Bundle Public Board Meeting 6 December 2024

Agenda
Final Agenda Public_Board_Meeting_6 December_2024 28 11 2024

83 09:00 - Welcome, introductions and apologies

84 Declarations of interest

85 Questions from members of the public
Minutes adoption for approval

86 Minutes of previous meeting and matters arising:

86.a Minutes of the meetings held on 4 October 2024
Item 86a Public Board Minutes 4 October 2024

86.b Actions' log
Item 86b Public Board Action log December 2024_

87 09:15 - Patient's story: Children's Physiotherapy Service

88 09:35 - Chief Executive's report
Item 88 CEO report - 6 Dec 2024

89 09:45 - Trust Priorities 2024-25 - Update
Item 89i - TP Dashboard Cover Report
Item 89ii - TP Dashboard Mid Year Update

90 10:00 - Digital, Data and Technology Strategy
Item 90i Board Cover Paper - DDaT Strategy - TB 06122024
Item 90ii LCH_DDaT_Strategy_2024-2027_V4Final

91 10:20 - Patient Safety Strategy Implementation Final Update Report
Item 91 PSS Final Sep 24

92 10:45 - Quality Committee Chair's Assurance Report: November 2024
Item 92 Quality Committee Chairs Assurrance Report Nov 2024 Final

93 10:50 - Business Committee Chair's Assurance Reports: October and November 2024
Item 93i Business Committee Chair Assurance Report Oct 2024
Item 93ii Business Committee Chair Assurance Report Nov 2024

94 10:55 - Audit Committee Chair's Assurance Report: October 2024
Item 94 Audit Committee Chair Assurance Report October 2024

95 11:00 - Performance report
Item 95i Performance Brief Highlight Report for Board October 2024_Final

96 11:15 - Emergency Preparedness, Resilience & Response (EPRR) •Statement of Compliance •Approval of EPRR Plans and Policies
COPY OF CORE STANDARDS ITEM 96iii ATTACHED AS A SEPARATE DOCUMENT TO THE COLLATED PACK
Item 96i Board Covering paper - EPRR Improvement Plan v0.1 - December 2024
Item 96ii Assurance process Statement of Compliance 2024-5 (signed)

97 11:25 - Guardian for Safe Working Hours - Quarter 2 Report
Item 97 GoSWH- Quarter2 report Dec 2024rb

98 11:35 - Significant Risks and Risk Assurance Report
Item 98 Board Significant Risks report 061224

99 11:40 - Board Assurance Framework Quarterly Update
Item 99i Board Assurance Framework Quarterly update Dec 24 Cover
Item 99ii 2024_25_BAF_November2024

100 11:45 - Chief Executive Officer/Chair Action: Approval of Auditor Panel Terms of Reference

Item 100 CEO and Chair Action (Auditor Panel ToR) Nov 2024
Item 100ii Auditor Panel terms-of-reference Nov 2024

101 11:50 - Contract Award Proposal: Voice and Mobile Data SIM Cards Plus Mobile Device Management Solution
Item 101 Mobile_Data_Contract_Award_Proposal_V2_TB_Dec24

102 11:55 - Any Other Business. Questions on Blue Box Items and Close

103 Blue Box Item: EPRR – plans and policies – reviewed by Business Committee
Item 103i LCH EPRR Policy - Final (Oct 24)
Item 103ii LCH Evacuation Shelter Plan v0.3 - Nov 24
Item 103iii LCH Incident Response Plan v12 FINAL - Oct 2024
Item 103iv LCH BC Policy & BCMS v0.2 - Oct 24
Item 103v LCH Adverse Weather Plan - Oct 2024 (Final)
Item 103vi LCH Fuel Disruption Plan v0.2 (Final) - Oct 24
Item 103vii LCH CBRN Plan v0.3 - Oct 24

104 Blue Box Item: Annual Green Plan Refresh – reviewed by Business Committee November 2024
Item 104i Green Plan Refresh cover paper Board December 2024
Item 104ii Green Plan Refresh 2025-2028 Presentation November

105 Blue Box Item: Mortality Reports Quarter 1 and Quarter 2 – reviewed by Quality Committee July and November 2024
Item 105i Mortality reportQ1
Item 105ii July 2024 Adult Mortality report V1
Item 105iii Leeds MES GP Flow Chart
Item 105iv Deep Dive Unexpected deaths Q3 2023 Q4 2024
Item 105v QAIG flash report CBU Child Death Q1 24 - 25 FINAL
Item 105vi Mortality Report Q2 2024_2025
Item 105vii QAIG flash report CBU Child Death Q2 24 - 25 FINAL
Item 105viii QAIG flash report Adult Deaths Q2 24 - 25 Final

106 Blue Box Item: Workplan
Item 106 Public Board workplan 2024-26 v6 27 11 2024

Leeds Community Healthcare NHS Trust

Trust Board Meeting Held In Public
Boardroom, White Rose Office Park
Millshaw Park Lane
Leeds
LS11 ODL

Date 6 December 2024
Time 9.00am - 12.00noon
Chair Brodie Clark CBE, Trust Chair

AGENDA			Paper
2024-25 83	9.00	**Welcome, introductions and apologies** *(Trust Chair)*	**N**
STANDING ITEMS			
2024-25 84	9.05	**Declarations of interest** *(Trust Chair)*	**N**
2024-25 85		**Questions from members of the public**	**N**
2024-25 86		**Minutes of previous meeting, action log and matters arising** *(Trust Chair)* *For approval*	
86a		Minutes of the meeting held on: 4 October 2024	**Y**
86b		Action log: 6 December 2024	**Y**
2024-25 87	9.10	**Patient story:** *Children's Physiotherapy Service*	**N**
STRATEGY AND PARTNERSHIPS			
2024-25 88	9.35	**Chief Executive's report** *(Selina Douglas)*	**Y**
2024-25 89	9.45	**Trust Priorities 2024-25 - Update** *(Andrea Osborne/ Lynsey Yeomans)*	**Y**
2024-25 90	10.00	**Digital, Data and Technology Strategy** – *for approval* *(Andrea Osborne)*	**Y**
2024-25 91	10.20	**Patient Safety Strategy Implementation Final Update Report** *(Lynsey Yeomans)*	**Y**
BREAK			
QUALITY AND SAFETY			
2024-25 92	10.45	**Quality Committee Chair's Assurance Report:** November 2024 *(Helen Thomson)*	**Y**
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2024-25 93	10.50	**Business Committee Chair's Assurance Reports:** October and November 2024 *(Rachel Booth)*	**Y**
2024-25 94	10.55	**Audit Committee Chair's Assurance Report:** October 2024 *(Khalil Rehman)*	**Y**
2024-25 95	11.00	**Performance report** *(Andrea Osborne)*	**Y**
2024-25 96	11.15	**Emergency Preparedness, Resilience & Response Improvement Plan (EPRR)** • Statement of Compliance *(Sam Prince)*	**Y**

WORKFORCE			
2024-25 97	11.25	**Guardian for Safe Working Hours - Quarter 2 Report** *(Dr Nallapetta Nagashree)*	**Y**
GOVERNANCE AND WELL LED			
2024-25 98	11.35	**Significant Risks and Risk Assurance Report** *(Selina Douglas)*	**Y**
2024-25 99	11.40	**Board Assurance Framework Quarterly Update** *(Selina Douglas)*	**Y**
2024-25 100	11.45	**Chief Executive Officer/Chair Action: Approval of Auditor Panel Terms of Reference** *(Trust Chair)*	**Y**
2024-25 101	11.50	**Contract Award Proposal: Voice and Mobile Data SIM Cards Plus Mobile Device Management Solution** (Andrea Osborne)	**Y**
CLOSING BUSINESS			
2024-25 102	11.55	**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 102.

***Blue Box**		
2024-25 103	**EPRR – plans and policies –** reviewed by Business Committee	**Y**
2024-25 104	**Green Plan Refresh –** reviewed by Business Committee November 2024	**Y**
2024-25 105	**Mortality Reports Quarter 1 and Quarter 2** – reviewed by Quality Committee July and November 2024	**Y**
2024-25 106	**Workplan**	**Y**

Agenda item:	2024-25 (86a)

Title of report:	Minutes Trust Board Meeting Held in Public: 4 October 2024

Meeting:	Trust Board Meeting Held in Public
Date:	6 December 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
	Sam Prince	Deputy Chief Executive/ Executive Director of Operations (Deputising for the Chief Executive)
	Professor Ian Lewis (IL)	Non-Executive Director
	Khalil Rehman (KR)	Non-Executive Director
	Alison Lowe (AL) OBE	Non-Executive Director
	Rachel Booth (RB)	Non-Executive Director
	Andrea Osborne	Executive Director of Finance and Resources
	Lynsey Yeomans	Executive Director of Nursing and Allied Health Professionals (AHPs)
	Dr Stuart Murdoch	Deputy Medical Director (Deputising for the Executive Medical Director)
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
Apologies:	Selina Douglas	Chief Executive
	Helen Thomson Deputy Lieutenant (DL) (HT)	Non-Executive Director
	Dr Ruth Burnett	Executive Medical Director
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
In attendance:	Helen Robinson	Company Secretary
	Rachel Livingston	Clinical Manager, Physiotherapy Leeds Community Healthcare (for Item 64)
	Michelle Potts	Self-Management Development Officer (for Item 64)
	Dawn Greaves	Associate Director of Digital Transformation (for Item 66)
Minutes:	Liz Thornton	Board Administrator
Observers:	Hannah Beal	Deputy Director of AHPs and Clinical Education
Members of the public:	None	

Item 2024-25 (60)

Discussion points:

Welcome introduction, apologies, and preliminary business

The Trust Chair opened the Board meeting and welcomed members and attendees. Lynsey Yeomans, the Trust's new Executive Director of Nursing and AHP's was attending her first Trust Board meeting. Rachel Booth was congratulated on her deserved appointment as a substantive Non-Executive Director following a lengthy and detailed recruitment process.

Apologies

Apologies for absence were received from Selina Douglas, Chief Executive, Helen Thomson DL, Non-Executive Director, Dr Ruth Burnett, Executive Medical Director and Laura Smith, Director of Workforce, Organisational Development and System Development (LS).

Item 2024-25 (61)

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 (62)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2024-25 (63)

Discussion points:

Minutes of the last meeting, matters arising and action log

a) Minutes of the meeting held on 3 September 2024

The minutes were reviewed for accuracy.

b) Action log 3 September 2024

The Board reviewed and noted the progress against all the actions. The following actions were closed:

2024-25(41):Clarification on the process for reporting details of claims made against the Trust to Board and Committees: this action would be carried forward to the meeting on 6 December 2024. **Ongoing.**

2024-25(52):Significant Risk Reports to include more information about how and why decisions had been made to changes in risk scores: included in the report for this meeting. **Action closed.**

2023-24(98):Progress report on developments in the Community Neurological Rehabilitation Service (CNRS) to be brought to the Board: the Executive Director of Nursing and AHPs informed the Board that CNRS was benchmarking stroke rehabilitation programmes against offers from local partners and reviewing options for developing a new model of care as part of the Quality and Value Programme. Proactive partnerships were in place with Enhance, Active Leeds, Carers Leeds, the Stroke Association and Speech and Language Therapy services. **Action closed.**

Item 2024-25 (64)

Discussion points:

Patient story: Ellen's story

The Executive Director of Nursing and AHPs introduced the story and welcomed Rachel Livingston and Michelle Potts to support the story. The patient was unable to attend.

Ellen had been attending the Integrated clinics for leg ulcer management. After several weeks the wound had healed but staff in the Integrated clinic identified that Ellen had increased anxiety and social phobia, she had stopped going out. Staff talked to her regarding her goals and aspirations

(using the 'what matters to me' tool) and found that Ellen wanted to meet people as she missed social contact. Ellen agreed to attend the local Self-Management Health Hub, where the Self-Management Facilitators were able to review her wound management care, and following this Ellen could join in the social activities supported by Enhance. The staff at the Health Hub were able to chaperone Ellen to introduce her gradually to the activities and increase her confidence. Ellen now attended the Health Hub weekly and described it as the 'best part of her week.'

The Trust Chair invited questions and observations from Board members.

The Trust Chair asked how many patient the Integrated Clinics were able to see. Over 42 clinics 15,000 patients were seen annually to undertake wound management. The Self- Management Team comprised of 22 members of staff with a caseload of approximately 30 patients each.

Non-Executive Director (AL) asked about involvement from 3rd sector organisations. She was informed that 3rd sector organisations were proactively involved in each hub setting, particularly Enhance, who were able to support patients to attend social activities. Other voluntary organisations were also present and fully involved.

Without the support from Enhance this patient would not have attended the Health Hub and joined the social activities on offer.

Non-Executive Director (IL) asked about capacity within the team to cover a city-wide service. The aspiration was to provide a city-wide service but there were areas which were not currently covered and at least three additional hubs would be required to cover the whole of the City. It was noted that capacity to support this would be a challenge.

It was agreed that the Business Committee would receive a report on the impact and outcomes of the service provided by the Health Hubs and the support provided by Enhance in November 2024.

The Trust Chair thanked Rachel and Michelle for attending the meeting to present Ellen's 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.

He reflected that the Trust was experiencing a huge time of change and this would feature in the agenda discussions today and formal and informal discussions over the forthcoming months around:

- Quality and Value.
- Funding updates and assurance.
- Partnership developments.
- A more strongly emerging Government focus – and how the Trust might influence the associated delivery.

He made the following points:

- The Trust Board Team was one of the strongest, most focussed, and most committed that he had ever worked with.
- It was important that the Team did not miss the obvious in favour of developing change and to remain vigilant in order not to miss the obvious

2024-25 Item (65)

Discussion points:

a) Chief Executive's report

The DeputyChief Executive presented the report which focussed on:

- Non-Executive Director recruitment
- The Darzi Review report: Independent investigation of the NHS in England
- Quality and Value Programme
- Collaboration

- I Thrive/We Thrive programme
- Audiology Service Review
- Annual General Meeting (AGM)

Outcome: the Board
- Received and noted the report.

Item 2024-25 (66)

Discussion points:
Digital, Data and Technology Strategy including sign off-off Year 1 Business Case
The Associate Director of Digital Transformation presented the report.

The Strategy and Business Case had been reviewed by the Trust Leadership Team, Business Committee, Digital Programme Board prior to presentation to the Board.

Strategy
Board members made a number of comments on the strategy and suggested areas which should be strengthened or added including:
- Evidence of collaboration and co-production with patients.
- Feedback from 3rd sector partners.
- References to Artificial Intelligence (AI) technology.
- Use of data to improve and drive the health equity agenda.
- Clinical leadership
- Putting the demonstration of effectiveness and evaluation monitoring at the heart of the strategy

The Board agreed that the strategy would benefit from scrutiny by the Quality Committee to ensure that it was reviewed from a clinical perspective including clinical leadership capacity before final approval.

The Executive Director of Finance and Resources agreed to revisit and improve the strategy considering the points made by the Board and to ensure that both Business and Quality Committee were sighted on the updated strategy.

Year one business case
The Executive Director of Finance and Resources drew attention to the year 1 business case which was 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. She said that it was time-imperative that the Board approved the business case at this meeting otherwise the Trust would be at risk of losing the national funding available through National Frontline Digitisation.

Outcome: the Board
- Reviewed and commented on the Digital, Data and Transformation Strategy
- Reviewed and approved the year 1 business case for delivery of the strategy noting the key points around funding risks.
- Agreed that the Strategy would be taken back through the Business and Quality Committees for further scrutiny.

Item 2024-25 (67)

Discussion points:
Children Young People and Families Strategy
The Deputy Chief Executive presented the paper which provided a six-monthly update on the progress made against the eight objectives defined in the Strategy. She stressed that 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.

Non-Executive Director (IL) asked about the Trust's interaction and relationship with Leeds Children's Hospital and wider engagement with children across the city. The Deputy Chief

Executive informed the Board that the relationship with Leeds Children's Hospital was developing positively and proactive steps had already been taken to link services together, for example in the Integrated Children's Additional Needs Service (ICAN) and the Community Intravenous Antibiotic Service.

Engagement with children was through individual conversations about their care, through the Youth Board and also connections with the Leeds SEND Parent and Carer Forum.

The Trust Chair noted that there would be an opportunity to raise greater collaboration over the Leeds Children's Hospital at the Board-to-Board session with Leeds Teaching Hospitals NHS Trust on 24 October 2024.

Outcome: the Board

- Noted the contents of the report and progress against the objectives set out in the Children, Young People and Families strategy 2022-2025.

Item 2024-25 (68)

Discussion points:

Workforce Headlines and Strategy Update

The Director of Workforce, Organisational Development and System Development (JA) presented the report which provided information about key headlines linked to the Trust's Workforce portfolio. The report had been discussed by the Business Committee prior to presentation to the Trust Board.

The Board noted that the intention was that a successor document to the current Workforce Strategy would be developed in the context of the Trust's new organisational strategy. This would ensure that the Trust's medium and long-term workforce plans and initiatives were designed to deliver the ambitions of the organisational strategy.

To enable this, the Board was asked to agree that the tenure of the current Workforce Strategy was extended to 31 March 2026.

Non-Executive Director (AL) made a number of comments and observations about the Strategy. It was agreed that these would be discussed outside the meeting.

Outcome: the Board

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

Item 2024-25 (69)

Discussion points:

Quality Committee Assurance Report: September 2024

Non-Executive (IL), presented the report on behalf of the Chair of the Committee and highlighted the key issues discussed:

- Waiting Lists position Statement – the Committee had 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 Specialist Business Unit, and severe issues were reported within the Children's Business Unit. Although the Committee felt assured the Trust had a grasp on the numbers, assurance was limited around managing risks associated with patients on the waiting list who were not in contact with the Trust .
- Performance Brief – the use of Statistical Process Control Charts (SPC) charts had been welcomed by the Committee, whilst noting that the Brief was a work in progress.
- Quality & Value Programme – progress against target and workstream updates had been reported. The Committee noted that 11 service redesigns were ongoing, with 5 currently 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 had been shared and well-received by Committee.

The Board noted that four of the five strategic risks assigned to the Committee had been assigned a **reasonable** level of assurance and one a **limited** level of assurance - Risk 2 Failure to manage demand for services.

Outcome: the Board

- Noted the update reports and the matters highlighted.

Item 2024-25 (70)

Discussion points:

Business Committee Assurance Reports: September 2024

Non-Executive Director Rachel Booth (RB), Chair of the Committee presented the report and highlighted the key issues discussed:

- The Digital, Data & Technology Strategy and the Year 1 business case had been discussed. A preferred option was recommended for approval by the Board but the risks around financing the plan were noted.
- The Active Recovery Single Care Record business case had been presented and the Committee had supported the recommended option to continue with implementation Benefits for clinical risk management were acknowledged.
- Quality and Value – good progress on delivery against target had been reported but there were some risks beyond current year as many of the savings were non-recurrent . Internal audit had concluded significant assurance in relation to the programme design. There would be a continued focus on the quality agenda and people engagement.
- The waiting list position had been discussed, including potential solutions for addressing the higher risk waiting lists. The Committee remained concerned about the wait times and volumes in high-risk areas but took reasonable assurance that the leadership team were well sighted on risk and doing all they reasonably could to manage risk and innovate to tackle wait times.
- The Enhance service internal audit report (limited assurance) was discussed – management actions had been agreed to improve data capture to demonstrate positive impact of the service and value for money.

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

Outcome: the Board

- Noted the assurance report and the matters highlighted.

Item 2024-25 (71)

Discussion points:

Charitable Funds Committee Assurance Report: September 2024

Non-Executive Director (AL) Committee Chair presented the report and highlighted the key issues discussed:

- There would be a focus on promoting Microhive (previously Pennies from Heaven) through local communications.
- The Charitable Funds Officer was proving to be an excellent appointment and she was developing local networks to support further development of the Charity.
- The Committee heard about the fundraising activity since the last committee meeting including the Trust summer show, “A slice of Saturday night.”
- The Committee welcomed a recent legacy donation for the charity.
- Received a finance report covering April – June 2024.

The Board agreed that to raise the profile of the Charity reports would be made twice per year to the Trust Board.

Outcome: the Board

- Noted the assurance report and the matters highlighted.

Item 2024-25 (72)

Discussion points:

Performance report

The Executive Director of Finance presented the report. The Board noted that the development of a published version of the Performance Brief remained in progress. In the meantime, the report presented provided key updates and escalations as follows:

- escalations against the Trusts High Level Indicators (HLIs)
- assurance to the Trust Board on progress relating to the development of the Performance Brief
- an update on Financial Performance and delivery of the 24/25 financial plan
- an update on the Quality and Value (Q&V) Programme delivery.

Non-Executive Director (IL) asked how the Trust assessed the impact of outcomes from the Quality and Value Programme on service delivery outside the organisation.

The Equality Impact Assessment process would pick up both internal and external impact. Assurance was provided that proactive engagement with various external groups would ensure that they were sighted on any changes. The Deputy Chief Executive shared some examples of where this had already happened.

The Executive Director of Finance and Resources provided a brief update on the Trust's current financial position drawing attention to the information in the finance section of the report.

Non-Executive Director (KR) asked about the wider West Yorkshire financial situation.

The Executive Director of Finance and Resources reported that the West Yorkshire Integrated Care Board (WYICB) was facing significant financial challenge. As part of the work to achieve financial balance for the year 2024-25 and reduce the underlying deficit, WYICB had commissioned a financial review from PWC which would report before the end of 2024.

The Trust had begun a self-assessment process as part of the PWC review which would be completed by the end of September 2024. A report on the outcome of the self-assessment process would be presented to the Business Committee. The final PWC organisation and System reports would be presented to a future Board meeting.

Outcome: the Board

- Received and noted the update.

Item 2024-25 (73)

Discussion points:

Nominations and Remuneration Committee Chair's Assurance Report

The Trust Chair as Chair of the Committee presented the report and highlighted the key issues discussed:

- 2024 Very Senior Manager (VSM) pay award recommendation and bonuses: the Committee had agreed that the 5% uplift could be paid to VSMs once final confirmation of the acceptance of the uplift was received. Bonuses would not be paid to the VSMs at the Trust for 2023/24. The Committee 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.
- **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.

Outcome: the Board

- Noted the assurance report and the matters highlighted.

Item 2024-25 (74)

Discussion points:

Medical Director's Annual Report 2023-24

The Deputy Medical Director presented the report on behalf of the Executive Medical Director which provided the Board with an update and overview regarding the Trust's responsibilities as an employer of Medical and Dental staff including:

- Appraisal and medical revalidation
- Managing concerns
- Pre-employment checks.

It fulfilled the requirements set by NHS England in relation to:

- Annual Organisational Audit
- Designated Body Annual Board Report
- Statement of Compliance

It was noted that the Statement of Compliance for 2023/24 had not been included in the report presented at the meeting and would be circulated by email.

Action: Statement of Compliance for 2023/24 to be circulated by email.

Responsible Officer: Board Administrator.

Outcome: the Board

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

Item 2024-25 (75)

Discussion points:

Annual Workforce Equality, Diversity, and Inclusion Report 2023/24 (Incorporating Overarching Equality, Diversity, and Inclusion Improvement plan)

The Director of Workforce, Organisational Development and System Development (JA) presented the annual update on progress 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.

The paper provided:

- A retrospective look at the Equality, Diversity, and Inclusion highlights during 2023
- The Overarching Equality, Diversity, and Inclusion Action Plan for 2024/2025 included:
  - the Workforce Disability Equality Standard (WDES),
  - Workforce Race Equality Standard (WRES) and
  - Gender Pay Gap (GPG) actions

Non-Executive Director (AL) referred to both the action plans and encouraged the Trust to place a greater focus on decreasing the percentage of "Not stated" staff disability data on ESR and promote the case to declare/update equality data to reduce the percentage of unknown/not declared on ESR.

In relation to the action on the WDES Action Plan about the development of the BME Talent Management Programme she suggested that access should be widened to disabled and LBQT staff. The Director of Workforce, Organisational Development and System Development (JA) said that further evaluation and analysis would need to be completed before further changes were made.

Non-Executive Director (KR) referred to the references to bullying and harassment from patients, relatives, staff, and managers in the actions in both plans and asked how the Trust intended to address the concerns raised. The Director of Workforce, Organisational Development and System Development (JA) said that services were interrogating the data so that there was a clear

understanding of what the precise problems and issues were, however subsequent actions were contingent on individuals identifying themselves to provide additional clarity. Further information on the work underway on bullying and harassment would be taken via the workforce reports presented to the Business Committee.

Outcome: the Board

- Noted the Equality, Diversity, and Inclusion highlights during 2023/24
- Agreed that the continued delivery of the Overarching Equality, Diversity, and Inclusion Action Plan for 2024-25 provided 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)

Item 2024-25 (76)

Discussion points:

a) Significant Risks Report

The Deputy 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.

It was noted that there was one risk on the Trust risk register that had a score of 15 or more (extreme). There were a total of 13 risks scoring 12 (very high).

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 (77)

Discussion points:

Board Assurance Framework (BAF) Quarterly update

Following the agreement of the Trust's strategic objectives and priorities for 2024/25, it was agreed that the BAF would be reviewed on a quarterly basis and the outcome shared with the Board. The BAF was presented for assurance on its completeness as of September 2024.

The Board reviewed the updated BAF which formed Appendix 1 of the report.

Outcome: the Board

- Received the BAF and was assured of the appropriateness of updates, including risk scoring and mitigating actions.

Item 2024-25 (78)

Discussion points:

Board Members Service Visit Reports

The record of Board Member service visits for June, July and August 2024 was noted.

The Board discussed whether observations made by non-executive directors during Quality Walks should be added to future reports.

The Executive Director of Nursing and AHPs agreed to give this further consideration before the next report was presented to the Board in February 2025.

Action: To consider whether future Board Member service visit reports should include non-executive director's observations on Quality Walks.

Responsible Officer: Executive Director of Nursing and AHPs.

Outcome: the Board

- Noted the report.

