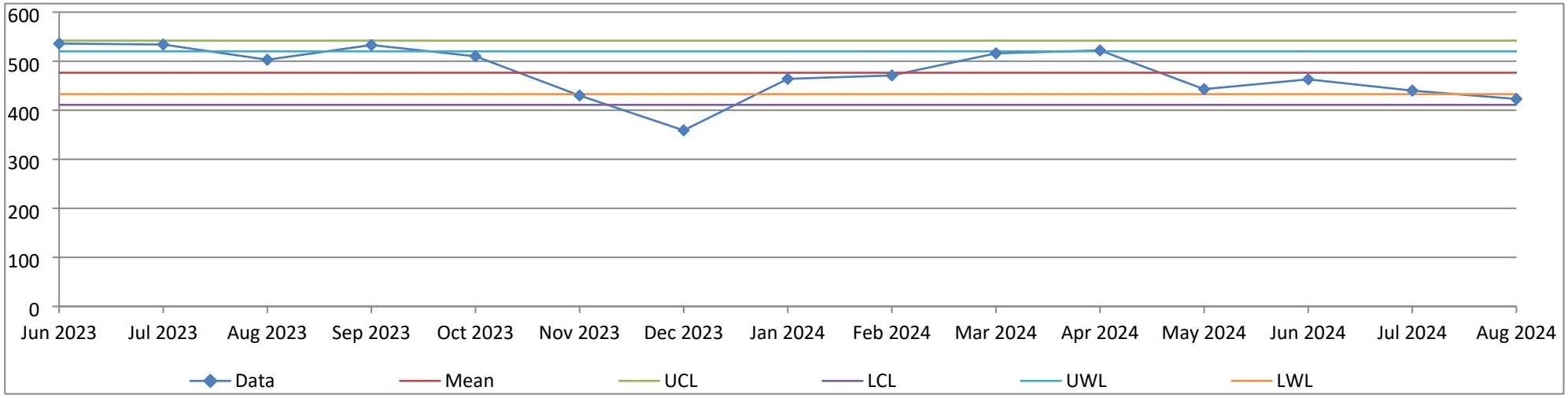
Other significant learning and themes

Following a small cluster (3 incidents) of patient safety incidents related to wound care with missed opportunities to identify and manage deterioration in line with the wound infection framework a number of actions have taken place:

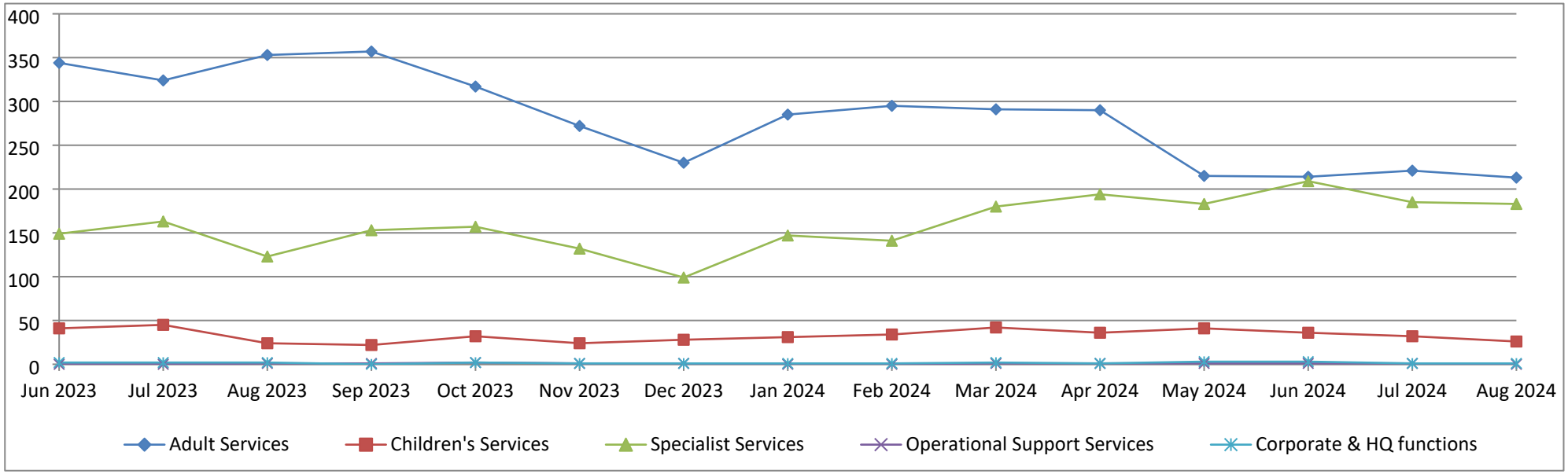
- A review, and slight revision, of the wound infection framework has been undertaken by the Practice Development Lead for Tissue Viability and Deputy Director of Infection Prevention and Control. The Tissue Viability Lead is presenting on this at the October IPC golden thread conference