Item 2024-25(79)
Discussion points: **Any other business Blue Box Items and Close** There were no matters raised. The Trust Chair closed the meeting at 12.00 Noon
Date and time of next meeting **Friday 6 December 2024 9.00am-12.00 noon**

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

AGENDA ITEM 2024-25 (86b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) action log: 6 December 2024

Key		Key colour code
Total actions on action log	4	
Actions on log **completed** since last Board meeting on 4 October 2024 with a **proposal to close**	4	
Actions not due for completion before 6 December 2024: **progressing to timescale**	0	
Actions not due for completion before 6 December 2024: agreed timescales and/or requirements **are at risk or have been delayed**	0	
Actions outstanding at 6 December 2024**: not having met agreed timescales and/or requirements**	0	

Agenda Item Number	Action Agreed	Lead	Timescale/Deadline	Status
4 October 2024				
2024-25 (74)	**Medical Director's Annual Report 2023-24:** • Statement of Compliance for 2023/24 to be circulated by email.	Board Administrator	Post meeting	Circulated by Email 4 October 2024 **Propose close**
2024-25 (78)	**Board Members Service Visit Reports:** • To consider whether future Board Member service visit reports should include non-executive director's observations on Quality Walks.	Executive Director of Nursing and AHPs	Trust Board meeting 6 December 2024	Verbal update to Trust Board meeting 6 December 2024 – **Propose close**
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 6 December 2024	Verbal update to Trust Board meeting 6 December 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	Update included in the CEO Report for 6 December 2024 meeting **Propose close**

Agenda item:	2024-25 (88)

Title of report:	Chief Executive's report

Meeting:	Trust Board Meeting Held in Public
Date:	6 December 2024

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

Executive Summary:	This report updates the Board on the Trust's activities since the last meeting and draws the Board's attention to any issues of significance or interest. This month's report focusses on: • Associate Non-Executive Director recruitment • Developmental Well-led review update • Quality and Value Programme • Business Development • Leeds Tier 3 Specialist Weight Management Service • Collaborating in Partnership • Long Term Plan • Safe space discussion post summer unrest

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 Associate Non-Executive Director Recruitment

We have now fully concluded the recent round of recruitment and I am delighted to announce that following a rigorous recruitment process, Lynne Mellor has been appointed as Associate Non-Executive Director for a term of two years from 1 November. Lynne is an experienced Board member, having served two terms as a Non-Executive Director at York and Scarborough Teaching Hospitals NHS Foundation Trust, and we are thrilled that she will be joining our Board as a non-voting member.

3 Developmental Well-Led Review Update

As a follow on to my update in September, Mersey Internal Audit Agency (MIAA) have now commenced the developmental well led review recently commissioned by the Trust. They have almost completed the round of interviews with Board members and key individuals, and are in the process of observing various Board, Committee, sub-Committee and leadership meetings over the next few weeks. In the background, a desktop document review is being undertaken and external stakeholder surveys have been carried out.

MIAA are due to report back their preliminary findings through an informal Board session in early January 2025, and we are eagerly awaiting this session in order to start targeted development work to secure and sustain the Trust's future performance.

4 Quality & Value Programme

The Quality and Value Programme continues to progress well and improve month on month. As a result, the Trust is forecasting to achieve full financial balance. 47% of this is currently attributable to grip and control measures and so this constitutes a high proportion of non-recurrent savings. This poses some risk to next year of the programme as could create an additional cost pressure. The remainder of the financial year will be to convert more of this into recurrent savings. Services going

through redesigns are starting to progress with costed workforce plans, and have started their Equity and Quality Impact Assessments, and engagement with stakeholders – all of these things will help make savings recurrent as they will provide more assurance that the savings can be made safely and sustainably. Planning for year two of the programme has started.

5 Business Development

We are pleased to report back that following a tender exercise LCH has retained the Custodial Healthcare Services at Wetherby Young Offenders Institute and Adel Beck Secure Children's Home. The new contract will start on 1st April 2025 and will include an additional service at Aldine House Secure Children's Home in Sheffield.

6 Leeds Tier 3 Specialist Weight Management Service

The Leeds Tier 3 Specialist Weight Management Service is making good progress in terms of service recovery and planning for the future redesign of the Specialist weight management service offer in Leeds:

- Additional resource has supported the treatment and discharge of 422 patients in the last 12 months, a reduction of 31% compared to the same time last year
- Delivery of Semaglutide (Wegovy) treatment has commenced in Leeds, with patients now in active treatment.
- The Healthy Lifestyle offer (includes behavioural intervention, physical activity advice and dietary approaches) has been redesigned and implemented
- Leeds Place of the West Yorkshire ICB is facilitating engagement with Primary Care to support redesign of the pathway for future referrals
- The remainder of 2024 will be utilised to track the impact/rate of recovery with opportunities being progressed within the service for redesign
- A digital referral pathway will be explored to facilitate Primary Care decision making and improve consistency of referrals for the Specialist Weight Management Service
- Jan-March 2025: Recovery progress and engagement with Primary Care will inform timeline/date for when it's feasible to resume to any new referrals (including surgical and medicines pathways). It is anticipated that this will by July 2025 at the latest.

7 Collaborating in Partnership

Leeds Teaching Hospital Trust and LCH held a joint board to board on the 24th October. This was the first time both trusts had come together to discuss how we can work together. It was a productive session with a wide range of topics on the agenda such as care pathways, purchasing and how the improvement cultures across both trusts could work together. A joint executive meeting will be held in December with a follow-up meeting of both boards in March.

The Community Collaborative Time Out took place Friday 22nd November. This was a space for us collectively to think of the future of community health and social care in light of Darzi, the upcoming 10-year plan. We had a focused conversation on neighbourhood and the shift that is required to allow us to achieve the outcomes of the 10 year plan. There is to be a further workshop in January to bring the relevant

providers together and review the blue print Neighbourhood paper and how we can bring this to life in Leeds.

Colleagues from the Homefirst programme presented at NHS Providers this month to highlight the great work between LTHT, LCC, LCH and the voluntary sector. This programme has made a significant contribution to this years winter planning. The programme is currently looking at how this is mainstreamed across Leeds to ensure the results for our residents is maximised.

8 Consultation on the Long Term Plan and System Development

NHSE Regional Teams held a consultation event on the 21st November on the Long Term Plan. The three big areas for discussion, as outlined in the Darzi report, are;

1. Analogue to Digital
2. Sickness to Prevention
3. Hospital to Community.

NHSE have asked for feedback. This will inform the draft plan which will be published in Spring/Summer next year. We are sharing the consultation details with staff to encourage them to take part. LCH is also part of a submission from the Leeds system.

NHSE held a national event to discuss the new operating model between the NHSE, ICB's and Providers. Discussions are ongoing but clarity around the role of providers in the system was helpful. This included quality, safety and delivery alongside a need to help the development of neighbourhood teams. Performance management was also highlighted as an area for improvement and a reduction in duplication. Further information will be shared with the board.

9 Second Safe Space Meeting

LCH and REN held a joint Safe Space meeting in November. The meeting heard feedback from estates and facilities about actions to be taken from the last meeting and also from allies who came along to highlight how they could support BAME staff going forward. It was a helpful session with lots of open discussion. A focus on Islamophobia at the next Equalities, Diversity and Inclusion forum to ensure the trust is listening and responding to LCH staff concerns/issues/best practice.

10 Anchor Institution Update

Over the past couple of months we, along with all Leeds Inclusive Anchor Network members, have been refreshing our Anchor Network Progression Framework self-assessment. The framework provides a consistent basis for Anchor Network members to reflect on progress to date and the potential to go further in relation to Anchor Network commitment to building positive presence for local communities, businesses and the environment through the way we act as:

- Inclusive Employers – policies on recruitment, pay and conditions, progression and health and well-being to support inclusion goals, lower paid workers, help recruit and retain staff and tap in to people's talents
- Procurement of goods, services and infrastructure – support local businesses and job opportunities, recirculate wealth and bring community benefits while

maintaining focus on the right price and quality and improving supply chain resilience and responsiveness

- environment and assets – by adopting targets, policies and actions to respond to the climate emergency, reduce energy, waste and pollution, and create better built and natural environments and using assets to support local communities
- service delivery – delivering services in ways designed to help those facing disadvantage and inequality
- civic and corporate - embed 'anchor thinking' across organisational ethos, planning and actions, and work with others to share good practice, help each other succeed and delver enhanced positive impact for their people and places.

The framework requires Network members to score their current status and future ambitions on a scale of 1 to 5 against descriptors. The framework is used by several other Anchor Networks in the UK. Leeds AN members last refreshed their self-assessments in 2021.

In my report to February Board I will report on progress since the last assessment and our priority focuses for the next 18 months.

➢ 11 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
November 2024

Agenda item:	2024-25 (89i)

Title of report:	Trust Priorities 2024-25 - Update

Meeting:	Trust Board Meeting Held in Public
Date:	6 December 2024

Presented by:	Andrea Osborne, Executive Director of Finance and Resources and Lynsey Yeomans, Executive Director of Nursing and Allied Health Professionals					
Prepared by:	Emma Tiernan, Senior Business Manager and Claire Gray-Sharpe, Clinical Lead for Children's Business Unit/Head of Clinical Governance					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	This report provides a mid-year progress update against the Trust's 2024/25 priorities. Our Trust vision is that **'we provide the best possible care in every community'** and is underpinned by our five Strategic Goals. This year we developed our key priorities to directly align to and provide evidence in the achievement of a Strategic Goal. However, whilst the Priorities are aligned to a specific goal, they have been developed with a cross-cutting intention to support achievement of the other goals.

Previously considered by:	SLT, 13th November 2024 Quality Committee, 25th November 2024 Business Committee, 27th November 2024

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 the report (for patient care	Yes		What does it tell us?	
	No	X	Why not/what future plans are there to	Provides an update re the work to underpin

and/or workforce)?			include this information?	achievement of our equity goal

Recommendation(s)	The Board is recommended to: • Note the progress made against the Trust's priorities so far during the year and recognise the contribution that our staff have made to that progress whilst striving every day to provide the best possible care to the communities we serve.

List of Appendices:	None

Trust Priorities: Mid Year Report, September 2024

NHS Leeds Community Healthcare NHS Trust

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

Key Focus Areas

- Make the best use of all Trust resources by maximising productivity and efficiency through service offers and pathway redesigns
- Maximise our opportunities for IT, digital and estates transformation
- Explore commercial income generation and review corporate running costs

Service Redesign

- 11 clinical services are currently being supported through a service redesign process, to help them achieve their savings in an equitable and safe way. Examples include the creation of self-management functions, review of referral criteria, and introduction of digital innovations.
- 86% of our financial plan to save £15.8m has been identified for this financial year, and we are forecasting to achieve financial balance by the end of the year. 58% of this is a recurrent saving we can count towards next year's savings too.
- £143k worth of savings have been made to date by spending less on things like refreshments and venue hire, compared to last year.
- Quality and Value Panel continues to meet weekly with all vacancies coming through this route, expectation being that these are business critical vacancies having already been through a robust business unit local panel process. There is confidence that the local processes are starting to embed with a higher level of vacancies coming into Q&V now being approved as business critical. Discretionary spend is also being reviewed by the panel alongside any spend over £10k that isn't in the run rate , as per prior year processes. Dashboards to monitor the impact of the "safety net" controls are now in place.
- L&D: A tender was submitted in August in partnership with SWYPFT (South Yorkshire L&D provider), TEWV (North Yorkshire provider) and Wakefield Council (West Yorkshire) and 8 VCSEs to provide a new regional L&D service. LCH are the named coordinating provider in the bid and therefore would hold the contract with commissioners if successful and coordinate the collaborative. However, SWYPFT, TEWV, Wakefield Council and LCH remain jointly responsible for service delivery; LCH are named provider of the Humber L&D service.
- LSH: The new Leeds Sexual Health Service mobilised on 1st July and the partnership is working together well. The new partnership consists of LCH, Leeds Teaching Hospitals, the Leeds GP Confederation and Forum Central and is underpinned by a jointly agreed MOU.

IT, Digital and Estates Transformation

- See tab 1 for digital update.

Digital business case was approved Sept 2024

- Estates workstream has achieved all £1m of its target ahead of schedule. The Estates Rationalisation workstream is in a strong position with approx. £575k of savings achieved upfront at the start of the year due to historic work to rationalise our leases and contracts. The remaining £425k savings will be achieved through planned ongoing rationalisation of leases and contracts as outlined in the summaries for Project 2 and Project 3. Narrative has been updated to reflect work taken place during this period. This means that the project resource can focus on initiating work now to release savings for years 2 and 3, such as the planned closure and sale of Otley and Horsforth Clinics. Estates Strategy Implementation Board (ESIB) will maintain oversight of these projects.

Business Development

- Q&V Board approved CBU Business Manager's proposal for LCH to deliver a Safeguarding training course for trainee Paediatricians as an income generation opportunity. This training is sought after and was previously delivered by Bradford who will be ceasing delivery due to retirement of the course leader.
- CBU progressing an income generation opportunity with the Leeds Early Attachment Observation template. The Infant Mental Health team currently has 23 interested parties but are yet to agree a training contract. We are hopeful this opportunity will be successful and will give us access to population health data to help us to monitor the effectiveness of the tool.
- A tender was submitted in September for Lot 1 (Physical Healthcare) and Lot 3 Dental incl Orthodontics (WYOI only). The tender included a third site, Aldine House, a secure children's home in Sheffield. We should know the outcome of the bid in November. We did not bid for Lot 2 (Mental Health including SLT and Substance Misuse Service).
- All corporate services have undertaken a self-assessment and are now planning for how their services will be changed through things like restructures, digital automation, and integration with other services.

Forward View - Upcoming Work

Corporate Review: Complete review of taxi usage & spend.

Monitoring of business process controls - reassessment of risk. Corporate Services to start planning their redesigns

Estates: Agree proposals for 25/26 potential opportunities & review efficiency opportunities as identified in NHS England's Model Health System (publish date TBC).

De/mobilisation of the WYOI, Adel Beck & Aldine House service. Go live date: 1st April 2025.

De/mobilisation of the Short-term Community Beds tender in partnership with Leeds City Council and GP Confederation. Go live date: 1st April 2025.

De/mobilisation of the L&D service. Go live date: 1st April 2025.

Finalise Digital Strategy and further develop benefits model and programme management approach for recently approved digital business case.

Trust Priorities: Mid Year Report, September 2024

Leeds Community Healthcare NHS Trust

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

Key Focus Areas

- We will ensure our care pathways are robust to ensure our patients receive the most appropriate intervention to meet their needs.
- We will utilise a digital technology to ensure we optimise our service provision for those patients able to engage with digital interventions and work to improve digital inclusion.
- We will work in partnership with patients, families, patient representatives and our diverse communities and our professional partners to maximise our service delivery.

Pathways

• The Service Redesigns workstream is one of five workstreams within the Quality and Value Programme. It is enabling LCH to look at all aspects of the organisation when planning how to achieve the £15.8m savings we need to achieve in the financial year 2024/25. As we have less money to deliver the same care we are using quality improvement methodologies to take a service led approach to review service offers and pathways. There are eleven service redesigns currently underway. As part of this work the teams are reviewing patient data and working with partners such as the Older Peoples Forum etc.

• Integrated clinics were set up as a joint venture between primary care and LCH, initially for patients requiring wound care and later expanded to the provision of line and catheter care. With PCNs unable to contribute financially, the clinics have been moved from GP estate to LCH estate and are focusing on LCH referrals. A small number of PCNs have recently expressed interest in providing funding, via the ARRS (Additional Roles Reimbursement Scheme) and this is currently being explored. This work has identified a commissioning gap for complex wound care in Leeds which the ICB are exploring – as a result they are intending to provide some short term funding for the clinics to re-open to primary care specifically for this provision.

• Work started in March 2024 to test a different way of organising our planned and unplanned care within the nursing element of Neighbourhood Teams. This involved piloting a 'Neighbourhood Response Team' which works alongside the existing 'Neighbourhood Core Teams' as dedicated resource to respond to unplanned, urgent workload and focus on patients who require an urgent visit within 0-24 hours. PDSA cycles and data have been used to continually change the way we work and the staffing model - staff feedback is demonstrating this has been a positive change.

Digital

• Wound Care App: Pilot site agreed as Morley. This app will enable remote management of wounds and decrease healing timeframes. The testing phase is being planned.

• SystmOne Connect: Testing phase underway with LSH and showing significant reduction in administration time. This will give patients the ability to communicate with services digitally for activities such as self referral, appointment management, and prescription requesting etc, with a view to reducing the administration burden of these activities on staff and will make our services more accessible for patients.

• The Digital Patient Communication Project Team in conjunction with 100% Digital have produced a training video. It covers the basics of digital inclusion and a systmone template which introduces a digital inclusion screening questionnaire. The screening questions have been co-designed and aim to support conversations with patients and service users to understand any barriers to accessing digital technologies. The template also includes links to relevant support networks which can be completed, from systmone, should additional support be required. Patient facing staff both registered and none registered are encouraged to use the screening questionnaire and to reassess at regular intervals with their patients and service users.

• The patient information hub is progressing well with a plan to go live for LSH on 4 November, which is a slight delay by 2 days, at the request of the service due to annual leave. This has been approved by commissioners. A survey was undertaken with service users in LSH with the feedback and comments used to inform the deisgn of the new website. Early adopter sites have been identified and service engagement has commenced with these services. Remaining services are being built into cohorts and will be engaged with in due course with an aim of being live with a minimum viable produce by the end of January.

Engagement

•Responding to patient focus on the 3Cs (communication, compassion and coordination) e.g. thematic analysis of complaints, contribution to learning from patient safety incident

•The Patient Experience Team supported services in how to access interpreters, and gave clear written guidance on MyLCH around access, including providing leaflets in different languages. This supported identified issues around access to interpreters, patients knowing their rights, services knowing how to access and work with interpreters, ensuring interpreter requirements were asked and recorded early enough after referral to meet communication needs during waiting times and at first appointment.

•The Patient Experience Team have supported services in updating information in plain English and accessibility and there is an AIS page on MyLCH. Information is provided on the LCH internet page to provide accessibility information. This supports provision of reasonable adjustment where needed. There is also a Digital Inclusion Lead.

*We are working with the Leeds Parent Carer Forum to support their voice is heard in service development.

*LCH has two Patient Safety Partners who are not employed by the trust and work as critical friends and patient advocates. They provide support and feedback with a patient safety lens for their workstreams which include Quality Walks, review of our literature, and attendance at Quality Committee.

Forward View - Upcoming Work

Continuation of service redesigns through to March 2025

Launch of LSH website - 4th November 2024

Trust Priorities: Mid Year Report, September 2024

NHS Leeds Community Healthcare NHS Trust

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

Key Focus Areas

- Enhance leadership capacity and capability ensuring leaders of teams understand their roles and responsibilities in relation to people management, with a particular focus on staff health and wellbeing and supporting attendance.
- Support our staff to be as efficient and productive as possible through better use of digital and technology
- Increase staff retention through targeted response to staff survey/workforce data, continuing to pursue our EDI agenda and promoting our staff health and wellbeing offer

Leadership

- LCH have received a certificate in recognition of achievement in improving the experience and engagement of colleagues within your organisation: 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.
- Developed and rolled out a LEAD programme for managers to support them through quality and value programme.
- LCH talent management programme in place for BME staff to ensure training cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career. BME Talent development has 42 delegates signed up.
- 100% of new starters and middle managers have been offered training in LCH's approach to inclusion via the LCH Leadership Essentials course

Digital & Technology

- Implementation of Applicant Tracking system in July 2024 which has led to a significant reduction in the number of vacancies: Vacancy fill rates achieve 90%, with more applicants for hard-to-recruit roles than in 2020/21.
- New Well Led dashboard developed and automated monthly providing managers with robust, up to date data to help them support their teams.
- eRostering fully implemented enabling systematic skills and capacity planning by services.

Retention

- WRES overall figures have been improving since April 2024: 14.5% of the LCH workforce have a Black, Asian & Minority Ethnic background, increasing from 10% in 2021 and working towards 18% by 2028
- 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%
- BME fair recruitment process operationalised and is in practice
- 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: Rates are trending improvement however overall sickness remains at 6.8%
- Staff reporting that LCH takes positive action on HWB rises by 5%
- Health & wellbeing conversations are embedded as a regular part of employee / leader conversations, supported by LCH leadership training and amendments to the appraisal paperwork to include these conversations.

Forward View - Upcoming Work

Continuation of above work to ensure:

- 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.

- We are working towards 18% of the LCH workforce being of a Black, Asian & Minority Ethnic background by 2028.

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

Trust Priorities: Mid Year Report, September 2024

Leeds Community Healthcare NHS Trust

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

Key Focus Areas

- Explore opportunities for care closer to home (the full spectrum from acute care to self-management) as part of the Quality and Value Programme
- Aim for the collaborative* (Alliance* plus third sector and primary care partners) to become the single provider of a range of intermediate care services.
- Engage with the universities and business community to utilise their capacity and capability in innovation.

Care Closer to Home

- Home Ward is now, where appropriate, accepting referrals from The Mount to prevent acute hospital admissions and ensure a consistent offer no matter where a patient is residing. This offer helps to support the system through hospital avoidance and ensure patients are cared for in the right place.
- Work on the Active Recovery pilot continues - it has been agreed that AR will be progressed to receive all step-down referrals requiring a response within 72 hours, and all medically stable therapy urgent response step up referrals. The model continues to be developed, rolled out and tested.

Community Collaborative

Two meetings have been held to assess the appetite for a Community Collaborative. The initial outlined the draft aims as:

- To amplify the voice of services working within community settings to explain the importance of the work we do in supporting people at home
- To balance the voice of people who work in community with those who work in hospital
- To work together to ensure funding follows the national aim to provide more services closer to where people live (through the promotion of a Community Investment Standard)
- To represent the whole collaborative when not all of us are represented
- To understand the impact and consequences of changes in the system on communities and community services
- To shape and influence what the city should be doing in terms of community services by creating potential solutions to challenges
- To consider business opportunities together

The aims were agreed in principle and a workshop was then held with representatives from LCH, Adult Social Care, St Gemma's Hospice, Healthwatch, GP Confederation and the Third Sector. Each sector agreed to discuss the concept of a collaborative through their own governance structures.

- Community Dental: The incumbent providers across West Yorkshire have been working together as a collaborative for 15 months, supported by the ICB, to understand, improve and integrate care across the Region. The ICB is currently considering options in relation to procurement of the service from 1st April 2025 and have consulted on a draft service specification through a Request for Information (RFI) in August. While we submitted an individual LCH response to the RFI, we collaborated with West Yorkshire partners to formulate a response to the generic answers in line with our ambition to develop a formal collaborative arrangement. The service hopes to hear by the end of October the intended procurement approach.

Engagement

- Leeds Trinity Uni: In 24/25, an SLT successfully led on, developed and delivered a Level 7 post-graduate certificate in Speech, Language and Communication Needs (PGCert). LTU has been incredibly complimentary all the way through and because of its initial success, the university has renewed its contract with LCH to deliver the course in the new Sept-24 term.
- Leeds Beckett University are undertaking an evaluation of the Enhance programme to understand the benefits to LCH. Findings will be shared once the evaluation is complete.

Forward View - Upcoming Work

De/mobilisation of the L&D service. Go live date: 1st April 2025.

Community Dental - contract extension/tender. Current contract expires 1st April 2025.

Continued community collaborative work with the key focus being the articulation of the value of community services.

Trust Priorities: Mid Year Report, September 2024

Leeds Community Healthcare NHS Trust

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

Key Focus Areas

- To improve access to, and use of data to understand and promote equity in access, experience and outcomes.
- Collaborate with people and diverse communities to ensure their experiences influences equitable approaches to change, such as for the Quality and Value Programme.
- Demonstrably utilise the Equity and Quality Impact Assessment (EQIA) process and outputs to ensure all changes are inclusive of an equity focus.

Data

- Heartt App: Scoping meeting and plans / proposals expected to understand the benefits for analysing our waiting lists using the protected characteristics via this app.
- Equity data on PIP now structured into access, experience and outcomes to support improved access to the data. PowerBI dashboard is being developed to improve analysis and breakdown of data.

Access: Referral rate per 1,000 population, Average length of patient waiting lists, Proportion of people waiting longer than 52 weeks, Number and rate of missed appointments per 1,000 population & Average number of sessions treatment

Experience: Rate of complaints per 1,000 LCH referrals, Proportion of complaints or concerns received by LCH relating to the 3C's (communication, compassion, and co-ordination).

Outcomes: Incident rate per 1,000 LCH referrals (falls and pressure ulcers), Patient mortality rate per 1,000 LCH referrals & Mean age of patient death

- This measurement framework will act as a starting point for equity measurement across the trust. The framework consists of the following indicators
- Addressing inequity in missed appointments and waiting times have been selected for focus this year due to their connection with the Quality and Value programme and a tangible 'to do' to tackle inequity for our services. The aim of this work is to reduce missed appointments for people in IMD1 (currently 10.7%) to be in line with IMD2-10 (6.8%). This would improve access to services and contribute to improved health outcomes for people in our most deprived areas, saving over 8,000 missed appointments each year and reducing the overall missed appointment rate. Across LCH, people in IMD1 wait on average 4 days longer than people in IMD2-10. The Equity team have contributed to two citywide workshops on missed appointments and held two internal follow-up workshops to identify key themes namely: Communication (written communication in advance of appointments, shared decision making at the appointment, follow-up after a missed appointment) and impact of poverty on accessing appointments (travel, ability to contact service).

Engagement

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

See Engagement section on Tab 1

EQIA

- EQIAs have been embedded as a vital part of the Quality and Value programme, with processes and governance structures established for this. An EQIA officer has been appointed to support their ongoing use and meaningful application to decision making.
- We recognise that service changes LCH makes have equity implications on patients and partners across the system. We are exploring how, for significant changes, we can use EQIAs to convene a conversation with our partners about system implications and mitigating actions. As a starting point, our Medical Director convened a partners forum to discuss implications of changes to our musculoskeletal services.
- 21 EQIAs are in the process of being reviewed and 19 are in the process of being approved. The majority of these have adequate controls in place.

Forward View - Upcoming Work

Equity team will continue work to address inequity in missed appointments and waiting lists. They will share common causes and contribute to understanding good practice elsewhere, leadership sessions, engagement with services and development of Quality and Value training sessions.

Equity Team will continue to work with BI to develop an equity dashboard.

Agenda item:	2024-25 (90i)

Title of report:	Digital, Data and Technology Strategy

Meeting:	Trust Board Held in Public
Date:	6 December 2024

Presented by:	Andrea Osborne – Executive Director of Finance and Resources Dawn Greaves – Associate Director of Digital Transformation					
Prepared by:	Andrea Osborne – Executive Director of Finance and Resources 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 for approval to Business Committee and Trust Board in September 2024. A number of comments of suggestion were made by Non-Executive Director members that meant the Strategy needed amending accordingly. To answer the comments, the Strategy has been strengthened in terms of the links to supporting the digital inclusion agenda; confirming that our work will reduce health equities and strengthening the clinical leadership requirements. We have also re-ordered and strengthened the view on our priorities and what this means for the Trust and stakeholders. Finally, we have added further detail to reflect the approach taken to stakeholder engagement in development of the Strategy and informing the strategic direction, with the commitment to maintain and enhance through the life of the Strategy. We have added as an appendix, the current workplan for delivery of the strategy. The workplan will iterate over time and future actions start to clarify. As a minimum the workplan will be reviewed quarterly in line with reporting on progress towards delivery of the Strategy. Following discussion at Quality Committee on 25 September and Business Committee on 27 September, we have also adjusted the wording to talk about the benefits of self management processes on reducing costs, improving patient outcomes and streamlining processes. As well as

	strengthening the use of our data to reduce health inequalities.

Previously considered by:	Updated version 13/11/24 Senior Leadership Team 20/11/24 – Trust Leadership Team 25/11/24 – Quality Committee 27/11/24 – Business Committee Earlier version 18/09/24 - Trust Leadership Team 24/09/24 - Digital Programme Board 25/09/24 – Business Committee 08/10/24 – Trust Board

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 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?	Delivering equitable services is at the heart of the strategy

Recommendation(s)	• Review and approve the Digital, Data and Transformation Strategy

List of Appendices:	N/A

NHS
Leeds Community Healthcare
NHS Trust

Digital, Data and Technology Strategy

2024-27

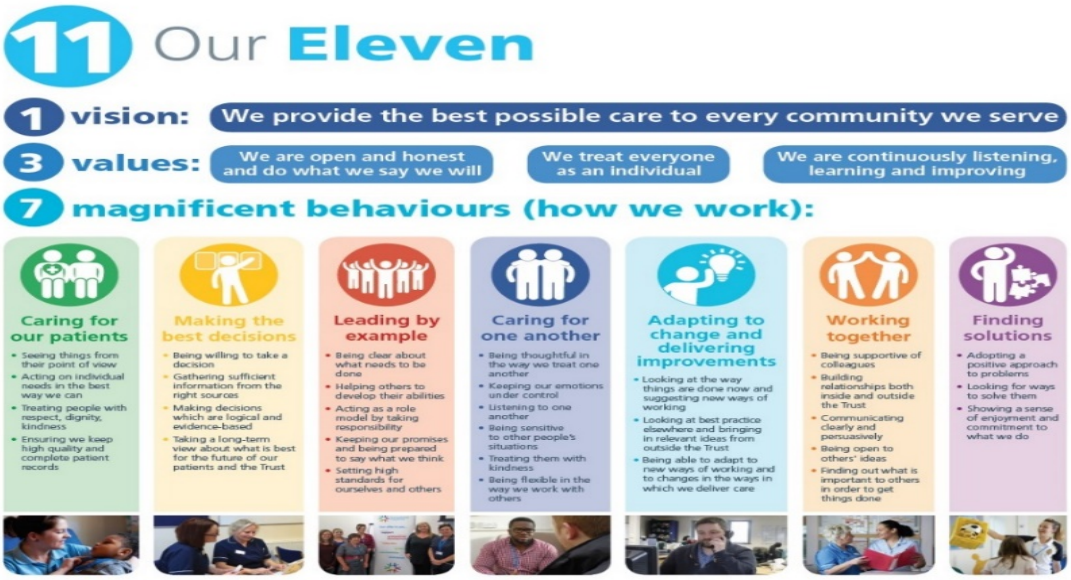
CONTENTS

1. Foreword:

Welcome to the Leeds Community Healthcare (LCH) NHS Trust's Digital, Data and Technology Strategy for 2024-27. This strategy succeeds the previous digital strategy which covered 2020-2023 and the business intelligence strategy which covered 2022-2025. It has been developed to define how digital and data will be used as a vital enabler to delivery of our 5 Trust strategic goals:

- 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.

Our Vision, Values and Behaviours, 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**.



This strategy is being introduced at a time when one of the main challenges faced by the NHS is the overwhelming demand on hospitals. Community health services play a key role in our health and care system, shifting care closer to people's homes, providing services that support intervention and recovery, and helping people maintain their independence in their preferred place of residence. This strategy will create the foundation for this shift but also recognises that it can't be achieved by a single organisation, so it is imperative that we continue to build and maintain collaborative relationships with other health and care partners across the Leeds City and wider West Yorkshire footprint.

In developing this strategy, we made a concerted effort to listen to the needs and perspectives of our staff, partners and patients. The start of the journey was our very first Trust Digital Innovation Event that took place in May 2024 with over 150 members of staff coming together to look at how digital solutions could transform our services; the energy and enthusiasm in the room from staff was immense.

This was followed by attendance at various Trust events including the admin celebration event, the Trust clinical conference and Trust IPC conference as well as participating in the Trust Listening Events (established for the Trust Strategy development) providing staff with an opportunity to input into the strategy and offer any suggestions. The team have also undertaken a number of service visits to see how services are delivered and make suggestions for improvements utilising digital solutions. Externally there have been engagement sessions with Leeds ICB, LYPFT and third sector partners, who we have looked to, at this early stage, to bring the patient voice into the discussions. In addition all of our clinical workforce were invited to complete a local Digital Maturity survey.

This engagement has provided valuable insights into the areas where our existing digital capabilities need strengthening and where opportunities for digital innovation can enhance the timeliness and quality of care we provide as well as enabling our staff to deliver efficient and accessible services that will reduce health equities. This feedback has informed the design of the 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.

“Strong clinical leadership, with a commitment to listening to the voices of our staff and service users combined with making them feel heard, is essential for driving meaningful digital transformation. We believe that both staff, who deliver, and patients, who experience, care are at the heart of our Strategy, together we will create digital solutions and pathways that enhance service delivery, staff experience and patient outcomes”.

Geraint Jones, Chief Clinical Information Officer

This strategy recognises the challenging financial environment within which the organisation and system is operating in and we must ensure we get the most out of the Leeds £. The Trusts 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.

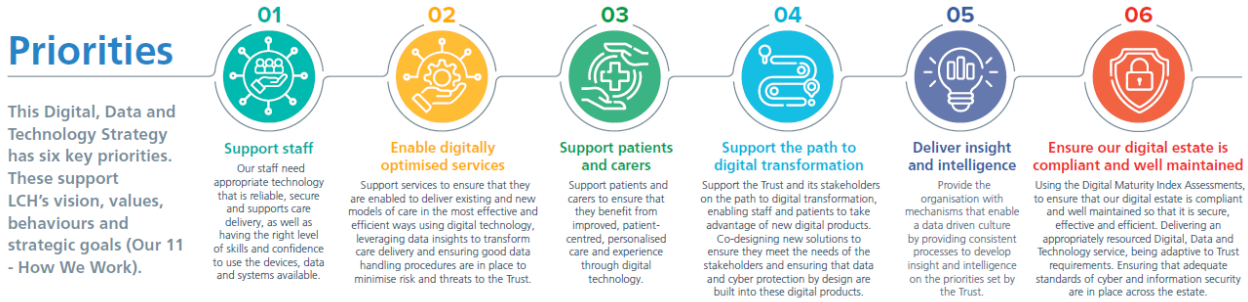
> *"I think it's great now we have a dedicated team looking at digital innovations. The trust must look towards digital solutions to improve overall business sustainability of the organisation. Overall the engagement has been good and wide reaching, I particularly found the digital event useful and eye opening to what is possible".*
>
> **Aaron Wray, Head of Admin Services**

It creates a drive for the organisation to embed its **data driven culture**, providing intelligence and insight, to optimise resource allocation and evidence the huge contribution that community services make to the wider system. Digital is an essential enabler and is integral to achieving clinical and financial sustainability

> *"The initial period of engagement has sparked a lot of exciting discussion about opportunities to improve our services. The digital solutions could help us reduce incidents, improve patient outcomes, reduce DNA's and allow us to save resources that can be channelled back into improving our services for patients and staff. There is an incredible potential to positively impact service and change the lives of patients, carers and family if we can get this right".*
>
> **Rachel Livingston - Service Development Lead for Self-Management and Ambulatory Care**

Our strategy also seeks to identify how digital products and services can make our services more accessible to communities and patients, improving **equity** and increasing **effectiveness**. 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. We will put our patients and staff at the forefront of our plans, ensuring we are co-designing every future solution, ensuring our new products and processes are designed in light of the needs of our staff and patients. We want to be ambitious; we want digital services and products to help transform the way we work and the services we deliver.

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"** and so over the next 3 years we will aim to recover and sustain our digital maturity whilst at the same time forging a path that will enable us to innovate and transform. We propose to achieve this by focusing on the following key priorities:



2. Context:

To develop the strategy, we have carefully considered 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.

2.1 National context:

The government intends to develop a 10 year plan for health and care, which will include three "big shifts". **From hospital to community services** – seeing greater investment in primary and community services that support people before they need hospital treatment. **From treating sickness to preventing it** – with more of a focus on public health strategies that keep people healthy and prevent illness in the first place. **From analogue to digital** – digital technology can improve patient experience and outcomes and support the delivery of moving care closer to home. There has also been a digital enabler group established to support and drive forward this agenda.

The merger of NHSx and NHS Digital into NHS England brings together NHS national data and technology experts together, creating a closer link between the collection and analysis of data to help drive improvement to patient outcomes. The power of digital and data has remained central to the NHS' ability to respond to major events and tackle extreme pressures. The merger of these organisations will ensure the NHS is enabling better, more joined up decision making at system, regional and national levels, and a more effective and efficient use of collective resources, and provides the capabilities to support organisations to deliver the "big shifts".

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 Trust needs to ensure that we 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. The Trust needs to comply with this plan to support delivery.

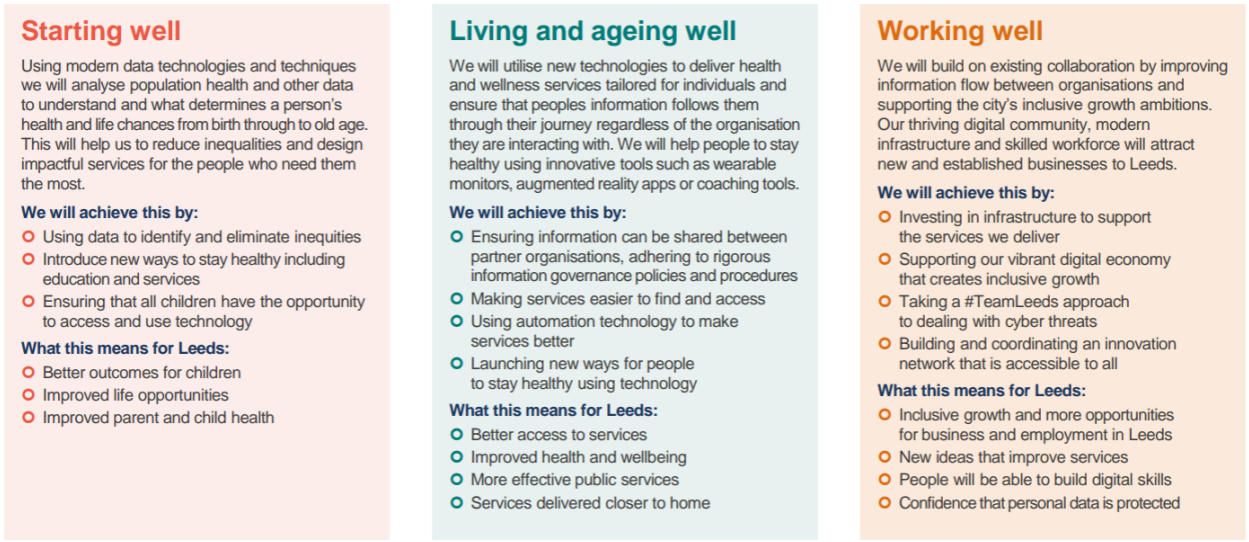
These and many other national publications and reports all emphasise the unique opportunity digital and data technology provides and the importance of embedding new ways of working to transform and improve health and social care services in helping to meet demand whilst resources are limited.

3.2 System and place 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 (WYHCP) 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 shared care record is a key deliverable to support transfer of care across the City and to organisations within the wider region. The Partnership also has a Digital Strategy that was published in 2022, with accessibility and data driven decision making being a key part of the WYHCP and Trust priorities.

> *"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

Our organisations sits within the Leeds Place, 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, which priorities for Data management, use and access; Connectivity and infrastructure; Digital inclusion; Digital skills, Digital and data ethics. All of which resonate with the Trust strategy and focus around improved health outcomes; enhanced quality of life and reduced costs.



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 in enabling staff to work efficiently and effectively

3.4 Leeds Community Healthcare NHS Trust context

Our own landscape is complex, we provide a wide range of community-based physical and mental health services across Leeds and the wider region of Yorkshire and Humber. We have a 3000+ strong workforce which includes Nurses, Therapists, Doctors, Dentists, Pharmacists, registered & non-registered clinical staff as well as non-clinical support teams, operating out of 52 separate sites (some of which do not belong to the Trust) / remote and agile working. Our services work alongside colleagues in social care, with 13 Neighbourhood Teams across Leeds based around GP registered practices and primary care networks, hospital-based staff, care homes, police and ambulance services

Our strategy recognises that integration and collaboration is essential to efficient and effective service delivery and as we continue our trajectory towards a much greater level of integration our priorities must support this by not tying the digital and data infrastructure to the organisation itself. The provision of "industry standard solutions" rather than bespoke systems will be a core aspect to implementation of this strategy.

As we shift towards greater collaboration this places a substantial strain on existing Electronic Patient Record (EPR) systems and IT networks, which were designed to support services in very linear ways within clearly defined organisational boundaries. We must respond to this by ensuring digital can enable new pathways of care, and delivery across organisational boundaries, this, in turn, is likely to lead to greater co-location and an 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.

The most recent NHS digital maturity self-assessment exercises against the National "What Good Looks Like" framework highlighted specific areas of strengths in the Trust, such as Digitisation of Records, Assessments and Plans, Strategic Alignment and Resourcing, however also highlighted areas where further work is required such as 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.

The Trust maintains a strong cyber defence posture, with Standards Exceeded in the DSPT return for 2023/24 and the achievement of Cyber Essential Plus in February 2024. Investment in software tools to enhance our monitoring and patching capabilities have also been made and we have enrolled our server and laptop/desktop estate on the NHS Microsoft Defender for Endpoints receiving monitoring alerts from the National Cyber Security Operations Centre to potential suspicious activity attributed to our estate. We also are registered to receive the High Severity Alerts from the NHS Cyber Alert Service and maintain a 100% response rate within the required timescales. The Trust continues to perform regular penetration tests to understand potential weaknesses and action taken to rectify these. Staff awareness to cyber issues is maintained through regular communication and awareness programmes. We cannot be complacent, as cyber threats continue to become more sophisticated so must our response.

Having access to accurate, timely data is key to how we plan, manage and sustain services making informed and effective decisions. We have already made good progress through our previous Business Intelligence strategy (Appendix B) however we know we can do more, improving our use of visualisation tools to monitor performance and improving data quality by supporting clinical services through bespoke interventions and the provision of Data Quality dashboards. Also using our data to reduce health inequalities.

Taking this further, joined up data and population health analytics is essential in enabling systems, places and neighbourhood teams, to understand the needs of different population groups and to design, tailor and target a range of evidence-based interventions that aim to prevent downstream risk to groups which are currently under-represented in services . Our priorities need to consider how we use of our patient level costing data and capitalise on place and system-wide data insight and infrastructure,

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 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 we will aspire to be outstanding in our use of digital and data services.

4. Priorities:

Our strategy is formulated around six key priorities, each supported by core objectives that enable the achievement of our strategic goals. Appendix A outlines the initiatives planned to support delivery of the priorities however recognising the pace at which the digital landscape can change it is acknowledged that these initiatives may evolve over the life of the strategy.

1. **Support our patients and carers:** to ensure that they benefit from improved, patient-centred, personalised care and experience through digital technology.

   We will :

   - Foster meaningful engagement with patients and communities in the development of digital technologies.
   - Ensure patients / carers have an opportunity to access technology that will allow them to self-manage their care as easily, efficiently and effectively as possible.
   - Seek to increase digital health literacy and confidence in the use of health technologies but ensure we increase digital inclusion and don't worsen health equity.

2. **Support our staff:** to ensure they have 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.

We will:

- Develop a sustainable training plan to ensure our workforce are fully competent, confident and capable in the use of digital technology in the workplace.
- Ensure that staff have the digital tools that they need to communicate effectively and efficiently with colleagues and patients.
- Ensure that staff are able to work efficiently and effectively when operating remotely and agile.

3. **Enable 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.

We will

- Optimise existing digital solutions and tools identifying areas for development and standardisation.

- Ensure services can adapt models of care delivery by seeking to adopt best of breed digital technologies which are tried and tested.

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.

We will:

- Ensure that Trust plans are aligned with national, regional and local initiatives, supporting digital transformation across the health and care system.
- Develop capacity & capability to deliver digital transformation at scale.
- Ensure our systems and infrastructure support cross-organisational working and new models of care.

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.

   We will:

   - Increase data quality in, and transparency of, National data sets.
   - Draw upon best practice, tools and techniques to extract, organise and examine data.
   - Derive targeted tangible value from the use of data to inform resource allocation, service delivery and reduce health inequalities.

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.

   We will :

   - 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.
   - Establish a robust contract management and replacement programme for all digital and data technologies.
   - Establish and maintain a high quality digital and data support service that is responsive and meets the needs of our stakeholders.

6. Achievability of the Strategy:

An implementation plan will be developed separately that details the plan for delivering the strategy. Our plan will set an ambitious timeframe noting that successful delivery of the priorities will require the following to be in place: -

Co-design – we will take a co-design approach for every new digital solution, ensuring we are listening to the voice of our staff and patients and using this feedback to design our future solutions. As set out earlier in this document initial steps have been made to engage staff and partners in developing the strategy through joining various Trust events and a sponsored Innovation Event, the latter gave staff the opportunity to hear about how other community organisations have gained benefit from the use of digital solutions as well as meet with suppliers to discuss opportunities for service transformation. We will look to continue and extend this engagement with staff, patients and partners.

The Informatics team will 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, it is the clinical services and the patients at the centre of those services that have key roles in determining, designing and 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 and will 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, and ensuring patients are equal partners in the process with more opportunities for self-management.

Culture - Essential to the successful delivery of the Digital, Data and Technology Strategy is the need to link into 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.

We will look to 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

Leadership – the Trust Board will 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. We will also consider the sustainable leadership arrangements for digital and data services, in line with Trust requirements and National guidelines.

Affordability – We will work towards ensuring sustainable arrangements are in place to enable a standardised delivery approach for digital and data implementations and replacement programmes. All new digital solutions will be required to deliver a positive return on investment, that will be quantified as part of the business case development approach. In our drive to achieve our objectives 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 – In line with our commitment to delivering high-quality care and services, our Workforce approach to digital will focus on integrating technology to improve operational efficiency, and elevate the employee experience. 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.

To do this we will 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, and support 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. This will require capacity and continued engagement from our workforce.

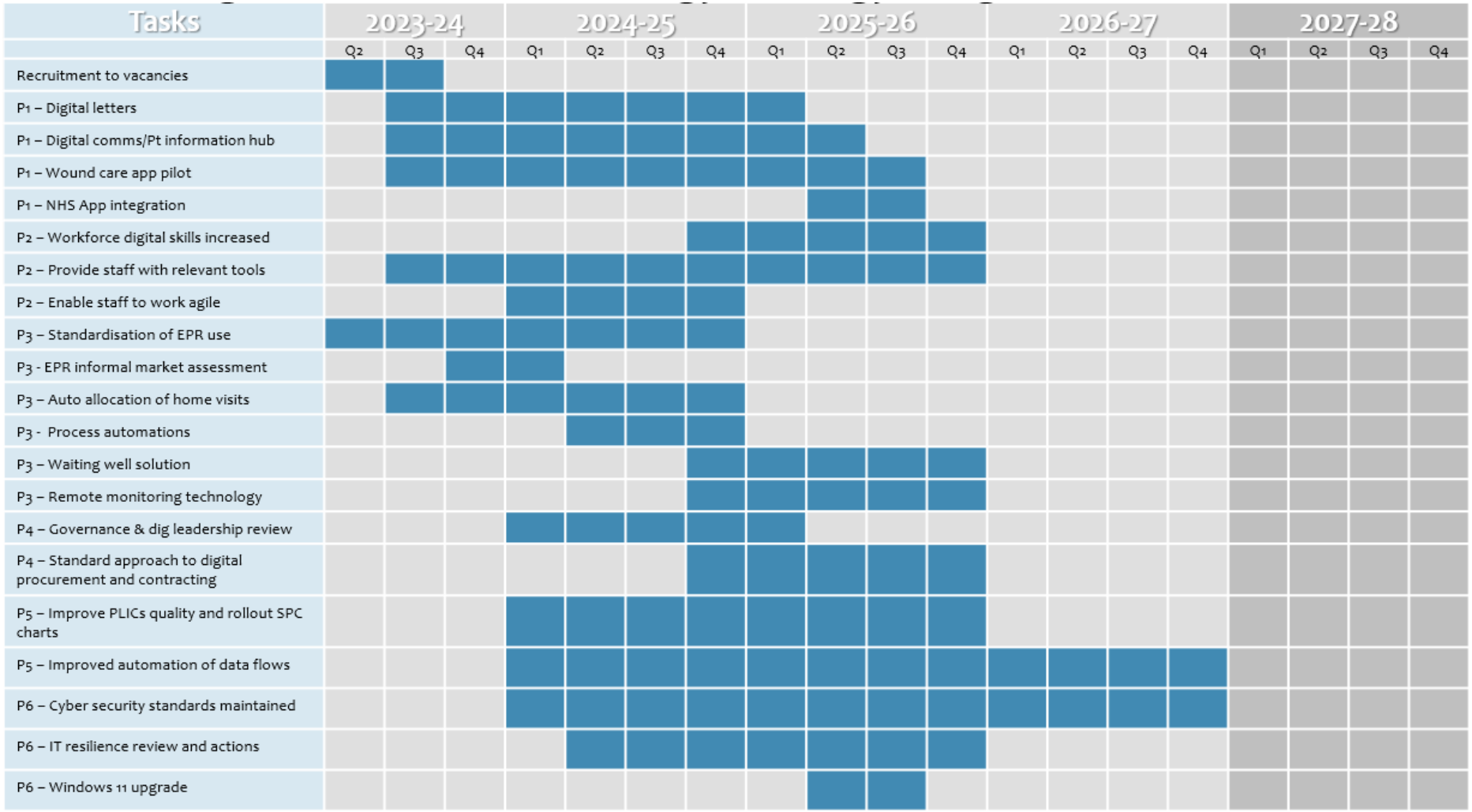
Governance - The true benefits possible from digital and data technologies will require a much closer connection of Equity and Inequalities, Finance, Workforce / Organisational Development and Estates strategies, which traditionally have been developed and operated in isolation. To really take advantage 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 our research and engagement , staff highlighted a number of key issues/themes and wanted to ensure this new strategy addresses them . Under each heading shows which of our six digital priorities each item supports.

	Current State	Future State
Appointments P1, 2, 3, 4	Majority of services requiring significant time and resources to arrange and manage appointments	Patients are empowered to manage their own appointments digitally, with greater flexibility of appointment availability to suit individual needs. Appointment management is through digital solutions such as NHS App
Capabilities P2, 3, 4	Staff confidence and competence in Digital is variable and we have limited specialist digital leadership within the Trust with the right level of expertise	We will have expert and dedicated digital leadership across the Trust with skilled individuals responsible for implementation and management of digital solutions. Our entire workforce will be supported to improve their digital literacy and make best use of digital solutions. Service digital champions will support with upskilling and implementations ensuring consistency in approach
Clinical Systems P1, 2, 3, 4, 5, 6	Some staff report that our clinical systems are overly time consuming, are not intuitive and lack functionality. Integration opportunities are limited	Our clinical systems will be designed to best support our teams to provide efficient high quality and safe care. Our systems will talk to each other, where appropriate and we will invest in functionality that makes our staff's working lives easier and more efficient. Empowering patients to capture data where required. Leeds City usage of systems will be considered in some instances
Data P2, 3, 5	We have improved our use of data, but services don't regularly access and interpret data to support decision making. Some staff don't understand how to interpret the data	All services will have easy access to detailed, service level data. They will be supported to interpret the data, to enable them to make informed decisions around service delivery models and analyse the data with an equity lens to enable a reduction in health inequalities
Digital Services P1, 2, 3, 4, 6	A limited number of our services use software to improve effectiveness and efficiency of service delivery	All services will have identified if there are opportunities for improvements in efficiency or quality of service delivery through digital solutions such as process automation or using apps. Gaining best value from all apps and digital solutions across the Trust
Infrastructure P2, 3, 4, 6	Our staff have reported inconsistencies in the quality of their equipment and connectivity	All staff will have the right equipment and connectivity for the job they undertake, which is reliable and efficient

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.
<u>Workforce</u> 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
<u>Expertise</u> Procurement of digital solutions may require a higher level subject matter	3	4	12 (High)	Utilise contracts register and develop a robust procurement plan for key renewals, establishment procurement timeline to ensure appropriate support can be identified .

Risk	Likelihood	Severity	Total	Mitigation
expertise. Lack of procurement capacity / capability may impact on any future procurement exercises and contract negotiation				Explore opportunities for further collaboration with SMEs across the WY footprint.
Finance There is a risk that the Trust may not have access to the financial resources required to implement the strategy.	3	4	12 (High)	Develop business cases that support a readiness to exploit all opportunities to benefit from National funding. Ensure a robust approach to benefits identification and realisation ; plan implementations to enable benefit achievement as early as possible Accounting arrangements for digital solutions can be complex, draw upon best practice to ensure opportunities for maximising affordability through procurement and accounting arrangements are maximised Develop a high level costed plan to underpin the strategy and ensure this is reflected in the trusts long term capital and revenue plans.
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:

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.

Our engagement has led to a focus on six key priorities. Our 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.

It is recommended that the priorities and objectives within this strategy are adopted and are a constant thread through the work we do. This will provide a direction of travel for the Trust over the next 3 years, and a foundation from which future interdependent strategies, plans and business cases can be built from. The workplan will develop and adapt over time based on our ability to deliver, changing priorities and affordability.

Appendix A: Priorities

Supporting Patients & Carers	To ensure that they benefit from improved, patient-centred, personalised care and experience through digital technology.