- Tissue Viability Nurses to peer review clinical training and ensure the focus on this is right within LCH training
- Further engagement with staff to understand any other barriers to implementing the framework in practice
- Further review of access to swabs to ensure timely care delivery

Appendix one- LCH patient incidents by month and year – 01/06/2023:31/08/2024 (produced 16/09/2024)



LCH Incidents by Month/Year and Portfolio 01/06/2023:31/08/2024 (produced 16/09/2024)



Appendix Two - Themes of learning from pressure ulcer incidents

Pressure ulcer risk assessment not completed at appropriate times i.e. new to caseload, return to caseload, change in clinical condition
Lack of personalised care for patients based on risk assessment findings
Multi-agency care not joined up (e.g. home care, care homes, hospice)
Lack of case management
Pressure relieving equipment to be provided in a timely manner and used / maintained appropriately
Lack of pain assessment
Lack of timely referral to specialist services (e.g. TVN, Podiatry, Vascular, CUCS)
Identifying and documenting the correct are of the body where pressure damage has occurred.
A task focused approach to care delivery with a lack of holistic review.
Lack of wound photography when pressure ulcers are identified or improve/deteriorate.

Appendix Three - Themes of learning from falls incidents

Theme
Inaccurate completion of Tier 1 falls risk screening questions
Tier 2 falls risk assessment not routinely completed when change of environment from patient's own home into a care home
No lying and standing BP completed or no documented rationale why
Lack of follow-through or escalation when postural hypotension identified
Falls risk management template not completed after a fall on caseload
Missed opportunity to identify and action osteoporosis risk
Delays in provision of Neighbourhood Team Physiotherapy
Strength and balance not consistently assessed as part of physiotherapy assessment for a falls risk patient Limited provision of evidence-based strength and balance exercise programmes to falls risk patients, with tendency to provide seated exercises only and no rationale for why no further progression into standing
Inappropriate delegation to therapy assistant practitioner
Task orientated approach to patient visits
Missed opportunity to identify and manage a deteriorating patient
Lack of case management

Appendix Four- Learning from closed Serious Incident Investigations

Learning from closed SIs
To ensure that staff are aware of the acute delirium tool and when to use this tool
Following the correct process for No Access Visits
Recognising a deteriorating patient including soft signs
Consideration of sepsis for patients with deteriorating wounds including adherence to the wound infection framework and taking clinical observations
Ensuring that care is personalised provided in the right place at the right time by the right person
Caseload management or oversight from senior clinicians.
To follow up and explore the reasons for no access visits/ cancelled appointments to ensure patients receive the appropriate care
To improve communication between providers so it is effective and robust when patients are known to multiple organisations
Consideration of referrals to other services for patients who may benefit from this eg: voluntary sector, social care
To ensure there are robust business continuity plans in place to manage core tasks when staffing capacity is low including a process for escalation.
Ensuring correct prioritisation of patients/clients at the point of referral
The communication of safety support services within Mental Health needs to be standardised, clear and supportive
Ensuring Equity and Quality Impact Assessments are completed to determine whether changes are likely to negatively impact on other patient groups in line with the EQIA policy

Leeds Community Healthcare NHS Trust

Agenda item 2024-25 (82)

Public Board workplan 2024-26
Version 5: 23 09 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	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 April	EDFR	SR 6,8							Final X						
Trust priorities update	3x year (Feb, June and Oct)	EDFR/EDN&AHPS	SR 6,8	X			Deferred to December 2024 X	X	X		X			X		X
Third Sector Strategy	2x year (Feb and Sept)	EDO	SR 10			X			X				X			X
Estate Strategy	2xyear (April and Oct)	EDFR	SR 6				X -Blue box Deferred			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	2xyear (April and Oct)	EDO				X -Blue box Deferred				X -Blue box						
Business Intelligence Strategy -part of Digital Strategy September 2024	2x year (Feb and Sept)	EDFR				X -Blue box Deferred										
Learning and Developement Strategy	Annual	EDN&AHPS	SR 1							X -Blue box						
Engagement Strategy - update	2xyear (April and Oct)	EDN&AHPS	SR 1				X -Blue box deferred			X				X -Blue box	X -Blue box	
Patient Safety Strategy	2x (April and Oct)	EDN&AHPS	SR 1,2,4				X Deferred to December 2024	X		X				X		
Health Equity Strategy	3 x year(April, Sept and December)	EMD	SR1,9			X		X		X			X		X	
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 (including patient safety incident investigations) update report	2 x year (April 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(April 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 (April, 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 (April, 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 (April, 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

= received
= deferred to another meeting
= not required