Year	Objectives	Initiatives	Outcomes
1-2	Foster meaningful engagement of patients and communities in the development of digital technologies	Engage in the work planned as part of the development of an organisational strategy with a view to creating a framework for patient/ carer engagement to test feasibility, usability and satisfaction of new digital technologies	Thriving / two way conversation with patient groups to design digital services around their specific needs. New technologies that are suitable for patient needs
1-2	Ensure patients and carers have an opportunity to access technology that will allow them to manage their care as easily, efficiently and effectively as possible.	Implement digital patient communication channels such as digital letters/ appointment management / patient information hub Investigate use of NHS App for community setting – which already allows patients to check their symptoms, book or cancel appointments with the GP practice, order repeat prescriptions and view the GP medical record	Easier for both staff and patients to have the “right” conversations at the right time; leading to reduction in DNAs & improvement to waiting times. Reduce costs and reduction in Trust’s carbon footprint towards the Greener NHS paper commitment of 50% paper reduction by 2025 Patients regularly access to their NHS App record to enable them to be more involved in their own care
2		Work with services to identify opportunities where digital technology can support self-referral routes, self-care and support implementation Establish baseline of current usage of digital apps by staff By the introduction of new solutions, based on need	Supported self-care service offer for patients becomes part of a standard offer from the trust Ability to support a larger caseload with the same or fewer staff (metrics to be developed) One for one reduction in face to face contacts, replaced with a “digital” encounter
1-3	Increase digital health literacy and confidence in the use of health technologies but ensure	Work with 100% Digital Leeds team to promote community opportunities for digital inclusion support and reduce health equity barriers	Our patients and staff are directed to support to promote digital inclusion

	no patients are digitally excluded	Encourage our services to seek support from 100% Digital Leeds team to understand opportunities to direct our patients for support Ensure our staff understand how to seek support if they are personally digitally excluded	

Supporting our Staff	To ensure they have appropriate technology that is reliable, secure and supports care delivery, as well have having the right level of skills and confidence to use the devices and systems available.

Year	Objectives	Initiatives	Outcomes
1-2	Develop a sustainable plan to ensure our workforce are fully competent, confident and capable in the use of digital technology in the workplace.	Audit of digital and data capabilities in the workforce to identify gaps Explore new methods for effective training Agree what training is needed and solutions for delivery Collaborating with key partners across Leeds and West Yorkshire for synergies	Staff developed to the required level of digital and data literacy to deliver their clinical or corporate role to an outstanding level. Board leadership and ownership of digital and data culture. Agreed role profiles for digital and data capabilities advertised for future roles.
2-3		Alignment with Workforce Strategy and Plans Addressing talent gaps within our DDaT workforce to align with the What Good Looks Like framework Assess how best to implement and utilise recommendations from HEE's 'Building a Digital Ready Workforce' programme, especially the Digital Literacy work stream and its capability framework Implementation of a learning management platform that allows seamless booking of courses, alerting when learning expires and reporting for assurance purposes	There is a clear set of digital skills identified for each major role within the Trust Staff take responsibility for own continuous digital and data development Increased use of digital champion network across the Trust Increased clinical informatics leadership network Staff are confident in using systems and identifying threats and risks
1-2	Staff have the digital tools that they need to communicate effectively and efficiently with colleagues and patients.	Evaluate "need" against available Apps Standardise offering across services to reduce the burden of support for multiple tools Create personas for staff roles to determine the type of devices required for each role Establish a standard procurement approach where all procurements of digital tools have a nominated digital lead Ensure devices have an adequate replacement programme built in	Standardisation of digital procurements that meet National requirements. A catalogue of approved digital tools that staff can use to support communications with colleagues and with patients and standardises approaches across our services.

1-3		Implement applicant tracking solution to support recruitment Consider opportunities to enable effective job planning in all relevant services Implement more self service offerings through Halo and ESR Consider opportunities for rostering solutions that align to attainment levels	Staff are more efficient with instant access to key information and processes Staff are able to self manage under certain circumstances
2	Enable staff to work effectively when operating remotely and agile	Investigate opportunities to provide collaborative office space with bookable hot desks and systems/equipment to allow people to work flexibly from home as well as LCH estate and wider community, where appropriate. Investigate opportunities to ensure reliable connectivity to network and/or wifi in all our buildings, as well as out in community for areas that are within our control. Collaborating with Citywide partners where required to influence decisions around increasing connectivity. Explore a private access point name (APN) via the mobile network, to provide a permanent connection to the Trust network and reduce the need for virtual private network (VPN) solutions	Staff are able to work from where they can provide the best care and be most productive

Enabling digital optimised services	To support services to ensure that they are digitally optimised 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.

Year	Objectives	Initiatives	Outcomes
1-2	Optimise existing digital solutions, tools and infrastructure identifying areas for development and standardisation	Undertake service focussed as well as National digital maturity assessments across the Trust to identify areas of development opportunities and standardisation across the Trust Develop financial opportunity tracker through the use of digital technology in a digital first approach (e.g. digital dictation, voice recognition, automation of processes, reducing duplication across processes, reducing travel time/costs) Focus on optimisation of our EPR - incremental development of the current system and standardisation of configuration to remove unwarranted variation e.g. developing new forms, templates of questionnaires in SystmOne or enabling e-referrals through the national service	National digital maturity assessment for year 2 is complete. Gap analysis undertaken for each service and workplan developed to increase maturity. Minimum of 2% increase in available patient facing time. Minimum 1% reduction in time spent travelling.
1-3	Services are able to improve their care through better use of digital and data technology	Development of integration opportunities, where they exist ie Yorkshire and Humber Care Record and ensuring wider access to data for services and third sector partners Understand digital maturity of our services and ensure consistency of use of digital solutions across our services e.g. a single approach to offering advice and guidance/ referral management Implementation of a visit allocation and route planning solution to reduce the admin burden and mileage claims	Implementation of software integration solutions, to “tie together” disparate information system used in the provision of care. Continued improvement in the use of the Leeds Care Record. Target is for 100% of services to have been provided with access. Implementation of the Yorkshire and Humber Care Record. Target is for 100% of services to have been provided with access. Options appraisal around EPR optimisation. Consistent mechanisms for recording patient information. Decreased resources required for the

		Consideration of implementation of a separate electronic document management solution to reduce storage requirements on the EPR Informal market assessment of options for EPR replacement Novel data views that are patient or clinician-centric Delivery of real-time data flows to “command centre” type applications Relevant reports are available to our partner organisations Implementation of self-service reporting	management of SystmOne, processing of data and creation of intelligence. More data driven decision making Fast frictionless access to information and more discoverable data More effective and dynamic monitoring of services’ performance including the delivery of equitable care
1-3	Services can adapt to new models of care delivery, by adopting best of breed digital technologies which have been successfully deployed elsewhere or have been developed in-house	Support clinical leaders to adopt a “digital first approach” (e.g. digital dictation, voice recognition,) where possible Establish and implement a rolling programme of robotic process automation solutions. Enable services to understand opportunities for further digitisation by showcasing the benefits and opportunities for use of : • remote monitoring and virtual visit technologies to reduce patient physical visits • waiting list management solutions to ensure patients are safe while waiting for care Drawing upon the NHS AI lab roadmap determine opportunities for adoption of AI technology within a robust governance framework that ensures implementation of technologies are safe, effective and ethical	Services are able to support the Green Plan to deliver sustainable services Services are able to offer more efficient care to patients, while ensuring patients remain well Services are able to take advantage of the advances in Artificial Intelligence or robotics (as examples), to enable patients to better access care or better self-manage their care working alongside clinicians

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.

Year	Objectives	Initiatives	Outcomes
1	Ensure that Trust plans are aligned with national, regional and local initiatives, supporting digital transformation across the health and care system,	Develop a clear and robust assessment and investment process to enable digital innovation to deliver benefits and add value. Working in tandem with the Making Stuff Better programme establish a route to sponsoring of digital “ideas”. Review current systems against national standards for interoperability and develop a set of recommended actions to meet these standards, exploring all options which are available to the market, building business cases for any subsequent implementation. Promote the use of the NHS App to the patients we serve Through collaboration with system partners develop a strategic approach to contract renewals / procurements (focus on benefit realisation and resourcing for implementation)	A process exists to take a concept or idea through to a finished “product” Our existing systems are developed to support the new multi organisation models of service being commissioned or we have transitioned to ones which can. Trust is prioritising investments where there will be the biggest return on investment Any proposed major development or replacement of systems has firstly considered any nationally available GDE Blueprint Increased digital maturity of the Trust
1-2	Increase capacity to deliver digital transformation at scale	Supported by our Trust clinical leadership team, investigate opportunities to enhance the level of digital clinical leadership in the delivery of digital transformation across the Trust Investigate opportunities to establish a digital programme management office, inclusive of digitally skilled implementation resources	All digital solutions are implemented in a standard approach, seamlessly Scale of transformation is increased and benefits of digital transformation are achieved more timely

		Implement a standard approach to digital procurements, where digital expertise is involved throughout the process, ensuring National standards are met such as MFA for all solutions	
2-3	The infrastructure used to deliver information to the organisation is robust, efficient and makes best use of new technologies	Consider the move to a shared Power BI tenancy with Leeds ICB Determine route to be taken in relation to AI in response to the AI roadmap and develop implementation plan Move reporting infrastructure to the cloud	Lower Power BI licensing costs in comparison to procuring our own tenancy Judged decision on how AI can best be used in LCH More robust reporting infrastructure and better ability to make use of new developments

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

Year	Objectives	Initiatives	Outcomes
2-3	Derive targeted tangible value from the use of data to inform resource allocation and service delivery	Improve the visibility and clinical engagement of PLICs data with an ambition of linking patient level costs with outcomes informing optimised resource allocation. In conjunction with the Community Collaborative further develop our approach to the measurement of productivity	Accurate assessment of financial costs of pathways and services Ability to demonstrate the capacity and cash releasing potential of the improvements we undertake Ability to demonstrate "value for money" of the services we provide, creating the case for investment in prevention.
1-3	Draw upon best practice tools and techniques to extract, organise and examine data	Development of Integrated Performance Reporting supported by tools such as statistical process control charts, a library of indicators , supporting the triangulation of data and to strengthen our approach to performance management. Implement faster data flows and review opportunities presented by federated data platform Maximise opportunities for automation of data flows, including strengthening of procurement and contract management activities to ensure automated data flows are included as a requirement. Information governance processes that enable the efficient and secure sharing of data Move to a shared Power BI tenancy with Leeds ICB	Establishment of data as an organisation asset that provides assurance and supports management of risk Increased efficiency in extracting data into a usable format Increased availability of data Increased ability to collate bespoke information to support processes Cross fertilisation and linking of data sets for reporting purposes
1-3	Increase data quality in and transparency of National data sets	Increase monitoring of data quality in National data sets Identify priority use cases for data quality improvements	Improved data quality in prioritised areas Better alignment of National and local reporting

		More closely align internal reporting structures with National data sets Create documentation to describe warehousing structures and principles Actively contribute to the definition of community services in National data sets	Improved consistency of data reporting facilitates external benchmarking and will underpin improvements in population health

Ensure our Digital Estate is Compliant & Well Maintained	Using the Digital Maturity Index Assessments, 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.

Year	Objectives	Initiatives	Outcomes
1	Establishment of a robust contract management and replacement programme for all digital and data technologies	Identification of all digital and data assets Consideration of whether all digital and data assets should be centralised in terms of management and support Development of a 5 year capital plan with clear details of expiring software and technologies to enable effective planning of funding and resource requirements	Enable effective resource planning Enable sufficient time for contract negotiations/ re-procurement exercises to ensure best value for money and support for the Green Plan Visibility of future requirements
1-2	Connect patients and staff to reliable systems that are clinically safe, cyber secure, flexible, accessible	Deliver modern secure IT systems to enable efficient working and reduce the potential for security breaches by • Impartial review of network, infrastructure and IT services, identifying any remediations • Upgrading to Windows 11 to maintain standards and compatibility • Investigating opportunities for delivering a VirtualPC (Windows365) to be device agnostic, enables onboarding of staff swiftly and reduces software upgrade timeframes • Maintain Cyber Essentials+ accreditation and ensure alignment with the Cyber Assessment Framework Develop a cyclical improvement plan to continually raise the awareness, understanding and individual responsibilities in relation to information governance and cyber security.	All systems are 100% compliant with NHS cyber security standards Network is effective and resilient . Reduce drops in connectivity for staff while working in community areas with low network connectivity Staff satisfaction in IT equipment is increased A robust plan to mitigate against cyber threats All staff are knowledgeable and confident and are able to use systems to minimise risks to

		Review IT disposals policy to ensure it meets the Trust's net zero approach and disposes of IT equipment safely, securely and sustainably Ensure all new implementations and upgrades consider the sustainability approach and net zero agenda	data protection, cyber threats and vulnerabilities Zero preventable Information Governance Incidents Sustainable disposals procedures are supporting the net zero approach
1-2	Establish and maintain a high quality digital and data support service that is responsive and meets the needs of our stakeholders	Undertake an independent review of the existing support model and develop an action plan to respond to the findings Implement automation solutions to ensure capacity is maximised so that resources within the digital, data and technology team are deployed to maximum effect Review and appraise opportunities for accreditation of our digital and data services e.g. ISDN	Increase staff satisfaction rates Additional capacity released for digital and data teams

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.

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.

Of the seven identified key deliverables from the previous Business Intelligence Strategy, 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

Agenda item:	2024-25 (91)

Title of report:	Patient Safety Strategy Implementation Final Update Report

Meeting:	Trust Board Held In Public
Date:	6 December 2024

Presented by:	Lynsey Yeomans, Executive Director of Nursing and AHPs					
Prepared by:	Claire Gray-Sharpe, Head of Clinical Governance					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	

Executive Summary:	The purpose of the paper is to provide Board with a six-monthly and proposed final update of progress against the implementation of the national Patient Safety Strategy into the Trust. The Trust completed a soft launch of the Patient Safety Incident Response Framework in January 2024 with full transition completed in April 2024. The Patient Safety Incident Response Framework and Response Plan is now in place and the supporting systems are in place. Completion of the national training schedule is in progress and in line with the national roll out. The Patient Safety Specialists will complete their training by December 2024 when the national course closes.

Previously considered by:	NA

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	No		What does it tell us?	NA

the report (for patient care and/or workforce)?	No		Why not/what future plans are there to include this information?	Health equity is considered within the improvement groups as part of the Patient Safety Incident Response Plan and monthly for incidents in the BU Quality Report.

Recommendation(s)	Read and consider the paper, agree the level of assurance provided. Agree that the Patient Safety Strategy is now business as usual for the Trust and to conclude Board reporting.

List of Appendices:	NA

Patient Safety Strategy Implementation Update

1 Introduction

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

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

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

- Appoint two **Patient Safety Specialists** as leaders within organisations to support implementation of the Strategy and keep a focus on safety.

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

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

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

2 Current position

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

Patient Safety Incident Response Framework (PSIRF): LCH completed a soft launch of the framework on 2 January 2024, the full transfer was completed on 1 April 2024. Full transition from the Serious Incident Framework 2015 to the PSIRF is

now complete. Improvements continue to be made to how we use PSIRF and the processes we have in place for concordance to the framework. Project support for the implementation has now concluded.

An involvement workstream remains in effect and will be continuously reviewed to ensure the group has defined goals to achieve and embed PSIRF in practice. There is a specific focus on how we involve patients in their own safety in a genuine and meaningful way.

The associated Patient Safety Incident Response Plan (PSIRP) was approved by Board and the ICB and the detail was shared in the last report.

A Patient Safety Incident Response Policy is a requirement of the Patient Safety Strategy and has been ratified by the Trust Leadership Team and published.

Patient Safety Specialists: LCH has nine Patient Safety Specialists. Six of the nine have commenced and continue the level three and four training of the Patient Safety Syllabus. The Syllabus completes in October 2024 for taught sessions and December 2024 for final coursework submissions.

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

Framework for Involving Patients: The Trust has recruited the nationally mandated two Patient Safety Partners. The Partners are joining various meetings and contributing a patient voice to linked projects. For example, by joining Quality Committee, contributing to Trust workshops, and supporting patient engagement initiatives. They attended the recent Clinical Conference and co led a dedicated workshop.

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

Levels three and four patient safety training is being completed. It contains five modules, six Patient Safety Specialists are currently completing the modules three, four and five.

The requirements for training for the Patient Safety Incident Investigations is planned. The training requirements are nationally mandated. HSSIB (Health Services Safety Investigation Body) are providing the training which equates to three and a half days as previous reported.

The Patient Safety Team are waiting for dates to be released by HSSIB. Completion of the training will be monitored at Service level with confirmation of completion of the training shared with the Patient Safety Team.

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

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

The overarching risk (1156) to timely implementation of the Strategy will be reviewed and closed.

3 Next steps

The Patient Safety Incident Response Framework and Response Plan is now in place and the supporting systems are in place.

Completion of the national training schedule is in progress and in line with the national roll out. The Patient Safety Specialists will complete their training by December 2024 when the national course closes.

It is proposed that this is the closing report to Board for implementation of the Patient Safety Strategy.

4 Recommendations

The Board is recommended to:

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

Agree that the Patient Safety Strategy is now business as usual for the Trust and to conclude Board reporting.

Claire Gray-Sharpe
Head of Clinical Governance

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	**Report to:**	Trust Board 6th December 2024
Date of Meeting:	25th November 2024	**Date of next meeting:**	28th January 2025

Introduction

Quorate meeting with a full agenda and good debate on key topics. Some issues with late amends to papers meant that the Performance Brief hadn't been reviewed in advance by all members, and the QAIG assurance report from 5 Nov had not been circulated in advance.

Alert	Action

Advise

- QAIG key issues for escalation – it had been agreed that for 2025/26 the clinical audit plan should be reviewed to ensure it reflected clinical and safety priorities and therefore BAF risks. Recent improvement work in the servicing of medical devices was noted, as was work to improve incident safety including addressing the administration of out-of-date medication incidents and the administration of a second dose of insulin at the same time of day. The final QAIG assurance report would be circulated to members after the meeting.
- Digital, Data and Technology Strategy was presented to the Committee, with strengthened information on stakeholder engagement, clinical leadership and priorities following previous discussions at Committee and Board. It was felt that the self-management element could be further strengthened, as could the use of data to reduce health inequalities, prior to further consideration at Board. The Committee noted that the work plan would be iterative as the strategy was implemented.
- Mid-year Trust Priority Report – whilst there was evidence of progress against deliverables, questions were asked around the format and whether this was aiming to be a retrospective or forward-looking report, and how data was being used to work with the community in a personalised way.
- Performance Brief – the discussion was limited as not all members had reviewed the report prior to the meeting. However, it was advised that the report reflected the journey to a new version. When asked what the main concerns of the execs were in terms of performance, Committee heard that these were the waiting lists (although a winter campaign to tackle them was being worked up), the CAMHS service, and getting the data quality right for the effectiveness domain.
- AB Action Plan – It was noted that there would be an LCH-specific action plan, following the system agreeing that each organisation would monitor their own actions. There was concern that the lack of a coordinated approach could lead to system learning being missed.
- Quality & Value Programme – progress against target and workstream updates were reported. Committee noted that the Trust was forecasting achievement of full financial balance, although 47% of this was non-recurrent. Detail was shared on the EQIA process and an offer to shadow the EQIA panel was made to members. It was noted that quality benefits were hard to quantify until the EQIAs had been completed and the end products realised.

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- Mortality Report – this was reviewed by Committee, noting that equity data had been rationalised on this occasion.

Assurance

- Airelogic Screening Tool – Committee received assurance that the system is safe to use, following a detailed investigation.
- The Bi-annual BAF sources of assurance paper was presented and no new sources of assurance were identified.

Risks Discussed and New Risks Identified

- The Risk Register report was presented, showing movement in clinical and operational risks scoring 8 and above. The new risk relating to capacity issues within Business Intelligence was noted. The role of the Senior Leadership Team in the escalation of risks overdue for review was welcomed.

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	**Risk score (current)**	**Overall level of assurance provided that the strategic risk is being managed (or not)**	**Additional comments**
Risk 1 Failure to deliver quality of care and improvements: If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm.	16 (extreme)	Reasonable	N/A
Risk 2 Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage.	16 (extreme)	Reasonable	N/A
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	N/A
Risk 4 Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with	9 (high)	Reasonable	N/A

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legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation, and adverse media attention.			
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)	Limited	Committee felt that with the service spotlight item not being brought this month, and with the equity data not being included in the mortality report, it was difficult to determine a reasonable level of assurance for this strategic risk.

Author:	Helen Robinson/Helen Thomson
Role:	Company Secretary/Committee Chair
Date:	28/11/2024

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 6th December 2024
Date of Meeting:	30th October 2024	**Date of next meeting:**	27th 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. This was a workshop based committee, the topic being workforce culture.

Alert	Action

Advise

- Finance quarterly update – committee received updates in 2 key areas. The first was medium term financial modelling as part of the ICS. Work is ongoing but is forecasting a Trust deficit. Will have a clearer picture of this by the end of Q3. Discussions across the ICS are ongoing, to identify and agree efficiencies. The second paper updated the Committee on the result of the PWC self assessment toolkit which identified further opportunities for the Trust to drive efficiencies and to help inform the Q&V programme. Action plans are being developed.
- Monthly finance report – Trust is still forecasting a £1m surplus but there remains considerable pressure across the system. PWC review due to conclude end of October. Costed workforce plans due at the end of Q3 which should assist in identifying recurrent benefits.
- Corporate benchmarking report identified that in a number of key areas, the Trust's costs are higher than other organisations due to economies of scale. Drivers for increase in costs were discussed and these include investment in digital and tech to address previous under-investment. Overall there are opportunities to identify further efficiencies through the data provided by this exercise and the Committee was assured this is being considered as part of Q&V.

Assurance

- Q&V update received – Continued forecast of financial balance. 90% of the £15.8m target saving identified but 42% of that is non recurrent, adding pressure on the workstreams to deliver recurrent savings. 12 service redesigns in progress using the Benefits Realisation toolkit. Committee asked for more detail on EQIA output.
- Estates strategy update – Committee was advised that currently, the strategy and plan is estates led rather than patient led, due to there being no aligned clinical strategy and was informed of a number of ongoing transactions and lease events. Some events are behind plan but there are mitigations in place.
- EPRR update on progress against new framework. The team continue to work hard to move the dial on compliance and have moved from 6 to 25 fully compliant standards with zero non compliant standards. However, due to the scoring framework, it is still technically "non compliant" overall which is likely

Committee Escalation and Assurance Report

to be the case for most trusts. ICS level risk assessment being prepared which should identify actual levels of resilience. Final submission to NHSE in December.

- Internal audits – Committee saw the finalised IA report for the Q&V programme which returned a significant assurance outcome; also the finalised IA report for e-rostering and critical shift incentives which had returned a limited assurance outcome. Committee was assured that the majority of management actions had been completed but one major recommendation had not been accepted and was being challenged.
- Workforce culture workshop – the Committee heard about the progress in staff retention and reducing turnover; also the impact that the communications strategy has had on engagement through the Q&V programme. Some discussion about the impact that the recent riots have had on staff sentiment and morale and how this is being managed. The Committee was assured that there is a good level of focus and attention from the Trust leadership on engagement, communication and driving a positive culture through action.

Risks Discussed and New Risks Identified

- No specific risk topics discussed but the risk of non recurrent cost savings and overall system financial pressures was discussed fully as part of the finance updates and Q&V pack. The Committee asked to be kept informed of developments through the Q&V updates and from the financial planning processes.

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	
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	

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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	
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	The Committee was reasonably assured at this stage but is mindful that there are significant system pressures and that the Q&V programme has not yet identified recurrent savings which could change the position in terms of financial balance in future years. The Committee will remain sighted on this through monthly Q&V and finance updates.
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	
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	Whilst the Trust is returning a “non compliant” result under the new EPRR framework, the Committee was reasonably assured that the Trust is no less resilient to operational threats than under the previous framework and the output of the ICB’s risk assessment will help inform any actual areas of weakness which the Committee will be appraised of in due course.
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	12 (high)	Reasonable	

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quality of care and staff wellbeing and a net cost to the Trust through increased agency spend.			

Author:	Rachel Booth
Role:	Committee Chair
Date:	15/11/24

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 6th December 2024
Date of Meeting:	27th November 2024	**Date of next meeting:**	29th January 2025

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 meeting was observed by a representative of MIAA as part of the Well Led review.

Alert	Action

Advise

- Proposed mobile phone/SIM contract extension was recommended for approval, due to the cost savings, staff convenience and other benefits over the contract lifespan. Committee approved the business case which will go to Board for sign off.
- Digital strategy – a revised paper was presented to the Committee which reflected recent comments through Board, including stakeholder engagement and clarity around priorities. Committee was satisfied with the changes to the strategy and confirmed its recommendation to approve the strategy at Board. The Committee heard that there were further amendments to make, following discussions at the Quality Committee, specifically to strengthen health equity elements. The Committee discussed the work plan in the strategy but acknowledged that this was an evolving piece of work and requested ongoing visibility of delivery against key priorities. The Committee was informed that the Year 1 business case was still considered to be achievable.
- Green Plan refresh – Committee was asked to support a refresh of the trust's sustainability plan which would see the timing for the emissions target brought forward from 2045 to 2040 to be in line with other parts of the NHS and to reignite Trust wide engagement. Committee was supportive and looks forward to sight of the refreshed detailed plans in Feb/March. Agreed that the approach needs to be both bottom up (engagement) and top down (Board commitment). Agreed to present benchmarking data for other comparable Trusts on carbon emissions reduction in the next update.
- Service focus – Integrated clinics (ABU). The team delivered an excellent presentation highlighting the work of the clinics across 16 locations; the benefits for patients, staff, sustainability, estates optimisation. The presentation highlighted the work done with Enhance partners across the clinics, the focussed work done to successfully reduce DNAs, time and cost efficiencies and the opportunities for income generation in the future as well as equity and accessibility of services for patients although it was acknowledged there was more to do in this space.
- PWC reports were shared and discussed. Committee was informed about the process of the exploratory work and challenges and was assured that the findings were being incorporated into the Q&V programme where appropriate.
- EPRR – some further draft policies to comply with the new framework were reviewed and approved by the Committee.

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Assurance

- Q&V update received. Committee was pleased to see full year's savings identified although concerns remain that 47% is not recurrent, placing greater pressure on delivery from service redesign and workforce plans, for recurrent savings beyond year 1. Committee was pleased to see more detail on EQIA and impact from service redesign work and asked for this to continue through future reporting, recognising the trade offs/tensions between cost savings and service levels for patients. Committee understood that the workforce planning is complex and there may be slippage in timescales into Q4. Committee also received a verbal update on recent contract bids.
- A Trust Priorities update was provided and whilst there was evidence of progress against deliverables, the paper lacked context around the extent of progress and gaps. The Committee requested some benchmarking or rating scheme to better understand the information provided in future updates.
- Performance brief and finance report – new format and approach to data presentation was welcomed by the Committee, particularly granularity in waiting lists which presents a clearer picture of risk. Committee was pleased to hear that the Audiology service with a 29 week wait had reduced to 13 weeks following a targeted approach. Validation of waiting list data continues. In the finance update, Committee was pleased to hear that there had been high engagement and ownership from staff on grip and control measures. Alerted to the likelihood of increased scrutiny around capital, due to new forecasting and Board assurance at month 8. Committee discussed the stretch ambition on surplus to support the WY position and the Committee questioned as to where the surplus is best spent across the system.
- Bi-annual BAF sources of assurance paper was presented and no new sources of assurance were identified.

Risks Discussed and New Risks Identified

- Risk register report was presented, showing movement in risks rated 8 or above. The Committee discussed the new operational risk around capacity in the BI team and was assured that the resource gaps were being tackled. Also requested further detail on the 3 risks which had remained static with no movement in over 12 months, and were advised that these were due to be reviewed at the Senior Leadership Team on 4 Dec 2025. The Committee asked for further visibility of fire safety controls and for this to be reported at the next BC meeting in January.

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	16 (extreme)	Reasonable	

Committee Escalation and Assurance Report

services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage			
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	
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	
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	
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	
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	
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	12 (high)	Reasonable	

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.			

Author:	Rachel Booth
Role:	Committee Chair
Date:	28/11/24

Committee Escalation and Assurance Report

Name of Committee:	Audit Committee	**Report to:**	Trust Board 6th December 2024
Date of Meeting:	11th October 2024	**Date of next meeting:**	13th December 2024

Introduction

Quorate meeting with a full agenda and good debate on key topics – good challenging conversations with constructive feedback provided on papers requiring comment.

Alert	Action
• N/A	

Advise

- Two limited opinion Internal Audit Reports were received and reviewed by the Committee – Enhance Programme, and eRostering and Critical Incentive Shifts. It was noted that the formal business case for the Enhance Programme would be presented to the November Business Committee and then Board, offering further opportunity for discussion. Further discussion around the eRostering audit would take place at the October Business Committee.
- An update on the number of open recommendations showed an improved picture compared to 2023/24, with additional executive management oversight leading to fewer being overdue.

Assurance

- The Internal Audit Manager would be joining the six-monthly Committee chairs meeting in order to review the Internal Audit plan periodically from a Committee perspective
- Committee received the Security Management Annual Report, noting that violence and aggression cases had reduced by almost 50% since 2022/23. Further analysis of incident trends would be welcomed, but consideration needed to be given to whether this reported through to the Business Committee or the Audit Committee in order to prevent duplication.
- Counter Fraud – quarterly update report received, and it was noted that the Local Anti-Fraud, Bribery and Corruption Policy was currently under review.
- External Audit – planning work for the 2024/25 audit had commenced.
- Board Assurance Framework Activity Report – The Committee had determined a reasonable level of assurance in relation to maintaining business continuity at both its April and July meetings. No additional sources of assurance were requested.

Committee Escalation and Assurance Report

- Cyber security – a six monthly update was received by Committee, noting that a new Information Security (cyber) Specialist had been appointed. The Data Security and Protection Toolkit (DPST) had now been aligned with the Cyber Assessment Framework, and Committee was reassured that work had commenced to complete this.

Risks Discussed and New Risks Identified

- N/A

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	**Risk score (current)**	**Overall level of assurance provided that the strategic risk is being managed (or not)**	**Additional comments**
Risk 7 Failure to maintain business continuity (including response to cyber security): If the Trust is unable to maintain business continuity in the event of significant disruption then essential services will not be able to operate, leading to patient harm, reputational damage and financial loss.	12 (high)	Reasonable	N/A

Author:	Helen Robinson/Khalil Rehman
Role:	Company Secretary/Committee Chair
Date:	07/11/2024

Leeds Community Healthcare NHS Trust

Agenda item:	2024-25 (95i)

Title of report:	Performance Brief – Highlight Report – October 2024

Meeting:	Trust Board Meeting Held in Public
Date:	6 December 2024

Presented by:	Andrea Osborne – Director of Finance and Resources					
Prepared by:	Andrea Osborne – Director of Finance and Resources					
Purpose: (Please tick ONE box only)	Assurance	x	Discussion		Approval	

Executive Summary:	This report seeks to provide: • An update on progress relating to the development of the Performance Brief (as we work towards to using Statistical Process Control (SPC) methodologies as the analytical foundation for the Performance Brief) • An overview of performance against the Trusts High Level Indicators (HLIs) including Financial Performance and delivery of the 24/25 financial plan,

Previously considered by:	Quality Committee 25the November 2024 Business Committee 27th November 2024

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

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	ü	Why not/what future plans are there to include this information?	Highlight report only
Recommendation(s)	The Board is asked to note the contents of the report.			
List of Appendices:	Appendix 1 – Summary of Indicator Performance			

Performance Brief Highlight Report – October 2024

Overview

Following discussion at the Board Workshop on 3rd September work continues 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.

As previously reported an Executive Summary table has now been developed, this has been included in Appendix 1 and categorises the high-level indicators according to SPC methodology, of variation and assurance, highlighting whether the target was met and whether performance is improving or deteriorating. For those indicators which are not currently reported via SPC methodology, a judgement based on a non-statistical assessment of performance has been taken to ensure completeness of reporting. This judgement may refine over time.

Key Exceptions/ Escalations by Domain :

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

Patient safety reporting has changed significantly over the past 12 months with the introduction of the Patient Safety Incident Response Framework (PSIRF) and the Trust's patient safety plan which describes how we will learn and improve care from patient safety incidents. It is encouraging to see, since the Trust mandated the national patient safety syllabus training levels 1 and 2, that the numbers of staff who have completed this is increasing. Our current position shows a stable position of patient safety through performance report indicators.

Trends relating to pressure ulcers reflect that Incident Handlers have completed more investigations during October than in previous months. There is currently no suggestion of any increased rates incidents.

Further work to address the performance against the data quality maturity index (DQMI) for Mental Health is ongoing.

Caring- By caring, we mean staff involving and treating people with compassion, kindness, dignity and respect.

Hearing feedback from people and using this to inform improvements is fundamental to achieving the best experience and outcome for the people we serve. The experience of our people matters to us. Our October word cloud continues to highlight the overwhelmingly positive feedback that we receive from patients relating to their experience.

With the implementation of SPC charts, we now have a clearer overall view of 'Very Good/Good' feedback across all services. The data indicates that we remain slightly below the target for FFT 'Very Good/Good' ratings. Based on this analysis, we will review additional feedback data from other areas to identify the factors contributing to this. This insight will inform the actions.

Effective - By effective, we mean people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

The Effective Domain is reported quarterly. As an organisation, we are committed to developing a new set of measures to help monitor our Performance in this Domain. In October 2024, Quality Committee held a joint workshop with members from QAIG focussed on identifying key metrics for the Effective domain to be incorporated into the quality dashboard and Performance Brief during 2025.

Responsive - By responsive, we mean services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care

Although patients continue to wait long times to access treatment in some of our services, there is also evidence of improvement in some key areas.

The total number of people waiting for care to start is now showing early signs of decreasing, as the significant growth seen in the first 6 months of this year has slowed, and now is tentatively reducing. Key improvements are also now visible in patients waiting for 6-week diagnostic tests and in performance against the Urgent Community Response 2hr Standard.

There are significant amounts of work being undertaken in services to respond to the number of people who are waiting more than 52 weeks, and even though this work is not yet visible in the overall indicators, excellent progress is being made in reviewing records and starting care.

Talking Therapies teams within Leeds Mental Wellbeing Service have continued to improve performance against targets.

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

The Trust's sickness absence rate shows there is a special cause variation of a concerning nature, this is likely linked to seasonal variations and organisational change. Stress, anxiety, depression, and MSK issues remain the primary reasons for absence, with the HR team actively addressing "hot spots" and promoting wellbeing support.

Statutory and mandatory training compliance averages in the high 80%, with national efforts underway to streamline requirements.

Appraisal completion rates consistently fall below the 90% target, noting that the quarter 2 deterioration has recovered and has remained stable slightly above 75%; further deep dive reviews to improve performance is taking place through the Trusts established performance panel process. Staff turnover remains below the 14.5% target, with low numbers leaving within 12 months of joining. The Trust is also on track to meet its goal of 14% BME representation by May 2025.

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

Prior Year £k	Key Financial Indicators	Year To Date Plan £k	Year To Date Actuals £k	Year To Date Variance £k	Full Year Plan £k	Full Year Forecast £k	Full Year Variance £k
(267)	**Adjusted (Surplus)/Deficit**	(595)	(617)	(22)	(1,005)	(1,005)	0
43,534	**Closing cash balance**	41,588	47,931	(6,343)	40,944	42,944	(2,000)
15,875	**Capital Expenditure / CDEL**	(7,266)	(3,937)	3,329	(15,020)	(9,526)	5,494
	Quality & Value Programme						
3,674	Recurrent savings	7,702	5,006	2,696	13,200	8,363	4,837
4,578	Non Recurrent savings	1,505	4,198	(2,693)	2,578	7,415	(4,837)
8,252	**Total savings**	9,207	9,204	3	15,778	15,778	0
	Temporary staffing						
3,793	Agency	2,204	1,330	(874)	3,790	2,168	(1,622)
5,259	Bank	2,984	3,222	238	5,144	5,785	641
9,052	**Total temporary staffing**	5,188	4,552	(636)	8,934	7,953	(981)
160,588	**Total Gross staff costs**	92,594	92,731	(137)	159,055	158,902	153
2.4%	**Agency as a % of gross staff costs**	2.4%	1.4%	-1%	2.4%	1.4%	-1%

Income & Expenditure: The Trust's year to date position has improved this month and is broadly in line with plan. This is mainly due to the grip and control measures in place. The forecast outturn remains on plan and there is increased confidence this will be delivered now the 24/25 pay award has been finalised and the Q&V programme is forecasting achievement in full.

Cash: The Trust's cash position remains strong reporting a closing cash balance of £47.9m, above plan by £6.3m mainly due to the receipt of additional income from interest and outstanding invoices from Leeds City Council and lower than planned lease costs. This favourable position is expected to be sustained with a forecast year-end balance of £42.9m.

Capital Expenditure: Expenditure remains less than planned at the end of October, the main reason for the underspend against plan both year-to-date and forecast is the continued delay in the agreement of the lease at St Georges, and the impact of lease remeasurements. Forecast expenditure by the end of March 2025 is £9.6m, this represents a considerable increase in spend in the latter half of the year. Capital planning for 25/26 is underway and options of bringing forward schemes to offset any unavoidable slippage will be considered where appropriate and necessary. A key risk to the forecast remains the signing of leases, this is being continually reviewed.

Quality & Value Programme: Delivery of the efficiency savings is now on track both year to date and forecast out-turn. There remains considerable risk regarding the non-recurrent nature of savings forecast at £7.4m (47%) against planned position of £2.6m. Work to identify recurrent plans remains ongoing through the Q&V programme to reduce the risk of impacting on 25/26 financial plans.

Temporary staffing: Year to date the Trust continues to have lower agency expenditure compared to the financial plan. In month agency spend is £172k, a reduction of £31k from last month despite an increase in agency usage within the Domestic service, approved by the Q&V vacancy panel as essential, to cover vacancies, sickness, and leavers. An active recruitment drive is underway, with new staff anticipated to begin early next year, which should further reduce the Trust's reliance on agency staff. The overall reduction is part of a broader trend, with agency spend in October accounting for only 1.1% of the total pay spend, down from 1.6% in August.

Appendix 1 – Summary of Indicator Performance

Categorisation of SPC Indicators

	Passing	Inconsistent	Failing	No Target
Improving	Community health services two-hour urgent response standard IAPT - Percentage of people referred should begin treatment within 6 weeks of referral		Staff Turnover Compliance in Level 1 and 2 Patient Safety Training Percentage of patients wating less than 6 weeks for a diagnostic test (DM01) Statutory and Mandatory Training Compliance	Data Quality Maturity Index (DQMI) CSDS Data score
No Change	Compliance with statutory duty of Candour IAPT - Percentage of people referred who should begin treatment within 18 weeks of referral Percentage of patient contacts where an ethnicity code is present	Data Quality Maturity Index (DQMI) - IAPT dataset score Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT) Reduce the number of staff leaving the organisation within 12 months Starters / Leavers net movement	% of CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment AfC Staff Appraisal Rate	IAPT - Number of patients starting screening within two weeks of referral Neighbourhood Team Face to Face Contacts Neighbourhood Team Productivity (Contacts per Utilised WTE) Neighbourhood Team Referrals (SystmOne only) Total Number of Formal Complaints Received
Deteriorating	Total sickness absence rate		Data Quality Maturity Index (DQMI) MHMDS dataset score % of patients waiting under 18 weeks (non reportable) Number of patients waiting more than 52 weeks (Consultant led) Percentage of patients currently waiting under 18 weeks (Consultant led)	Difference in access to services for patients living in IMD1 vs IMD2-10 LMWS Access Target: Local Measure (including PCMH)

Categorisation of Non-SPC Indicators

No Concern

Attributed MRSA Bacteraemia - infection rate
Clostridium Difficule - infection rate
Mixed Sex Accommodation Breaches
Never Event Incident
Number of overdue PSII Actions
Number of Patient Safety Incident Investigations (PSII)

Concern

% CAMHS ACBI & Neurodevelopmental Initial Assessment patients currently waiting less than 12 weeks
% CAMHS Eating Disorder patients currently waiting less than 1 week for urgent treatment
CAS Alerts Overdue
Number of incidents by PSIRP priority

Agenda item:	2024-25 (96i)

Title of report:	EPRR Improvement Plan

Meeting:	Trust Board Held In Public
Date:	6 December, 2024

Presented by:	Sam Prince, Executive Director of Operations/Deputy Chief Executive					
Prepared by:	Rebecca Todd, Emergency Planning Manager Peter Ainsworth, Operational Support Manager					
Purpose: (Please tick ONE box only)	Assurance √		Discussion		Approval √	

Executive Summary:	**Part 1 – Compliance against National Core Standards** The Trust has improved its compliance rating from 6 fully compliant standards to 27. The Trust has also reduced the number of non-compliant standards to zero. In line with the new Standard scoring system across the North East and Yorkshire region the Trust is again declaring a non-compliance rating. The NHSE Annual Assurance self-assessment was submitted to the ICB on 31st October 2024. Check and challenge reviews have been underway between Trust Accountable Emergency Officers, Emergency Planning Managers and the ICB. LCH were reviewed by the ICB on 19th November. The ICB will now report the review outcomes\ final ratings to NHSE. The outcomes from these reviews may increase or decrease the level of compliance before the final submission to NHS England on 31st December 2024. **Part 2 – Policies and Plans** A number of additional policies and plans are now ready for final Approval: • EPRR Policy • Incident Response Plan • Business Continuity Statement, Policy and Management System (BCMS) • Adverse Weather • Fuel Disruption • Evacuation and Shelter Plan

	• Chemical, Biological, Radiation and Nuclear (CBRN) / Hazmat plan

Previously considered by:	Trust Leadership Team – 23/10/2024 & 20/11/2024 Business Committee – 30/10/2024 & 27/11/2024

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?	All revised policies and plans have been developed and assessed in line with LCH Policy. There is no specific Equity data included within EPRR overarching documents.

Recommendation(s)	Approval of submitted EPRR policies and plans

List of Appendices:	Appendix 1 – LCH Statement of Compliance Appendix 2 – NHSE Annual EPRR Assurance Submission Appendix 3 - EPRR Policy Appendix 4 - Incident Response Plan Appendix 5 - Business Continuity Statement, Policy and Management System (BCMS) Appendix 6 - Adverse Weather Appendix 7 - Fuel Disruption Appendix 8 - Evacuation and Shelter Plan Appendix 9 - Chemical, Biological, Radiation and Nuclear (CBRN) / Hazmat plan

Report title

Emergency Preparedness, Resilience and Recovery (EPRR) update and request for approval of policies and plans – November 2024

Part 1 – EPRR annual compliance

1 Introduction

The majority of the Trust's EPRR policies and plans have been rewritten in line with the requirements of the NHS England EPRR Core Standards and the NHS England Annual EPRR Assurance Audit.

2 Current position/main body of the report

Every year NHS England request that Trusts carry out their own EPRR compliance self-assessment against a set of national core standards. Up until 2023, the Trust declared a substantially compliant rating, as most standards were either compliant, or substantially compliant.

Last year a new process was introduced across the NHS NE&Y region. This resulted in all Trusts in the region reporting a reduction in their level of compliance to non-compliant. At recent peer review meetings it has become clear this remains the situation, however every Trust has reported improvements.

2024/25 Compliance scores

There are two parts to the self-assessment, the EPRR standards (which are reportable) and the 'deep dive' which does not count towards the final rating.

The current (November 2024) EPRR compliance score for the Trust is as follows:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	4	2	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	3	8	0
Command and control	2	2	0	0
Training and exercising	4	0	4	0
Response	5	3	2	0
Warning and informing	4	0	4	0
Cooperation	4	3	1	0
Business Continuity	10	2	8	0
Hazmat/CBRN	10	8	2	0
CBRN Support to acute Trusts	0	0	0	0
Total	58	27	31	0

Whilst this demonstrates an improvement from the 2023 score where the Trust was only fully compliant with six standards, there remains a lot of work to be done to reach a partial compliance rating.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
2023	58	6	45	7
2024	58	27	31	0
Target for partially compliant rating	58	42	16	0

This year's 'deep dive' assessed our arrangements for responding and recovery from a cyber-attack. The scores were:

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	8	3	0
Total	11	8	3	0

➢ **Areas of improvement**

Most of the areas of improvement reflect the work carried out directly by the EPRR Manager such as updating policies and plans.

Where the improvements were linked to other Trust departments, or other Trusts/ NHS organisations there has not been as much of an improvement in compliance levels. For this reason, the EPRR Improvement Plan will be managed by the new Senior Leadership Team through their fortnightly meetings. This will ensure that all responsibilities are visible, and updates can be monitored more effectively.

Similarly, the ICB/ICS will be running workshops around some of the harder to achieve standards.

It is likely that the two hardest standards to achieve will be:

- The EPRR training standards, where NHS England (NE&Y) have implemented a very ambitious training/competence programme underpinned by personal portfolios to be held by managers. All Trusts in the region are in the early stages of understanding the impact of this development, but an ICB Working Group has been established to support this process.
- Meeting the requirements for business continuity arrangements in line with the Trust Business Continuity Management System/overarching plan has been a challenge in recent years. Internal audit will be reviewing the process in December and will assist in the production of an improvement plan for this area following the inspection. The process will then be disseminated to all Business Continuity Plan holders at the Operational Managers Forum in early Spring 2025.

3 Impact

- **Quality Resources**

In 2025, the EPRR Improvement Plan will be tested against the resources available. Some of the improvements can be achieved within the EPRR function, or by other departments. Agreement within the Senior Leadership team meetings will determine whether additional EPRR resource will be required to meet all standards.

- **Risk and Assurance**

EPRR has a recorded risk on Datix 'Non-compliance with NHSE EPRR Annual Assurance process'. The re-writing of the Trust EPRR Policies and Plans has contributed significantly to the reduction in this risk whilst working alongside partner Community and Mental Health Trusts across WY has ensured that the new plans are robust and in line with the latest national guidance.

The outcomes from the Business Continuity inspection by Internal Audit in December will also be incorporated into the EPRR Improvement Plan to increase compliance in this area.

4 Next steps

- EPRR Improvement Plan to be re-written in line with the outcomes of the NHSE Annual EPRR Audit submission and the Internal Audit Business Continuity inspection. We will also continue to work with colleagues locally and regionally to address any gaps and achieve compliance.
- MOU to be developed between LCH and LTHT to formalise evacuation arrangements for the Wharfedale Recovery Hub.
- Internal Audit to review the LCH Business Continuity Management System (BCMS) and sample BCPs in December 2024 with outcomes to be shared with the Audit Committee.
- Learning & Exercising Group is to be established in January 2025 to demonstrate the continuous improvement of our plans through learning from live events and incidents.
- The Trust Lockdown Plan requires further development. The plan shares similar challenges to the CBRN Plan in that the staff providing the initial response will be Front of House\Reception staff, therefore the decision-making process and follow-up actions required to lock down a building are being explored in more detail.
- Training and CBRN are both complex pieces of work to be addressed and the Trust is awaiting clarity regarding the recently launched Training Portfolios and an audit by Yorkshire Ambulance Service to develop our CBRN planning and response arrangements.

5 Recommendations

The Board is recommended to: Approve the submitted policies and plans.

Rebecca Todd
Emergency Planning Manager

Peter Ainsworth
Operational Support Manager
22nd November, 2024

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-2025

STATEMENT OF COMPLIANCE

Leeds Community Healthcare NHS Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, Leeds Community Healthcare NHS Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

30/10/2024

Date signed

30/10/2024	06/12/2024	01/09/2025
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Agenda item:	2024-25 (97)

Title of report:	Guardian for Safe Working Hours- Quarter 2 update

Meeting:	Trust Board Meeting Held In Public
Date:	6 December 2024

Presented by:	Nagashree Nallapeta, Guardian of Safe Working Hours					
Prepared by:	Nagashree Nallapeta, Guardian of Safe Working Hours					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	**Main issues for consideration** • Progress made to improve community paediatric training.

Previously considered by:	Nil

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

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

Recommendation(s)	• Support GSWH with the work in relation to community paediatric training opportunities. • To note that there is a risk for the Trust from the grievance case raised by Junior doctor affected by CAMHS historic rota issue.

List of Appendices:	Nil

Guardian for Safe Working Hours report

1 Introduction

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

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

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

2 Current position/main body of the report

There are 22 Junior Doctors employed throughout the Trust currently (in different specialities, both full time and less than full time training) as detailed in the table below. This includes Junior doctors employed directly by LCH and on honorary contracts.

Department	No.	Grade	Status
Adults	0		LCH contract
Foundation year	2	FY1	Honorary contract
CAMHS	6	ST	LCH contract
	0	ST	Honorary contract
	2	CT	Honorary contract
Community Paediatrics	4	ST Level 1	LCH contract
	4	ST Level 2/ Grid trainee	Honorary contract
Sexual Health	1	ST	LCH contract
GP	2	GPSTR	LCH contract
Community Gynae	1	ST	Honorary contract
Dental Services	0		Honorary contract

3 Impact

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

- **Quality**

Exception reports
No exception reports were filed during this quarter.
Fines
No fines levied by the GSWH during this quarter.

- **Resources**

Rota gaps and CAMHS ST rota
The CAMHS ST non resident on call rota consists of a 1:5 rota, and gaps (currently 3 gaps) on this rota are covered by locums, typically doctors who have worked on the rota in the past or doctors currently working for LCH who are willing to do extra shifts. The current CAMHS ST on call rota is checked by senior CAMHS admin staff with experience in managing CAMHS consultant rota to double check the Locum shifts picked up by Junior doctors.

Rota Gaps (number of night shifts needing cover)		Sep 2024		Oct 2024		Nov 2024	
		CT	ST	CT	ST	CT	ST
	Gaps	n/a	2	n/a	1	n/a	2
	Internal Cover	n/a	2	n/a	1	n/a	2
	External cover	n/a	0	n/a	0	n/a	0
	Unfilled	n/a	0	n/a	0	n/a	0

- **Risk and assurance**

Feedback from Junior doctors
Resident Doctors Forum (RDF) was held on MS teams on 24/10/2024.

There was a poor turn out of Junior doctors and BMA IRO could not attend the meeting due to school holidays. Junior doctors continue to be well supported by the Medical Directorate and Director of Workforce team.

Head of Medical Education updated about the progress made by the with regards to the actions outlined in the “Improving the working lives of doctors in training” guidance published by NHS England.

Resident doctors in community paediatrics raised issues related to working conditions during on call sessions. These issues fall under the remit of GSWH at Leeds Teaching Hospitals Trust who is aware of the issue. LCH GSWH has offered support to liaise with the GSWH at LTHT as necessary.

CAMHS Historic ST rota issue

Since the last Trust Board meeting, GSWH has worked with BMA team and has been informed that some of the affected Junior doctors are considering further actions through formal grievance case route, as offered by the Trust.
One Junior doctor has raised a grievance case on 23/11/24 via correspondence to Director of Workforce.

Community paediatric Training issue

Work continues to improve the community paediatric training for speciality doctors sub specialising in community paediatrics. GSWH, College tutor, rota lead at Leeds

Children's hospital and LCH's DMD, College tutor, LNC Junior doctors representative have worked together and changes are in place to ensure doctors have more time in community paediatrics. Plans to change the current rota pattern to ensure doctors get around 70% of the time for training is being investigated for the next cohort of doctors starting in March. This is a significant achievement that will improve the training in community paediatrics.

➢ 4 Next steps

GSWH will continue to work with Key people to improve community paediatric training. The next meeting is planned for December 2024 or January 2025.

GSWH is awaiting further information and advice from NHS Employers with regards to potential fines.

➢ 5 Recommendations

The Board is recommended to:

- Support GSWH with the work in relation to community paediatric training opportunities.
- To note that there is a risk for the Trust from the grievance case raised by Junior doctor affected by CAMHS historic rota issue.

Name of author Nagashree Nallapeta
Title Guardian for Safe Working Hours
Date paper written 22/11/2024

Agenda item:	2024-25 (98)
Title of report:	**Significant Risks and Risk Assurance Report**

Meeting:	Trust Board					
Date:	6 December 2024					
Presented by:	Selina Douglas, Chief Executive Officer					
Prepared by:	Anne Ellis, Risk Manager					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	This report is part of the governance processes supporting risk management in that it provides information about the effectiveness of the risk management processes and the controls that are in place to manage the Trust's most significant risks. There are three risks on the Trust risk register that have a score of 15 or more (extreme). There are a total of 10 risks scoring 12 (very high).

Previously considered by:	Trust Leadership Team 27 November 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 (October 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 (October)
Total Open Risks	70	70
Risks Scoring 15 or above	3	1
New Risks	3	13
Closed Risks	3	3
Risk Score Increasing	3	1
Risk Score Decreasing	5	3
Risk Score Static > 12 months	7	10

2.2 The following changes have taken place to risks scoring 15 (extreme) or above since the last risk register report.

Risk	Risk Type	Current Score	Previous Score (September 2024)
1187: Insufficient IT Resilience leading to the risk of extended outages of the infrastructure	**Operational**	**16**	**12**
Risk increased back to 16 (4x4) at request of Executive Director of Finance. Implementation of recommendations from the THIS review continues with actions being led by the Head of IT, Helpdesk Manager and AD of BI.			

Risk	Risk Type	Current Score	Previous Score (September 2024)
Recruitment to third line position to provide permanent support is in progress with interviews planned for the 25th October. Further planning meeting scheduled for 23rd October 2024. THIS review presented to SLT 18th September 2024. Date to present options review / case for change and business case to be agreed. (Update 22/10/24) Next review is due 11/11/24			
1048: Mind Mate SPA increasing backlog of referrals (system-wide risk).	**Operational**	**15**	**15**
The CAMHS service is midway through an Integrated Design Office (IDO) approach to reviewing how referrals can best be managed into and through MindMate Spa. This is being led by the ICB with LCH project support and CAMHS input. The ICB are responsible for completing an options appraisal/business case in addition to an EQIA. Both are expected to be completed by 31/12/24. In the meantime, safeguards remain in place to ensure all referrals are risk assessed and escalated clinically as appropriate. (updated 4/11/24) The aim is to reduce the risk to 12 by 31/3/25. Next review is due 31/12/24			
1179: Impact/Management of Neurodevelopmental Assessment Waiting List.	**Operational**	**15**	**12**
Risk increased to 15 following discussions at TLT in September. The likelihood has been increased to 5 (Almost Certain) due to Q&V not yet having an impact on the waiting lists. Business case underway to assess options to reduce pre-school and school-age waits for ND assessment. All options involve additional investment. Both pre and school age assessment pathways are undergoing review by the MDTs concerned plus engagement with the wider system and children and families. Pilot underway in pre-school ND pathway to reduce numbers of children needing to see a paediatrician which will reduce the overall waiting time for that cohort of children. (updated 4/11/24) Next review is due 2/12/24			

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
1171	Patient safety concerns in Yeadon Neighbourhood Team	12	12	Unchanged
1198	Impact of ADHD medication waiting list	12	12	Unchanged
1199	The impact and management of the CYPMHS Therapies waiting list	12	12	Unchanged
1217	Digital and BI teams have insufficient capacity	12	12	Unchanged
1218	Lack of capacity in services to engage with digital transformation projects	12	12	Unchanged
1220	A large proportion of the population are digitally excluded	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

All 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 24 open clinical risks and 46 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	2	1	0	0	3
4 - Major	0	6	5	1	0	12
3 - Moderate	1	10	24	5	1	41
2 - Minor	0	3	6	1	1	11
1 - Negligible	0	1	1	1	0	3
Total	1	22	37	8	2	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, fourteen risks relate to an increase in referrals and service demand[1]	The BAF strategic risks directly linked to demand for services are: BAF Risk 2 Failure to manage demand for services BAF Risk 8 Failure to have suitable and sufficient staff resource (including leadership) BAF Risk 9 Failure to prevent harm and reduce inequalities experienced by our patients.
Theme Two: Patient Safety	
The second strongest risk theme is patient safety due to staff working outside their role, lack of incident management, workload pressures, capacity to complete clinical supervision, clinically essential training, and safe operation of medical devices [2].	The BAF strategic risks directly linked to patient safety are: BAF Risk 1 Failure to deliver quality of care and improvements BAF Risk 2 Failure to manage demand for services BAF Risk 4 Failure to be compliant with legislation and regulatory requirements
Theme Three: Compliance with Standards/Legislation	
There is also a risk theme relating to compliance with standards/ legislation[3] This includes 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

[1] Risks: 772, 913, 954, 957, 984, 994, 1015, 1048, 1112, 1179, 1198, 1199, 1211, 1042
[2] Risks: 877, 981, 1070, 1109, 1139, 1168, 1171, 1187, 1196, 1231
[3] Risks: 902, 1089, 1178, 1204, 1206, 1221, 1223, 1230, 1240, 1242, 1243, 1250
[4] 1226, 1227, 1228, 1229

Theme Five: Digital Transformation	
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 February 2025.

8. Recommendations

The Board is recommended to:

- Note the changes to the significant risks since the last risk report was presented to the Board; and
- Consider whether the Board is assured that planned mitigating actions will reduce the risks.

Author: Anne Ellis, Risk Manager
Date written: 8 November 2024

[5] Risks: 1217, 1218, 1220, 1224

Agenda item:	2024-2025 (99i)

Title of report:	Board Assurance Framework Quarterly Update

Meeting:	Trust Board Held In Public
Date:	6 December 2024

Presented by:	Selina Douglas, 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 is now 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 second quarterly review which has taken place during November 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. The Board is reminded that the BAF is presented here for assurance on its completeness as of November 2024.

Previously considered by:	Trust Leadership Team 27 November 2024

	Work with communities to deliver personalised care	✓

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

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	✓	Why not/what future plans are there to include this information?	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_November2024

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 6 November 2024

Ref	Strategic Risk	Lead Director(s)	Current Score (Nov 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. Actions are progressing against the deadlines set. The deadline for developing assurance on the EQIA process has been extended to the end of March 2025 due to the current review of corporate services.
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. The business case for year 1 of the digital strategy has been approved. Actions due to complete by the end of this quarter following the approval of the digital strategy, include the development of a strategy implementation plan, medium term financial plan and outline cases for investment.
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 remains at 6. The actions are progressing, the deadline for completion of the well-led review has been extended to Q4.
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. Two new actions have been added in relation to year 2 of the Q & V programme.
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. There is one action due to complete in Q3 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.
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.
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. Board to Board meeting with Leeds Teaching Hospitals has taken place with agreement to work together on key strategic projects.

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				✓		Sep 24 Quality Committee: 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.
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			✓	✓		Sep 24 Quality Committee: 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. Sep 24 Business Committee: This was deemed as reasonable assurance on this occasion but the Committee remained 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.
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				✓		Sep 24 Quality Committee: The early benefit of the SPC reporting approach was noted, as was the positive digital approach in the CYP&F strategy.
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				✓		Oct 24 Business Committee: Reasonable assurance overall, noting the comment against SR7 in terms of EPRR compliance.

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**				✓		Oct 24 Business Committee: Reasonable assurance overall but the Committee was mindful that there were significant system pressures and that the Q&V programme had not yet identified recurrent savings which could change the position in terms of financial balance in future years. The Committee would remain sighted on this through monthly Q&V and finance updates.
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**				✓		
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**				✓		Oct 24 Business Committee: Reasonable assurance overall, whilst the Trust was returning a "non compliant" result under the new EPRR framework, the Committee was reasonably assured that the Trust was no less resilient to operational threats than under the previous framework and the output of the ICB's risk assessment would help inform any actual areas of weakness which the Committee will be appraised of in due course.
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**				✓		
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

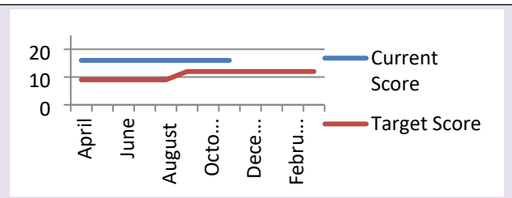
Risk Appetite: Minimal (low) to **cautious (moderate)** appetite to risk that could compromise the delivery of high quality, safe services.

Lead Director/risk owner: Executive Director of Nursing and Allied Health Professionals

Committee with oversight: Quality Committee

Date last reviewed: 5 November 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, Q&V is 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
- Clinical Supervision
- Quality Challenge & Process
- Quality Strategy
- Engagement Principles
- EQIA process
- Safeguarding Strategy
- Children's 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

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
Development and embedding of Statistical Process Controls (SPC)	Director of Finance and Resources	End 2024/25
Implementation of the new CQC single assessment framework to align with Quality Challenge + programme	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	• 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
EQIA – develop clear oversight by clinical Directors and appropriate escalation through corporate governance processes	Director of Nursing and AHP's.	~~31/12/24~~ 30/3/25

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1042: Provision of equipment from Leeds Community Equipment Services (12)
Risk 1139: General risk of non-concordance with the overarching process for medical devices (9)
Risk 1125: National supply issues with enteral feeding supplies (9)
Risk 1228: 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

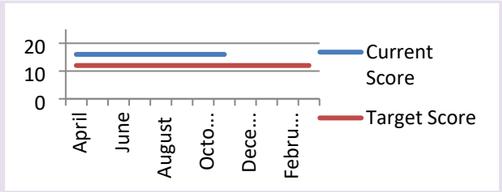
Risk Appetite: Minimal (low) to **cautious (moderate)** appetite to risk that could compromise the delivery of high quality, safe services.

Lead Director/risk owner: Executive Director of Operations

Committee with oversight: Quality and Business Committees

Date last reviewed: 24 October 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	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	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 (15)
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

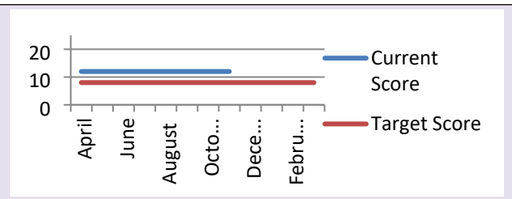
Risk Appetite: Open (high) risk appetite in pursuing innovation and challenging current working practices without compromising the quality of patient care. In the implementation of changes, the Trust has a **cautious (moderate)** risk appetite.

Lead Director/risk owner: Executive Director of Finance and Resources

Committee with oversight: Quality and Business Committees

Date last reviewed: 4 November 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
- Business Case (Year 1 approved)

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 – December 2024	Executive Director of Finance and Resources	~~Oct Board~~ Q3 24/25
Agree outcome reporting measures for the Digital Strategy Progress report	Executive Director of Finance and Resources	Q4 24/25
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	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	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 Digital Strategy Programme reporting arrangements	Executive Director of Finance and Resources & Executive Medical Director	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

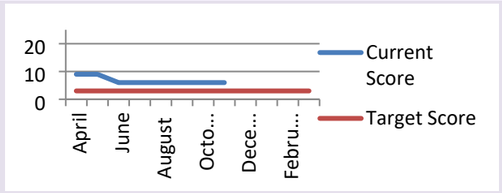
Risk Appetite: Minimal (low) to **cautious (moderate)** appetite to risk that could result in non-compliance and reputational damage. The Trust has no appetite for non-compliance with NHS Employers standards, fraud or financial loss.

Lead Director/risk owner: Trust Leadership Team

Committee with oversight: Quality and Business Committees

Date last reviewed: 28 October 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 is 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.
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 Q3~~ Q4
Implementation of the new CQC single assessment framework to align with Quality Challenge + programme	Executive Director of Nursing and Allied Health Professionals	March 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 (QC) • Patient safety and serious incident report (QC) • Safeguarding report/minutes (QC) • Quality Strategy report (QC) • IPC BAF Report (QC) • Premises Assurance Model update (BC) • Health and Safety compliance report (BC) • Sustainability report (BC) • Workforce report (BC) • Information Governance Reporting (BC) • CEO report to Board (Board) • Employee relations report (Board) • Code of Governance compliance report (Board)	• Emergency Planning quarterly updates and annual report (BC) • Performance brief (statutory compliance) (QC and BC) • NICE guidance compliance (QC) • Mortality report (QC) • Medical Director's Report (appraisals info) (QC and Board) • Annual report to Board (Board) • MHLDA Committees in Common minutes and report (Board)	• CQC system assessment reports • Internal audit

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 1178: Uncoordinated fire evacuation arrangements (12)
Risk 1243: Fire Evacuation Chair Training and Competence (10)
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

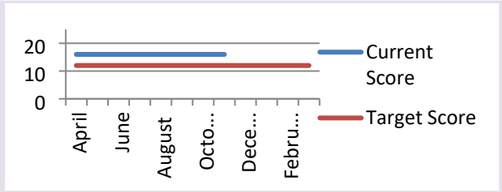
Risk Appetite: Open (high) appetite to the financial risk associated with new expenditure plans for existing services as the benefits for patient care may justify the investment. For investment in new services, the Trust's risk appetite is **cautious (moderate)** if the benefits to existing patients cannot convincingly be demonstrated.

Lead Director/risk owner: Executive Director of Finance and Resources

Committee with oversight: Business Committee

Date last reviewed: 4 November 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.
- Internal Audit assessment of Q&V programme structure (Part 1)

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 for Year 1	EDO	End Q3
Develop Year 2 (25/26) savings plan	EDFR	Jan 25
Commission Internal Audit review of effectiveness of Q&V Programme	EDFR	Q1 25/26
Develop an action plan that draws together key findings from across a number of best practice checklists including HFMA Financial Sustainability, NE&Y and PWC checklists.	EDFR	Q4 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	Q3 2024
Investment policy requires review – completion delayed to Q4 2024/25	EFDR	~~Jan 2025~~ Q4 2024
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	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	End Q3
Refreshed strategic implementation plan for Procurement to support service level assurance	EDFR	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	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

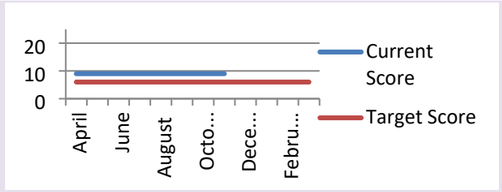
Risk Appetite: Open (high) appetite to the financial risk associated with new expenditure plans for existing services as the benefits for patient care may justify the investment. For investment in new services, the Trust's risk appetite is **cautious (moderate)** if the benefits to existing patients cannot convincingly be demonstrated.

Lead Director/risk owner: Executive Director of Operations

Committee with oversight: Business Committee

Date last reviewed: 24 October 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
- Digital strategy
- Greener plan
- Partnership arrangements
- 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)

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
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

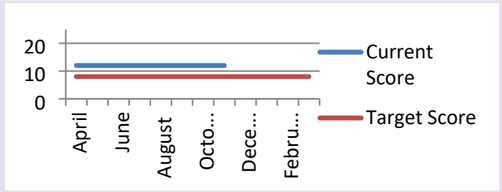
Risk Appetite: Cautious (moderate) appetite for risks relating to its reputation, the Trust's appetite is to ***avoid* risk *(*zero appetite*)*** of financial loss and **minimal (low)** to **cautious (moderate)** appetite to risk that could compromise the delivery of high quality, safe services.

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: 24 October 2024 (Executive Director of Operations) 4 November 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
- Cyber response service contract with Jumpsec Ltd in place until September 2025 (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
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	2025/26
Establish and implement target operating model for IT function, responding to findings from IT resilience review (risk 1187)	EFDR	Q2 2025/26
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 • Cyber Security Report (AC)	• 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 • Assurance from external contractors re: cyber security resilience recovery

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	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

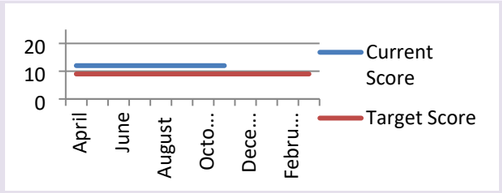
Risk Appetite: Avoid (zero risk appetite) noncompliance with NHS Employers Standards, employment fraud or lapses in professional qualifications. The Trust has an **open (high)** risk appetite to for learning and development opportunities which allows it scope to implement initiatives and procedures that 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: 4 November 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 staff side expertise on Q&V programme board and relevant workstreams
- Staff side 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

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 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)
Risk 1250: Staff shortage Domestic Services (cleaners)

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

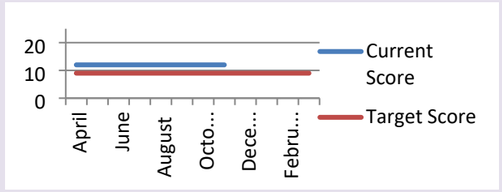
Risk Appetite: open (high) risk appetite for collaboration with people and communities to ensure their experience influences equitable approaches to change, such as for the Quality and Value Programme. Priority will be given to changes that protect equity and the Trust has a **cautious (moderate)** risk 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: 4 November 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	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	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	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

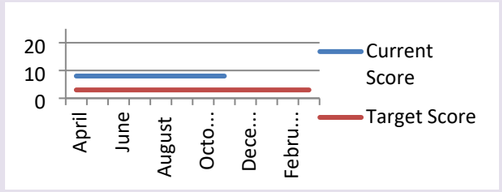
Risk Appetite: Open (high) risk appetite for developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with its statutory duties.
The Trust is supportive of innovation and has an ***open*** **(high)** risk appetite in 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: 28 October 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
- Board to Board meetings with Leeds Teaching Hospitals – agreement to work together on key strategic projects

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	Chief Executive Officer	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

Agenda item:	2024-25 (100i)

Title of report:	**CEO and Chair's Action** (Auditor Panel Terms of Reference)

Meeting:	Trust Board Meeting Held in Public
Date:	6 December 2024

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

Executive Summary:	Under Leeds Community Healthcare's Standing Orders, Board committees and other groups undertake work on behalf of the Board. At times it may be necessary for urgent matters that the Board, Board Committees and other groups would normally consider at meetings to be dealt with between meetings. These matters would then be formally reported at subsequent meetings for ratification. For the purposes of this document, the procedure relating to such actions is referred to as 'CEO and Chair's action'. An action to approve the Terms of Reference for the Auditor Panel in order to commence the selection process for the Trust's external auditors has been recently taken by the CEO and Chair outside of the Board's usual meeting schedule. The action was approved by the CEO and Chair in November 2024, in consultation with two non-executive directors: Ian Lewis and Helen Thompson.

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	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?	N/A

Recommendation(s)	• To ratify the Auditor Panel's Terms of Reference.

List of Appendices:	Appendix 1 – Auditor Panel Terms of Reference Nov 2024

Leeds Community Healthcare NHS Trust

Auditor Panel Terms of Reference

1. Constitution

The Local Audit and Accountability Act 2014 requires every 'relevant authority' (NHS trusts) to appoint an auditor panel to exercise functions set out in the Act (part 3, section 9).

The Trust Board (the Board) hereby resolves to nominate its Audit Committee to act as its Auditor Panel in line with schedule 4, paragraph 1 of the 2014 Act. The Auditor Panel is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Membership

The Auditor Panel shall comprise the entire membership of the Audit Committee with no additional appointees. This means that all members of the Auditor Panel are independent, non-executives or associate non-executives.

This satisfies the requirement that an Auditor Panel must have at least three members with a majority who are independent and non-executive members of the Board.

In line with the requirements of the *Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015* (regulation 6) each member's independence must be reviewed against the criteria laid down in the regulations.

3. Chairperson

The Audit Committee chairperson is appointed by the Board to chair the Auditor Panel.

4. Removal/ resignation

The Auditor Panel chairperson and/ or members of the panel can be removed in line with rules agreed by the Board.

5. Quorum

To be quorate, independent members of the Auditor Panel must be in the majority AND there must be at least two independent members present or 50% of the Auditor Panel's total membership, whichever is the highest.

6. Attendance at meetings

The Auditor Panel's chairperson may invite executive directors and others to attend depending on the requirements of each meeting's agenda. These invitees are not members of the Auditor Panel.

7. Frequency of meetings

The Auditor Panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the Audit Committee.

Auditor Panel business shall be identified clearly and separately on the agenda and Audit Committee members shall deal with these matters as Auditor Panel members NOT as Audit Committee members.

The Auditor Panel's chairperson shall formally state at the start of each meeting that the Auditor Panel is meeting in that capacity and NOT as the Audit Committee.

8. Conflicts of interest

Conflicts of interests must be declared and recorded at the start of each meeting of the Auditor Panel.

A register of Auditor Panel members' interests must be maintained by the panel's chairperson and submitted to the Board in accordance with the Trust's existing Managing Conflicts of Interest Policy.

If a conflict of interest arises, the chairperson may require the affected Auditor Panel member to withdraw at the relevant discussion or voting point.

9. Authority

The Auditor Panel is authorised by the Board to carry out the functions specified below and can seek any information it requires from any employees/ relevant third parties. All employees are directed to cooperate with any request made by the Auditor Panel.

The Auditor Panel is authorised by the Board to obtain outside legal or other independent professional advice, for example, from procurement specialists and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any such 'outside advice' must be obtained in line with the Trust's existing rules/Standing Orders/Scheme of Reservation & Delegation.

10. Functions

The Auditor Panel's functions are to:

- Advise the Board on the selection and appointment of the external auditor. This includes:
  - agreeing and overseeing a robust process for selecting the external auditors in line with the Trust's normal procurement rules
  - making a recommendation to the Board as to who should be appointed
  - ensuring that any conflicts of interest are dealt with effectively
- Advise the Board on the maintenance of an independent relationship with the appointed external auditor
- Advise (if asked) the Board on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
- Advise on (and approve) the contents of the Trust's policy on the purchase of non-audit services from the appointed external auditor
- Advise the Board on any decision about the removal or resignation of the external auditor.

11. Reporting

The chairperson of the Auditor Panel must report to the Board on how the Auditor Panel discharges its responsibilities.

The minutes of the panel's meetings must be formally recorded and submitted to the Board by the panel's chairperson. The chairperson of the Auditor Panel must draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

12. Remuneration

Payments shall be in line with the Trust's existing approach to remuneration and allowances.

13.0 Administrative support

The Trust's Company Secretary shall be responsible for organising effective administrative support to the Auditor Panel. The duties of the person appointed to fulfil this role shall include:

- Agreement of agendas with the chairperson
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking the minutes and helping the chairperson to prepare reports to the Board
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the chairperson
- Maintaining records of members' appointments and renewal dates, etc.
- Advising the auditor panel on pertinent issues/areas of interest/ policy developments
- Ensuring that panel members receive the development and training they need
- Providing appropriate support to the chairperson and panel members.

Date: ***November 2024***

Agenda item:	2024-2025 (101)

Title of report:	Contract Award Proposal: Voice and Mobile Data SIM Cards Plus Mobile Device Management Solution

Meeting:	Trust Board Meeting Held in Public
Date:	6 December 2024

Presented by:	Andrea Osborne Executive Director of Finance and Resources					
Prepared by:	Richard Slough Assistant Director of Business Intelligence					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	✓

Executive Summary:	This contract award proposal is to make a direct award , under the framework contract RM6261, to the existing suppler (O2/Virgin Media) which includes the following benefits: • Provides value for money with a reduction in mobile data charges • Has a zero cost to change – a move to any other supplier would involve a significant challenge of manually swapping SIM cards and porting telephone numbers for all laptops and handsets. • All staff retain their same mobile telephone number. The proposal also includes the extension of a Mobile Device Management solution which enables security updates and device protection for a further twelve months. Total value of business case over the lifetime is £1,157,366 inc VAT The expected cost reduction is c£2m over the life of the contract

Previously considered by:	Senior Leadership Team 30th October 2024 Business Committee 27th November 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	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?	Not applicable to this case

Recommendation(s)	Trust Board are asked to approve a direct contract award via Framework RM6261 with O2/Virgin Media for a three-year contract.

List of Appendices:	

Contract Award Proposal:
Voice and Mobile Data SIM Cards Plus Mobile Device Management Solution

Background

This contract award proposal supports access to voice and mobile Data SIM Card services for the Trust Mobile Phone and Laptop estate.

The Trust has invested significantly supplying staff with a smart phone and laptop, each of which is equipped with a 4G SIM card to support mobile access to the Trust's Electronic Patient Record System, Corporate Systems such as Electronic Rostering, Lone Worker / Staff Safety apps as well as regular voice communications.

In total there are:
2650 Mobile Handsets
2600 Laptops
} across the workforce

The Trust presently operates the mobile data allowance through a shared data pool of 16TB's per month although we regularly exceed this by an average of around 2TB per month and a number of Smart Connect (unrestricted roaming SIMS) which consume 7TB-8TB per month.

The previous 12 months charges associated with the mobile data and voice charges is presented below:

Charge Area	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Total 12 Months	Average 12 Months
Fixed Cost £	55,693	55,674	55,828	55,930	55,928	56,028	56,038	56,105	56,079	56,095	56,116	56,155	671,669	55,972
Usage Cost £	268	218	269	289	249	313	296	331	345	323	357	453	3,711	309
Airtime Subtotal £	**55,961**	**55,891**	**56,097**	**56,218**	**56,177**	**56,341**	**56,334**	**56,436**	**56,424**	**56,417**	**56,473**	**56,608**	**675,377**	**56,281**
Smart Centre Global Services £	6,469	6,798	7,788	12,163	11,681	7,458	10,263	10,622	15,728	18,442	20,840	20,738	148,990	12,416
O2 Rental Charges £	0	858	476	0	528	1,495	767	0	1,671	0	796	0	6,591	549
Total Cost £	**62,430**	**63,547**	**64,360**	**68,382**	**68,385**	**65,294**	**67,364**	**67,058**	**73,823**	**74,859**	**78,109**	**77,346**	**830,957**	**69,246**

To try and ensure best coverage, approximately 1200 of the SIM cards have been provided as roaming SIM cards (known as Smart Centre) in Trust laptops, so the device will connect to the service provider with the strongest signal in that area.

The laptop and mobile phone SIMs are currently with the same telco (O2 / Virgin Media) provider and the contract expires on the 14th of December 2024.

Proposal

This proposal recommends a direct award under the framework contract RM6261 to the existing suppler (O2/Virgin Media) with the following benefits:

- Provides value for money (see Finance / Costings) with a reduction in charges in the costs of mobile data and the price per SIM card reducing from £2 per device per month to 28p.
- Has a zero cost to change – a move to any other supplier would involve a very significant challenge of manually swapping SIM cards and porting telephone numbers for all laptops and handsets.
- All staff retain their same mobile telephone number.

Also, the proposal includes the renewal of the mobile management solution for a period of 12 months, within which time the Trust would transition to a new solution whose licence fees are included in our national Microsoft licencing agreement.

The specifics of the contract would be:

- O2 Monthly Data Bundle 30TB – this would provide headroom of approximately 5TB-6TB of additional capacity per month and will mitigate the risk of incurring overage charges. However, the contract does provide for a reduction in the data pool with 30 days' notice so if there is a decrease in devices or data consumption, the Trust is not tied into an inflexible arrangement and can scale down to a smaller data bundle to reduce costs.
- Voice all Inclusive SIM cards (28p per connection per month) – which is a reduction of £1.72 per connection per month
- Smart Connect (Roaming SIMS) – with a minimum spend over the contract life of £50k.

As part of the transition, there would be a phased withdrawal of the Smart Connect (roaming SIMs) as a report from O2 indicates only 4% of these SIM cards are operating in a roaming capacity, with 94% joining and remaining with the O2 network. We would retain the capacity to provide roaming SIMs but use them only where strictly necessary. The contract would require a minimum spend of £50k over its lifetime to secure a competitive £ per Mb of data. The current spend on Smart Connect SIMs is around £23k per month so we would expect this commitment to be reached within 3 months of the contract, which would then allow the SIMS to be removed from use without any penalty.

The contract would be for a period of 3 years to secure the maximum discount available.

To confirm the proposed contract award provides value for money it is based in the findings of a national, NHS England facilitated independent audit of Trust's mobile phone and data estate which identified the opportunities for savings based on the new national Framework Contract (RM6261). This exercise used actual consumption metrics and costs from the current supplier and then compared these to the rates which are available under the new Framework Contract from both the incumbent and alternative suppliers. The findings of the Audit were received by the Trust on the 9th of September, and then combined with a quotation from the incumbent supplier based on our requirements to provide the basis for the costs and savings presented in this paper.

Options appraisal

a) Critical success factors

The proposed investment seeks to deliver a cost reduction of between £40k-£63k per month by moving with a monthly 30TB O2 data bundle and an all-voice inclusive tariffs and removing as many of the Smart Connect SIMS as safely as possible on Framework Contract RM6261

b) Options appraisal

Option	***Description***	***Pros/ benefits***	***Cons/ disbenefits***	***Risks***
Option1 – do nothing	*Leave all SIMs with O2 and operate "off contract"*	*None*	*No discounted rates, therefore paying higher than necessary charges*	*Operating out of contract, risk of commercial challenge*
Option 2	*Move to lower cost supplier*	*Max cost reduction (per annum) of £46k over O2 / Virgin costs*	*Lowest price supplier has more a limited national network coverage* *Cost to change all the SIMs and port telephone numbers to the new provider would eliminate most of a full year's reduction*	*Lack of internal capacity to manage all the SIM transfers* *Disruption to staff who would need to support the transfer of the SIMS affecting productivity.* *Potential risks to patient safety as the porting of the staff members telephone number could take up to 24*

				hours leaving them out of mobile phone contact.
Option 3	*Recontract with O2*	*Savings of between £40k-£63k per month** *No need to swap any SIM cards or Port any numbers.* *Ability to resize to a smaller data bundle e.g. 20TB and benefit from lower charges*	*Potential for greater cost reduction with alternative supplier.*	*Overage charges are £20 /GB vs £5 currently so important we do not exceed the 30TB monthly limit.*

Finance/ Costing

The existing and proposed costs forecast over the 3 year life of the contract (at 24/25 price base and including VAT) are presented below:

Spend Type	Current Spend (3 Year Forecast) £'k	Proposed Spend (3 year Forecast) £'k	Difference £'k
O2 Data Bundle	2,123	934	-1,189
Voice All Inclusive	304	43	-261
Smart Connect	1,024	60	-964
Overage Charges	333	0	-333
Total	**3,784**	**1,037**	**-2,747**

The proposal includes the continuation of Smart Connect SIMS to provide a service for those who would genuinely benefit. The minimum spend of £60k (inc VAT) over the life of the contract will ensure the price per GB remains competitive.

This proposal also includes the provision of a Mobile Device Management solution, which is used to manage the mobile phone estate, ensuring software is kept compliant and controlling what Apps can be installed. This provides a vital security component of the mobile phone estate.
The charge for this solution raised outside of RM6261 is £120k and would be affordable from the savings in the contract

The price to recontract for one year is proposed as within the first year, the Trust would migrate the management of these devices to a product called Intune which is provided as part of the Trust's Office 365 licencing arrangements through NHS England and hence could be had a no additional charge.

Recommendations

Board are asked to approve the award of a 3 year contract with the existing supplier, securing savings of £2.7m over the life of the contract whilst minimising the impact on staff and mitigating the clinical risk of swapping all of the SIM cards and porting the numbers to the new supplier.

Richard Slough
Assistant Director of Business Intelligence
18th November 2024

Appendix 3

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

FINAL

Emergency Preparedness Resilience and Response (EPRR) Policy

1. This document is part of a suite of Emergency Preparedness, Resilience and Response (EPRR) plans which have been developed to provide the framework by which Leeds Community Healthcare NHS Trust will respond to specific incidents\events.
2. This document must be read and applied in conjunction with the LCH Incident Response Plan, incident specific plans and service level Business Continuity Plans as appropriate.
3. An electronic copy of the latest version of this document is available in the On-call channel on MS Teams and the Trust H:Drive.
4. All On-call managers are asked to familiarise themselves with the contents of the LCH emergency documentation.
5. In the event of an emergency, to contact the On-Call Manager please ring:

0845 2657599

The key message the reader should note about this document are:

1. This document contains Leeds Community Healthcare NHS Trust's EPRR Policy, which sets out the Trusts approach to delivering EPRR (Emergency Preparedness, Resilience and Response)

2. This document is supported by the LCH Business Continuity Policy.

Document title	Leeds Community Healthcare Emergency Preparedness, Resilience and Response Policy
Document Reference Number	
Key searchable words	*Emergency, incident, response, disruption, contingency, EPRR, emergency planning*
Executive Team member responsible (title)	Executive Director of Operations \ Accountable Emergency Officer
Document author (name and title)	Rebecca Todd Emergency Planning Manager
Approved by (Committee/Group)	LCH Trust Leadership Team LCH Business Committee
Date approved.	September 2024
Ratified by	LCH Trust Board
Date ratified.	October 2024
Review date	October 2025
Frequency of review	Annual

Amendment detail

Version	Amendment	Reason

Table of Contents

1. EPRR Policy Statement

1.1 Introduction

This policy sets out how Leeds Community Healthcare NHS Trust (the Trust - LCH) will meet its statutory responsibilities for emergency preparedness, resilience and response (EPRR) in line with:

- the Health and Social Care Act 2022
- the Civil Contingencies Act 2004 and subsequent Cabinet Office guidance issued under Emergency Planning guidance.
- the Emergency Preparedness, Resilience and Response Framework – July 2022
- the National Risk Assessment\Register (NRA)
- WY Community Risk register
- NEY Local Health Resilience Partnership Risk Register
- NHS Core Standards for EPRR
- All other legislation or government Office guidance that refers to Planning for and responding to Emergencies.

The NHS England Core Standards for Emergency Preparedness, Resilience and Response requires organisations to have in place an overarching policy for building resilience in order that EPRR and business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. This policy demonstrates our Trust commitment to EPRR together with the requisite training, exercising and annual work plan to both build and maintain resilience.

1.2 Strategic Goals

This Policy is written to reflect the Trust's Strategic Goals to:

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

Having robust EPRR arrangements that are built on citywide and regional shared processes and systems helps the organisation to better support staff and communities in managing disruption caused by incidents/ events.

1.3 Scope

NHS England requirements are for all Trust services to comply with the NHS England Core Standards for EPRR as far as these standards apply to the service or directorate. Services or directorates whose services or responsibilities overlap with specific EPPR areas such as outbreak management, security and communications, will be expected to produce plans in collaboration with the EPRR manager that meet all specific NHS England EPRR requirements. This also includes supply arrangements, liaising with estates and facilities and external providers.

The policy relates to all staff who in the course of their work undertake duties in relation to the NHS England Core Standards for EPRR. This includes staff working directly in clinical services and also those working in corporate services, including Finance and Contracting, Procurement, IT, Human Resources, Facilities, Risk, Health and Safety, Security and Communications. The policy is to be read in conjunction with other EPRR policies and plans that are contained in the EPRR library.

The Trust works with partner NHS bodies, particularly other West Yorkshire Community and Mental Health Trusts on areas of joint interest. In terms of the joint development of plans and other resilience arrangements, the Trust works closely with a number of statutory and non-statutory organisations including 3rd and voluntary sector partners.

1.4 Roles and responsibilities

1.4.1 Chief Executive

The Chief Executive has ultimate responsibility to ensure the organisation can continue to function at appropriate levels following a disruptive event.

Under the Health and Social Care Act 2014, the specific responsibility for ensuring Emergency Preparedness, Resilience and Response (EPRR) arrangements are in place falls to the Executive Director nominated by the Trust as Accountable Emergency Officer (AEO) who for Leeds Community Healthcare is the Trust's Operational Director of Care Services.

1.4.2 Accountable Emergency Officer

This role cannot be delegated and while another Executive Director may assist in attending meetings and other duties the AEO retains accountability and responsibility for the items (i to iv below).

The AEO must be a Board-level Director responsible and have executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements in regard to EPRR. The AEO will provide assurance to the Board that strategies, systems, training, policies and procedures are in place to ensure LCH responds appropriately in the event of an incident.

The AEO will be aware of their legal duties to ensure preparedness to respond to an incident within their health community to maintain the public's protection and maximise the NHS response.

Specifically, the AEO will be responsible for ensuring that the organisation:

- itself and any sub-contractors are compliant with the EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract, including this Framework and the Core Standards
- is properly prepared and resourced to manage a major incident or civil contingency event
- itself and any sub-contractors it commissions have robust business continuity planning arrangements in place that align to ISO 22301 or subsequent guidance that may supersede this
- has a robust surge capacity plan that provides an integrated organisational response and has been tested with other providers and partner organisations in the local area served
- complies with any requirements of NHS England, in respect of monitoring compliance
- provides NHS England with such information as it may require for the purpose of discharging its EPRR functions
- is appropriately represented by director-level engagement with and effective contribution to any governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate
- links closely with other Leeds providers to address any OPEL escalation requirements as previously agreed with the ICB and the wider system, including the activation of the city's Mutual Aid arrangements as required.

The AEO is also accountable for the Trust Chemical, Biological, Radiological and Nuclear (CBRN) response as part of their role.

Additionally, the AEO has responsibility for ensuring that the Emergency Planning Manager:

- Reports to the Board twice a year on the EPRR Workplan and the NHSE Annual Assurance process for final Board approval.
- Reports via the AEO\Executive Director of Operations to Senior Leadership Team, Business Committee and Trust Board in a specific EPRR section.

1.4.3 Medical Director (Deputy AEO)

The Medical Director will deputise if the AEO is unable to represent the Trust at a meeting or make decisions in regard to EPRR on behalf of the Trust.

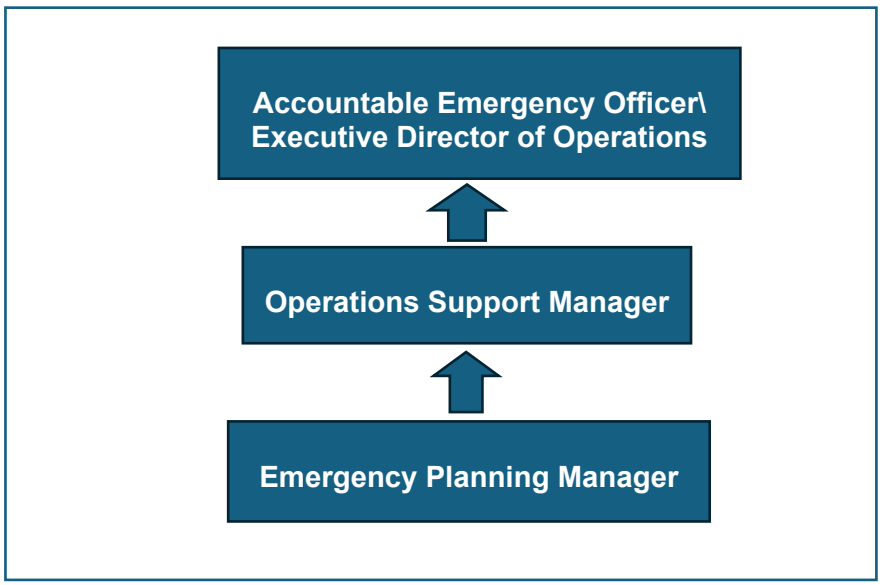
1.4.4 Operational support manager

The Operational support manager will line manage the Emergency Planning Manager, and will oversee the annual EPRR compliance audit, the EPRR annual work plan and the production of Board/ Business Committee papers.

1.4.5 Emergency Planning Manager

- provides day to day management of the EPRR function
- supports the AEO with technical advice
- has responsibility for plan maintenance, updates and communication in consultation with the Company Secretary following successful ratification of plans and policies at the LCH Business Committee and Trust Board
- has responsibility for the operational response and readiness of the Trust for CBRN incidents, training and equipment checking
- is responsible for undertaking risk assessments for CBRN
- has responsibility for equipment checks, procurement of Initial Operational Response (IOR) equipment and liaison with staff regarding IOR boxes
- is responsible for the delivery of relevant\proportionate training.

Operational reporting lines are shown below with the Emergency Planning Manager reporting directly to the Operations Support Manager.

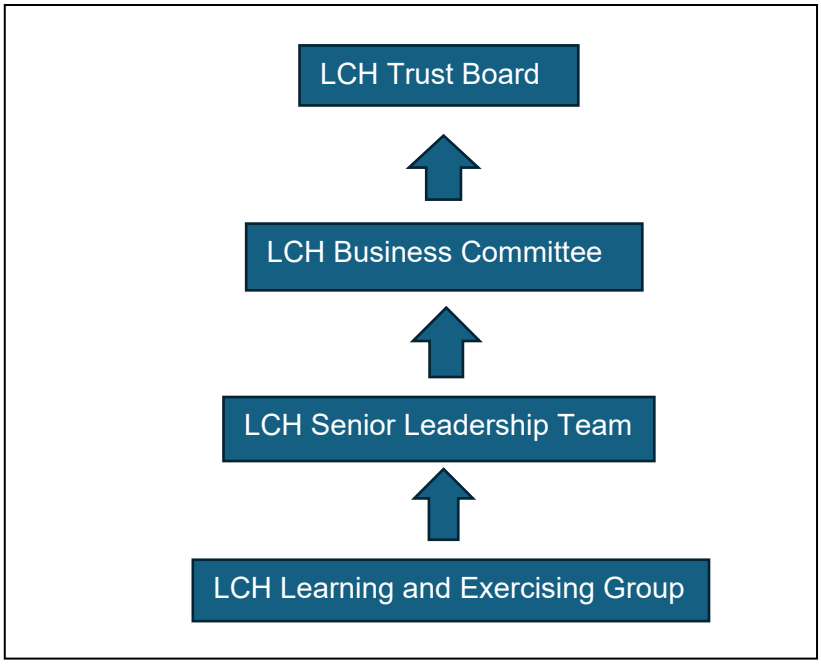


1.5 Governance and Reporting

The Trust Senior Leadership Team meeting is chaired by the Chief Executive and attended by senior operational and corporate staff/service business continuity leads.

Clinical and Operational Oversight of the EPRR function is provided by the Trust Senior Leadership Team (SLT) and the LCH Business Committee which is a Sub-

committee of the Trust Board. This group provides initial oversight of EPRR assurance declarations, and any issues escalated via the Operational Director of Care Services' report which contains a section about EPRR in every report. See organigram below.



Management of urgent escalations regarding operational EPRR matters, resource issues such as increased funding for EPRR or the ongoing reporting of significant disruptions/threats to business continuity will be managed initially by the Trust Senior Leadership Team. In the latter category examples such as EU Exit and the Covid 19 pandemic have been reported through this route.

The Board of Directors receive the annual EPRR report, the declaration against the Annual NHS England EPRR Core Standards Assurance and annual approval of the Trust's EPRR Policy and Business Continuity Management System document.

1.6 Working in partnership

The Trust works very closely with partner organisations across Leeds, and also at a West Yorkshire level. The following arrangements are in place:

WY Local Health Resilience Partnership, chaired by the ICB and attended by Provider Accountable Emergency Officers and Emergency Planning Leads, Local Authorities and WY Resilience Forum.

WY Emergency Planning Leads Group – chaired by the ICB EPRR Team and attended by WY provider Emergency Planning Leads.

Yorkshire and Humber Mental Health & Community EPRR Group – peer support group – rotating chair attended by provider EPRR leads from across Yorkshire and the Humber

WY Resilience Forum Business Continuity Sub-group – chaired by Wakefield Council and attended by the emergency services, health partners, local authorities, transport companies and the voluntary sector.

Leeds Pandemic Planning Group – chaired by LCC Public Health and attended by UK Health Security Agency (UKHSA), ICB EPRR, IPC Leads, Environmental Health and Leeds provider EPRR Leads.

All plans and policies are shared on the WY EPRR Managers MS Teams channel for consultation and feedback purposes.

During a mass casualty or mass fatality event LCH will support the wider system response in line with WY plans and arrangements.

2. Procedure

2.1 Risk assessment

The Trust has a robust method of reporting, recording, monitoring, communicating and escalating EPRR risks internally and externally.

2.1.1 EPRR Risk register

It is the role of the Resilience Manager to ensure that key EPRR risks are reflected on the Trust's Datix Risk Register and ensure that they are updated on a regular basis. These currently include an overarching risk re EPRR compliance with the NHSE Annual Assurance process and individual risk listings for CBRN, Major Incident and Adverse Weather.

Risks will be reviewed on an annual basis by the Senior Leadership Team and plans and mitigations updated in line with the outcomes.

2.1.2 Horizon scanning and EPRR risks

The Emergency Planning Manager, in consultation with the Trust Risk Manager, will maintain a number of relevant risks in line with the National Risk Assessment, the WY Community Risk Register and the Trust's risk profile, ie the likelihood these risks will adversely impact the Trust. Risks assessed as relevant are included on the Trust's Datix risk register as EPRR risks, signed off by the AEO and maintained either solely or in collaboration with identified officers by the Emergency Planning Manager. The Trust's risk management process involves overall monitoring of actions, reviews and

completion of actions and the Emergency Planning Manager will be notified of any risk approaching a milestone through this process.

EPRR only risks are reviewed twice per year by the Emergency Planning Manager and the Trust Risk Manager. In terms of risk tolerance – risks classified as low risk are archived as a live risk, however they will continue to be monitored\reviewed for any changes that may require a re-assessment.

2.1.3 Risk assessment governance

Extreme EPRR risks are escalated to the Senior Leadership Team by the AEO. These may, depending on the views of the Trust Leadership Team, be escalated to the Senior Leadership Team, Business Committee and ultimately Trust Board.

The Datix risk system records any changes, re-assessments and updates to risks ensuring they are auditable.

Escalation of any risk considered as a risk to be held by the WY Local Health Resilience Partnership is via the West Yorkshire Emergency Planning Managers Group which is chaired by the WY ICB.

2.2 EPRR Core standards

EPRR core national standards apply to the arrangements our trust have in place to prepare for and respond to an emergency/ incident.

Compliance against these standards is audited annually, and the Trust publishes its compliance rating in its annual report.

If any aspect of EPRR is not fully compliant, then this becomes a key focus for the EPRR annual plan.

2.3 EPRR Plans

The Trust maintains a suite of EPRR plans developed by the EPRR Manager in consultation with subject matter experts to manage specific disruptions as well as service specific business continuity plans. These plans may also, depending on subject matter, be taken through other governance routes but are always approved by Business Committee and Board.

Plans are shared with other Community and Mental Health Trusts, both locally and with wider West Yorkshire Trusts and peers through the Yorkshire & Humberside Mental Health & Community EPRR Leads Group. Given its breadth of coverage this is the main group where approaches to EPRR preparedness, incident response and plans are shared and consulted upon.

Development of plans is based on two main influences, the requirements of the NHS England EPRR standards which specify several plan requirements, and the risk profile of the Trust which is a driving factor in plan development.

The EPRR plans are all individually numbered (EP- 0001 and onwards) and located within the EPRR library.

2.4 Planning EPRR work

An annual EPRR workplan is developed by the EPRR Manager in conjunction with the Operations Support Manager and approved by the Trust Leadership Team. The plan includes areas of activity across all the domains of EPRR including actions required to improve areas assessed as non-compliant in the annual EPRR assurance process. Updates and areas of slippage are also communicated via the AEO report to Board.

2.5 Training and exercising

The Trust is committed to training staff and exercising EPRR arrangements. A training schedule is published annually and is a standing item on the Senior Leadership Team agenda.

2.5.1 EPRR Training

The Trust has conducted a training needs assessment against the new requirements for NHS Commanders. The attendance of strategic and tactical commanders at the Principles of Health Command training is monitored and logged by the Emergency Planning Manager and reported to Trust Leadership Team.

Personal training and exercise attendance portfolios, developed by NHSE are also to be completed to evidence EPRR training. The Trust is also committed to supporting staff to meet training and exercising requirements through frequent tabletop and subject specific exercises.

2.5.2 EPRR Exercises

The Trust requires all services to hold a business continuity tabletop exercise annually. These are developed and facilitated at service level with support from the Emergency Planning Manager. Additionally, communication exercises to test on call arrangements are held every six months. These are undertaken and debriefed by the Emergency Planning Manager and any lessons learned communicated to relevant staff.

The Emergency Planning Manager develops exercises to test the Trust's ability to respond to a disruption as part of the annual exercise plan. Subject specific plans are tested on a rotational basis unless a specific need to test is identified by:

- NHS England directive (see below – 2.5.3)
- An incident indicates a need to test a specific plan
- Specific management requests.

Logs of attendance at training events and debrief reports are maintained by the Emergency Planning Manager.

Every three years a command post exercise and live exercise will be carried out.

In line with the requirements of the Data Security & Protection Toolkit the Trust Deputy CIO\Head of Community Informatics will also run a specific cyber or IT themed scenario annually.

2.5.3 National NHS EPRR Exercise Programme 2024 – 2030

In 2024 NHS England set out a seven year exercise programme:

- Casualty and mass casualty
- Hazardous materials (HAZMAT) and chemical, biological, radiological and nuclear (CBRN)
- Business continuity
- Cyber and digital
- Infectious disease and pandemics
- Adverse weather
- Security, shelter and evacuation

The Trust will participate as appropriate in the national/ regional and local exercises, including exercises that are managed within the Trust.

The Trust Exercise and Learning group will coordinate all Trust wide exercises and will be responsible for disseminating the learning.

2.6 Lessons Learned

All exercises are debriefed and for major exercises or live incidents a full debrief report will be produced including an action plan allocating actions to named officers with an agreed completion date. Depending on the nature of the incident the debrief report may be escalated for review by Trust Leadership Team or the Senior Leadership Team. Incident debriefs will also be included in the EPRR Report to Trust Senior Leadership Team and Business Committee.

Lessons learned that indicate any ongoing risk to the organisation will also be captured on the Trust's Datix risk management system.

2.7 Resources

The annual work plan will be used to calculate the EPRR resources required to carry out all of the EPRR requirements. The resources required may be specialist EPRR resources/ staffing or may be activities carried out by other teams such as communications/ facilities or front line teams.

Trust Board/ Business Committee will be assured on an annual basis that there are sufficient resources to carry out all of the activities in the EPRR work plan.

Additional resources can be accessed through the Senior Operations budget to cover any excess expenditure associated with disruptive incidents.

3. EQUALITY IMPACT

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender, and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I ~~have~~ / have not identified any potential negative impacts for any of the nine protected groups.

Print name:

Job title:

Date:

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email:

*Delete as appropriate

4. Plan Checklist

To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document.

This checklist is part of the working papers.

	Title of document being newly created / reviewed:	Yes / No
1.	**Title**	
	Is the title clear and unambiguous?	*Yes*
	Is the procedural document in the correct format and style?	*Yes*
2.	**Development Process**	
	Is there evidence of reasonable attempts to ensure relevant expertise has been used?	*Yes*
3.	**Content**	
	Is the Purpose of the document clear?	*Yes*
4.	**Approval**	
	Does the document identify which committee/group will approve it?	*Yes*
5.	**Equality Impact Assessment**	
	Has the declaration been completed?	*Yes*
6.	**Review Date**	
	Is the review date identified?	*Yes*
	Is the frequency of review identified and acceptable?	*Yes*
7.	**Overall Responsibility for the Document**	
	Is it clear who will be responsible for co-ordinating the dissemination, implementation, and review of the document?	*Yes*

Board of Directors			
Final sign-off of the Business Continuity and EPRR Policy as required by standards.			
Name		Date	

Appendix 8

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

FINAL

Evacuation and Shelter Plan

1. This document is part of a suite of Emergency Preparedness, Resilience and Response (EPRR) plans which have been developed to provide the framework by which Leeds Community Healthcare NHS Trust will respond to specific incidents\events.
2. This document must be read and applied in conjunction with the LCH Incident Response Plan, incident specific plans and service level Business Continuity Plans as appropriate.
3. An electronic copy of the latest version of this document is available in the On-call channel on MS Teams and the Trust H:Drive.
4. All On-call managers are asked to familiarise themselves with the contents of the LCH emergency documentation.
5. In the event of an emergency, to contact the On-Call Manager please ring:

0845 2657599

Please note: All approved and ratified policies and procedures remain in place until there is notification of an amended policy or procedure by the EPRR Team.

Document details:	Leeds Community Healthcare NHS Trust Evacuation & Shelter Plan
Version:	Version Final
Persons / committees consulted:	External: ICS colleagues Internal: LCH Communications Team LCH Workforce LCH EPRR Testing & Learning Group Trust Leadership Team LCH Business Committee
Approved by:	Trust Leadership Team
Date approved:	October 2025
Ratified by:	LCH Business Committee
Date ratified:	November 2025
Title of originator / author:	Emergency Planning Manager
Title of responsible committee / group (or Trust Board):	LCH Trust Board
Title of responsible Director:	Executive Director of Operations (Accountable Emergency Officer)
Date issued:	November 2024
Review date:	November 2025
Frequency of review:	Annual Review in line with NHSE EPRR Core Standards
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Amendment number	Section	Subject

CONTENTS

1.Introduction

To comply with the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, NHS Organisations and providers of NHS funded care must demonstrate that they can respond to disruptive events and maintain patient care.

All NHS funded organisations are required to have arrangements in place to evacuate their facilities and shelter patients, the public and staff in the event of major disruption.

This Plan is written in conjunction with the Evacuation and Shelter Guidance for the NHS in England – May 2023, which whilst focusing primarily on the evacuation and shelter of acute hospital sites, requires that its principles are sufficiently flexible to be adapted for use in respect of other buildings and facilities such as social, community care and independent sector facilities.

There are a number of events which may require the Trust to shelter and\or evacuate patients, the public and staff, these include:

- power or other utility failure
- building denial eg structural failure, RAAC
- an explosion or suspect package
- adverse weather ie flooding
- a fire
- a release of irritant fumes or hazardous materials
- a terrorist event

2. Purpose

This Plan provides guidance to Leeds Community Healthcare staff and services in the preparation and response to the evacuation and\or shelter of patients, staff and the public from Trust premises in line with the requirements of the Civil Contingencies Act 2004 (CCA) the NHS Act 2006, the Health and Care Act 2022, and the NHS Standard Contract.

This plan dovetails with other relevant Trust generic and specific organisational plans including the LCH Incident Response Plan and has been developed in collaboration with partners and relevant stakeholders.

3. Scope

The Trust's evacuation and shelter arrangements are flexible to allow the response to be tailored to any specific event.

Evacuation and shelter planning forms part of the Trust's broader emergency preparedness and aligns with the Trust's existing plans\arrangements including:

- LCH Operational Response Guidance
- Incident Response Plan
- Security Policy
- Fire procedures
- Business Continuity Management System (BCMS

Leeds Community Healthcare will be responsible for the decision to evacuate any of its premises, however the Emergency Services may have primacy over the overall response depending on the cause of the evacuation\nature of the incident.

Depending on the size of the incident it is important the Trust follows JESIP (Joint Emergency Services Interoperability Principles) principles to ensure decisions are jointly agreed and based on a joint understanding of risk and shared situational awareness to align with the Emergency Services.

The Trust is responsible for patients evacuated from its facilities and for the continued delivery of care and treatment until those patients are formally discharged from its care.

4. Roles & Responsibilities

Providers of NHS funded services and care are required to develop shelter and/or evacuation arrangements for each site or building with assistance from the organisation's EPRR manager.

For LCH the following internal stakeholders have been involved in this process this process:

- Estates
- Facilities Management and Safety
- Trust Security Manager
- Emergency Planning Manager
- Risk Team
- Communications Team

5. Communications

The Trust is required to have robust arrangements in place to communicate to patients, staff and the public both on and off site during an incident. A Communications Strategy has been developed in line with the considerations raised in Section 3 of the Evacuation and Shelter Guidance for the NHS in England – version 4, May 2024.

When developing the Communication Strategy the Trust has considered:

- methods of communicating using on site communications to activate an evacuation plan and direct patients, the public and staff as appropriate
- methods of communicating with patients, the public and staff who:
    - may have difficulty understanding complex messages
    - have specific communication needs ie do not speak English as a first language or have hearing difficulties.
- using social media eg Twitter and Facebook to direct people away from the location and provide updates on the incident and the resumption\recovery of services.

The Trust will ensure that:

- through the Integrated Care Board (ICB) there are links with the wider WY Resilience Forum (WYLRF) warning and informing strategy
- contact details are up to date for staff and relevant stakeholders
- communication methods are considered if a building is compromised
- messaging is clear

- a method of communicating a full site evacuation is in place if a fire alarm system is being used

6. Risk

The Trust is required to ensure that all sites are risk assessed with specific plans in place for any buildings assessed as high risk. The outcomes of these risk assessments undertaken by the Trust Security Manager will be held by the Trust Security Team.

7. Staff Safety

Accounting for staff in an emergency can be a challenge and Leeds Community Healthcare has a duty of care to know which staff are working and their location. This includes any contractors working on the unit at the time.

To achieve this staff rotas should be accessible at short notice to enable them to be checked.

Staff should not be expected to undertake roles they are not comfortable performing or be expected to put themselves at risk as part of any evacuation.

8. Building Security

This is a principal concern whilst a building evacuation is underway. A decision may be made to lockdown the building to control access and egress as this may also prevent any other safety issues arising. In such circumstances the Trust Security Policy may be activated. In the event a criminal act has\is taking place it is likely that the Police will attend.

9. Stakeholder arrangements

West Yorkshire ICB

During an evacuation and/or shelter event, the WY ICB is responsible for:

- establishing strategic and tactical leadership arrangements and support structures to effectively manage and co-ordinate the NHS response and recovery across their integrated care system, representing the NHS at Strategic Co-ordination Groups and Tactical Co-ordination Groups when required
- providing leadership should mutual aid arrangements be activated to support an evacuation and/or shelter incident
- ensuring robust escalation procedures are in place through the EPRR command structure in line with the NHS EPRR Framework.

NHS England

NHS England should ensure integration of planning arrangements across the region to deliver a unified response to any emergency in line with this guidance. This includes supporting organisations during the response and recovery phases of an incident or emergency.

During an evacuation event, NHS England are responsible for supporting:

- the WY ICB in brokering mutual aid requests to assist evacuating organisations
- the multi-agency response through attendance at TCG/SCG as appropriate
- escalating incidents as appropriate through the EPRR command structure.

This can be supported by the activation of national and/or regional incident response plan as necessary.

Yorkshire Ambulance Service
Ambulance services have a role in assisting the evacuating organisation if necessary. Assistance should be provided as appropriate through:

- patient transportation to other organisations/locations
- redirecting ambulances to other organisations

Leeds City Council – alternative location \ transportation
The Local Authority may be able to assist with the identification of an off-site relocation site, and transportation by commercial providers.

NHS Partner organisations who may assist as part of a mutual aid agreement
Neighbouring NHS organisations will be essential for the provision of support with mutual aid requests and potentially transportation

Police
During the response, the Police will be able to provide a reactive response to criminal activity on site, as well as provide assistance with traffic management if required.

Fire & Rescue
During the response to an evacuation event, fire and rescue service(s) will provide a firefighting and rescue service. They may also be able to provide advice and assistance where there is difficulty moving a patient.

10. Emergency Service Liaison

Knowledge of building\access all areas\access routes
The Trust should identify an individual able to liaise with the emergency services on site. This individual should be familiar with the site layout including pedestrian and vehicle access routes and have access or the ability to access all areas on site.
This individual could be responsible for:

- allowing the emergency services on site
- directing the emergency services to an appropriate meeting point.

11. Mutual Aid Arrangements

Should an off-site evacuation be required it may be necessary to transfer patients to other organisations. In this case the Trust will ensure that patient documentation is transferred with the patient to any new location. Consideration should be given to different systems, prescribing and access to essential drugs, transportation and patient escorting. Mutual aid will have a key role to play here.

12. Shelter

In the event of a Terror attack\chemical plume it may be advisable to take refuge within the current location (in situ), however an evacuation may be required at a later stage and should also be considered.

If it is deemed safer to remain within the location the following actions should be taken:

- Close doors and windows
- Move patients away from windows
- Consider how building access will be managed\controlled
- Consider proximity to on-site facilities – food\kitchen, toilets
- Consider power and communication

There are a number of facets in this plan which are more relevant to the Trust's in-patient locations which are Hannah House and the Wharfedale Recovery Hub. At these sites the Trust must ensure that the correct equipment is available, and that staff are trained in its use to an appropriate level. It may also be necessary to consider the transportation of patients away from the site to a different location for continuity of treatment or to return home.

Patients who may require additional support

In the case of the Wharfedale Recovery Hub and Hannah House a number of patients will require additional support to evacuate the building due to the nature of the service, for example those:

- with a disability or health condition that may affect their mobility
- who are frail
- with speech, language and communication needs.

There may also be patients within Trust clinic\health centre settings who will require special assistance should an evacuation be required.

When evacuating consideration will be given to:

- the patients' specific needs
- the number of staff required to accompany the patient
- ensuring appropriate equipment is available for and during transportation
- maintaining safeguarding arrangements
- ensuring the shelter/evacuation location has sufficient resources eg drugs, fluids, consumables, etc

13. Evacuation Equipment

Evacuation equipment needs to be in place with relevant staff appropriately trained and suitably familiar in the safe operation eg evacuation chairs and ski pads. Equipment to support bariatric patients should also be available.

14. Equality and Diversity

During an incident where evacuation is required Leeds Community Healthcare will continue to maintain arrangements for reducing inequalities in access to our treatment and healthcare.

15. Transportation

The Trust will need to consider transportation to support evacuation from the Wharfedale Recovery Hub and Hannah House. This will be included in local partnership mutual aid plans and could involve transportation:

- between buildings
- to a place of shelter
- to a different healthcare location
- home

In addition to the Ambulance Service\PTS, sources could include:

- private companies
- secure patient transfer
- Local Authority
- taxis
- voluntary services.

16. Recovery

- Both business continuity and recovery planning should be started as soon as possible, ideally during the incident response
- Early consideration of recovery and patient repatriation options will ensure a smooth transition through each stage of the incident.
- The Recovery team should be led by a senior director, independent of the Incident Co-ordination Team, but liaising closely with them.

17. Community Evacuation

The Trust also needs to consider its potential role in a larger scale community evacuation where the population of an area may need to be evacuated. Although the Trust's primary responsibility in an evacuation is to evacuate its own premises, there is also a need to consider how the Trust can support the wider planning for community evacuation, for example this could include supporting:

- Medical and emergency aid cover at an established evacuation or humanitarian assistance centre which may include emergency provision at transport hubs. This provision should be considered in the context of the wider evacuation, and resources required to undertake the evacuation.

- Ensuring information relating to vulnerable people can be gathered and collated quickly from across the community being evacuated for use by emergency responders and those coordinating the evacuation. This will need to include information held in primary and secondary care.

- Assessing the suitability of evacuation centres for use by those that are currently under care. This may include ensuring centres have areas suitable for patients under the care of mental health providers, or suitable access facilities.

- Continuing patient care of those in the community, this may be the continuation of the care being received from an organisation, or the tracking of the patient into the care of another provider in the receiving community or area. These patient groups are likely to be under the care of outreach or district nursing teams in their own homes, therefore any evacuation may occur prior to the organisation becoming aware.

- Although evacuees are asked to take supplies of medicines with them, health services will need to be prepared for a surge in demand following any community evacuation as patients present to replace medications. Consideration also needs to be given to those who are reliant on others for the administration of their medicines. It is highly likely there will be further healthcare demands on mental health providers following a large-scale evacuation.

- Ensuring that the Trust is made aware of the areas under evacuation and can maintain the safety of our own staff during this evacuation. The ability to rapidly communicate with teams working within the community where the evacuation is happening will be necessary.

- Some or all our staff may have been placed under the evacuation order. As such it will be necessary to consider their welfare arrangements and reassure them during the evacuation. It is also important to ensure they are aware of arrangements for the evacuation of schools and care homes in their area.

18. Shelter

In some scenarios, such as a chemical plume or terrorist incident, it may be safer to take refuge or cover within the current location. This sheltering 'in situ' may however lead to a subsequent evacuation, therefore, while sheltering, staff should be preparing for an evacuation.

When developing plans for in situ sheltering the Trust must ensure that the following elements have been considered:

- Building integrity – ie can windows and doors be closed to prevent any contamination if there is a chemical plume. It may be necessary to compartmentalise buildings into areas which are safer for sheltering

- Some sheltering situations may require patients to be moved away from windows or doors to prevent possible injury from flying glass. This will result in a smaller shelter footprint than the building size.

- How access to the building will be maintained if it is not directly connected to a main site. Smaller buildings may not be suitable for long term occupation. This will be especially important if emergency teams need to access the building, or supplies need to be sent to the building.

- On-site access to toilets, kitchen/food provision and other facilities to maintain the comfort of those people remaining within the building. These facilities should be able to support the number of people in the building.

- Where possible buildings will need to be resilient to the loss of essential services such as power for a period of time. Where buildings have no resilience, they should be flagged for earlier evacuation.

- How communication between buildings and sites will be maintained especially if there is disruption to routine communication methods and if the use of runners is inappropriate.

- Capability to respond to the needs of those who may find changes in environment and increase sensory disturbance/overload challenging.

19. Evacuation Stages

Stage one: decision to shelter and/or evacuate

The decision to shelter and/or evacuate should be made by a nominated individual on behalf of the Trust's Chief Executive Officer, eg On call Director. A ward or facility within a building will be evacuated based on a risk assessment conducted by the Senior Manager on duty. The following should be considered:

- nature of incident (including any known infrastructure risks) overall risk to patients, the public and staff
- nature and diversity of patients cared for on site
- staffing available
- command and control arrangements required
- risks associated with the location(s) of certain types of patients
- substances kept on site and the cordoning arrangements for this.

The Trust will be required to establish Incident Co-ordination Arrangements and an Incident Co-ordination Centre (ICC) in response to an event requiring the shelter and/or evacuation of one of our sites and will therefore need to consider activating other supporting LCH business continuity and relevant incident response plans.
An alternative ICC location may also be required if the primary location (White Rose Park) is unavailable.

Stage two: patient assessment

Initial patient triage

In the event of an incident which requires an evacuation it is essential that appropriate mechanisms are in place to triage and track patients. The initial evacuation triage process should determine the:

- patient's mobility and resources required to evacuate the patient
- patient's ongoing care needs
- type of transport required to facilitate the onward evacuation of the patient.

When considering whether to move a patient, there are a few factors which should be considered including the:

- difficulty of movement eg mobility of the patient and what equipment is required to ensure safe patient care
- time required to move one patient versus moving other patients

Risk to:

- the patient if moved
- the patient if remaining in-situ
- staff.

The Trust must ensure there is a robust mechanism for evacuating patients including their records\notes. This will be the responsibility of the clinician caring for the patient.
Conducting an initial triage of patients will enable transfer to the most appropriate care setting and establish an order for evacuation based on mobility.
The most mobile patients should be moved first, especially those who are able to walk through self-evacuation.

An initial triage should assign patient mobility as one of the following:

- able to walk
- chair required
- bed/stretcher required
- more complex needs, eg bariatric, ventilated

Additionally the patient should be assessed as:

- not requiring ongoing care
- requiring ongoing care
- those who will need to be transferred off site for continued care

Following any evacuation, it is likely there will be a requirement to reassess (re-triage) patients.

- **Healthcare Evacuation Triage Priorities**
  The healthcare evacuation triage priorities table is a reversed adaptation of the national ambulance service major incident triage card system based on mobility and dependency to determine evacuation priority by categorising patients into 'very dependent', 'dependent', and 'independent' groups.

The healthcare evacuation triage priorities table has been developed to assist healthcare staff with making decisions on whom to evacuate and in what order. It should be noted that the definitions of each category are not prescriptive or exhaustive. It is also important to remember that any triage process is dynamic and iterative and should be repeated at appropriate intervals.

The triage should be undertaken based on the practicality of evacuating individual patients in line with their own mobility, dependency and resource required, this includes staffing, equipment and time. Patients should not be prioritised/deprioritised solely in terms of their pre-existing conditions (ie in isolation of the impact on an evacuation situation).

i) Evacuation Register

At all stages of the evacuation, a record/register should be maintained of patient movements for each area being evacuated. The evacuation register should be retained by someone trained and competent ie a senior ward sister. When leaving an area, the patient's details, mobility and care requirements should be recorded in an evacuation register along with their intended destination.

ii) Deferred Evacuation Register

In some situations it may be appropriate to defer the evacuation of a patient, eg if there is limited equipment/staff available initially to safely evacuate them.

The decision to defer evacuation of a patient for medical reasons should be made by two clinicians. This must be recorded on a 'deferred evacuation register' along with the reason they are deferred. The organisation should then appoint a senior clinician to have oversight of all deferred evacuation registers. This person will assume responsibility for ongoing patient care.

This person must assess the reasons for deferral and make all reasonable attempts to resolve them. This can include, where appropriate, a discussion with the Fire and Rescue service regarding the availability of additional or specialist resources to facilitate patient evacuation.

In extreme circumstances, where a patient is deemed unfit to survive evacuation, the demands of the situation outstrip available resource, or staff are likely to be put at risk moving a patient, it may be appropriate to leave a patient in-situ until appropriate resource or mitigations of risk become available.

As previously stated, the decision to leave a patient in-situ should be made by two clinicians and recorded on the deferred evacuation register along with the reason.

The Incident Co-ordination Team should provide formal approval to continue or stop further rescue attempts for a patient who cannot be moved. These attempts should not place staff at risk of harm.

Stage 3: Dispersal

i)Evacuation Clearing Station

Once assessed, patients can be directed to an appropriate evacuation clearing station. These should provide:

- a place of temporary shelter for evacuees
- a safe place to facilitate the onward movement of patients requiring further care.

Initial triage can also identify patients eligible for early discharge to create additional capacity in inpatient facilities.

Evacuees can be directed to a specific clearing station according to their need, ie:

- patients with immediate/urgent healthcare needs
- patients without immediate/urgent healthcare needs

A larger location may need to establish multiple clearing stations, which could be on or off site.

The naming convention for any clearing stations and potential locations should be shared with multi-agency partners to avoid confusion during an evacuation.

ii) Patient Dispersal Team (PDT)

When undertaking an evacuation, organisations may wish to consider establishing a patient dispersal team (PDT). This team should be made up of staff able to identify available capacity and allocate patients for evacuation according to their care need.

As appropriate to the organisation, a Patient Dispersal Team could consist of:

- senior clinician
- decision loggist
- transport officer
- other health organisations able to offer support, eg ICB, other community trusts, adult social care representatives.

The PDT should receive evacuation registers, and match patient care and transport needs with the available resources.

Patients should be allocated transport and resources eg beds, based on their care needs and their priority categorisation as determined by the evacuation clearing station.

As soon as care is allocated, the evacuation clearing station must be informed of the estimated time of arrival for transport to ensure the patient is ready.

The PDT should be informed when the patient has been transferred off site and should update the Patient Dispersal Register with the transfer time.

iii) Transport Team

When an evacuation is underway, the Trust may consider establishing a transport team to work closely with the PDT. The Transport Team will be responsible for transporting patients to an appropriate location.

During a multiagency response and/or off-site evacuation, the above teams will need to be made up of multi-agency partners. In the case of LCH this is likely to include YAS, the Leeds Teaching Hospitals Trust and any additional Local Authority or voluntary sector partners.

iv) Secondary Triage

While in a place of safety a secondary triage can take place. This process would involve recording the patient's:

- main health complaint(s)
- allergies
- additional information eg care requirements and isolation
- National Early Warning Score 2 (NEWS2) and corresponding evacuation priority eg P1, P2 or P3.
- transport requirements.

Once secondary triage has been conducted, the patient's main complaint and priority should be recorded on a 'Patient Dispersal Register' along with the following patient requirements as appropriate:

- type of bed
- care
- details of the transport type required.

The PDT can use this information to allocate the required resources eg appropriate bed, equipment, and mode of transport.

v) Patient Receipt

A record should be kept of all patients received at an 'assisting organisation'. This record should include details of the patient's new location and reported back to the requesting organisation.

Systems in place across geographies must ensure that they have suitable arrangements that are inter-operable as part of their pre-determined triage and tracking system.

20. Training

The Trust should ensure staff are familiar with evacuation and shelter arrangements.

It is important that all staff understand what is expected of them, their role and responsibilities during a shelter and/or evacuation event.

Staff should be involved in the development and review of training, and where evacuation equipment is provided, staff should be adequately and regularly trained in how to use it correctly.

There should always be enough appropriately trained staff on duty and a training record should be maintained.

21. Exercising

Exercising using an evacuation and shelter scenario should be a formal part of the Trust's EPRR exercising programme.

Staff should be given the opportunity to practice their use of all available evacuation equipment during exercises.

Any new evacuation equipment purchased should be tested in-house to ensure that it is compatible with the building infrastructure, eg testing new beds and ensuring all equipment fits through pre-identified fire escape routes etc.

Learning from exercises will form part of the Trust's continuous improvement, incorporating lessons identified into LCH evacuation arrangements and other response plans where relevant. The Trust's Learning & Exercising Group (Chaired by the Accountable Emergency Officer) and Senior Leadership Team and will maintain an overview of lessons learned and continuous improvement.

Definitions

Evacuation	Defined as the movement of patients, the public and staff from a building to a place of greater safety.
Partial Evacuation	Involves moving away from the area of danger to a safe place within the same building, taking account of known potential hazards including structural integrity.
Full Evacuation	The total evacuation of a provider site, including all the buildings on it. All inpatient care facilities should have incremental plans in place including whole site evacuation.
Off-site Evacuation	Evacuation to an off-site location to provide an area of safety away from the affected site, which may be a temporary location until patients are either redirected to another healthcare setting or are discharged/taken home. These may include: • Churches • Town Halls • Community Centres • Local Authority rest centres
Shelter	Defined as taking refuge or cover in the current location. Shelter locations should consider local fire compartment planning.
Evacuation Clearing Station	An area – usually on site, although it can be off site – which can provide a place of temporary shelter for those being evacuated.
Patient Dispersal Arrangements	Pre-defined arrangements outlining the dispersal of patients evacuated to other organisations. Patient dispersal arrangements should form part of the organisation's off-site evacuation plan, made in consultation with multi-agency partners. To ensure system wide tracking and interoperability all providers should ensure that they have in place appropriate and robust arrangements for both the sending of patients (where they are the affected site) and receiving of patients from other providers that they may reasonably be expected to receive patients from. Any system must have the ability to track a patient from end to end to ensure appropriate clinical governance arrangements are in place.
Mutual Aid	An agreement between responders - within the same sector, or across sectors\boundaries – to provide assistance, through additional resource, during incident response which may go beyond the resources of an individual responder.
Lockdown	The process of controlling access and egress to a facility, site, service or building.

APPENDIX A

Hannah House

Description of the service
Hannah House operates a 24\7, 365 day a year service working with children who have complex health needs and require a significant amount of nursing care.

The service offers short break care to children and young people who have complex health needs requiring a significant amount of nursing care, and who either live within the Leeds Metropolitan Boundary or are registered with a Leeds GP, up to their 18th birthday. They must have a completed care assessment and meet the criteria of the Leeds Children's Nursing Dependency Score

Hannah House provides short breaks in a purpose-built unit for families and their children (3-18 years of age) with complex health needs. The unit is a purpose built self-contained 'home from home' style facility.

The building is both innovative and award winning in design with a circular multi-sensory room as the focal point and also consisting six bedrooms, a quiet room, a sitting room, an open plan dining\activity area and an enclosed garden and patio area.

Critical Service Elements
Care of children\Young People who are long term ventilated.
Provision of overnight and day respite for children who are not long term ventilated and/or receive continuing care in the home.

Evacuation Criteria
The service's business impact analysis identified the following risks or threats which, if realised, would require the evacuation of Hannah House:

- Loss of Building/Premises
- Utility Failure
- Severe Weather

Activation
In the event of an activation, the responsible manager or officer should undertake the following actions:

1. Refer to the service level BCP and associated appendices\plans
2. Utilise the Joint Decision Model (JESIP) to establish the impact of the incident on the service
3. Initiate the recording of entries and assignment of actions into an Incident Log
4. Initiate escalation of the incident via the Head of Service to the On-Call Manager
5. Continue to update the Head of Service and other staff/managers as appropriate if the disruption is likely to have an impact on service delivery
6. Continually re-assess the impact of the incident on the service using the Joint Decision Model (JDM)
7. Contact key personnel as appropriate, advising them of the incident and requesting support as required
8. Monitor the situation and provide regular status reports to the Head of Service
9. Take control of the incident and continue to revisit the JDM to prioritise those functions\ elements of the service to be recovered first
10. Oversee the response or recovery actions until the service is fully recovered.

Procedures for responding to and recovering from Loss of Building			
No	**Action Required**	**Target Time (hours or days)**	**Responsibility**
1	Arrange a place of safety for resident children and staff on duty.	Immediate	Team Lead / Nurse in Charge
2	Inform Service Manager / On-Call Manager (out of hours)	Within 1 Hour	Team Lead/ Nurse in Charge
3	Inform parents/carers of children resident/booked in.	1 Hour	Team Lead / Nurse in Charge
4	Liaise with named responsible adult and/or Martin House Hospice for any child where parent/carer cannot collect child within 2 hours	1 Hour	Team Lead / Nurse in Charge
5	Inform Passenger Transport for change of arrangements for children receiving school transport.	2 Hours	Team Lead / Nurse in Charge
6	Inform Estates/Facilities dependant on issue.	2 Hours	Team Lead / Nurse in Charge
7	Arrange to re-deploy staff to Continuing Care/LCNT/INS.	2-4 Hours	Team Lead / Nurse in Charge
8	If denial will be long term inform parents/carers of children booked in near future.	4-6 Hours	Team Lead / Nurse in Charge
9	Liaise with Continuing Care regarding extra home based respite.	Next working day	Team Lead Nurse in Charge

Recovery Locations	
'Walk to' Alternative Site	**'Remote' Alternative Site**
1-2 Coppice Head Rothwell Leeds LS26 0DX	Children's Nursing Team Hunslet Health Centre Church Street Hunslet Leeds LS10 2PT

Considerations/Dependencies/Requirements

- Place of safety for children
- Immediate evacuation to Coppice Head group home
- Contact parents to collect their children\Young People
- Children and families
- Maintain a register of where all children\young people have been relocated to
- Ensure any records remain with the children\young people
- Paper copy of rotas, copy of staff phone numbers, diary
- Access to shared drives

Procedures for responding to and recovering from Utility Failure			
Service Site		**Estate Management Company**	
Hannah House		**FES**	
No	**Action Required**	**Target Time (hours or days)**	**Responsibility**
1	Ensure each resident child's safety, switch to battery back up on all machinery.	Immediate	Team lead / nurse in charge
2	Contact Electricity Board, Gas Board and Yorkshire water (**Contact FES on 01786 458 995**) as an emergency who will contact Electricity/Gas Board on our behalf)	Immediate	Team Lead / Nurse in charge
3	Contact Service Manager / On-Call Manager (out of hours) **0845 265 7599**	Immediate	Team Lead / Nurse in charge
4	Arrange a place of safety for any resident ventilated children – LGI Paediatric Intensive Care	1 hour	Team Lead / Nurse in charge
5	Contact Parents of resident children and arrange for collection of children.	1-2 hours	Team Lead / Nurse in charge
6	Inform staff due on duty of change	1-2 hours	Nurse in charge
7	Inform Estates/Security of closure of building. (Estates Help Desk on 0113 8433166 & Security on 0113 2033425)	1-2 hours	Team Lead / Nurse in charge
8	Electricity failure during hours of darkness. x3 torches kept in equipment room Battery checking done as part of night shift duties on daily basis	Immediately	Team Lead / Nurse in charge

Other Considerations/Dependencies/Requirements
Electricity Company Gas Company Yorkshire Water

Consequences \ Mitigations

Increase in demand on continuing care staff team to visit children in their homes.

Appendix B

Leeds Community Healthcare NHS Trust

Wharfedale Recovery Hub

Bilberry and Heather Wards – 2nd Floor, Wharfedale Hospital
Evacuation Plan

The Wharfedale Recovery Hub is for patients who require a short stay of up to six weeks to undertake additional rehabilitation and/or planning for discharge before they return home. The aim of the unit is to support patients to achieve their recovery goals with the support of the nursing and therapy team which includes Occupational Therapists, Speech and Language Therapists, Physiotherapists, Dieticians, support workers and Doctors where necessary.to enable them to regain their independence and return home at the earliest opportunity.

Site Access

- Wharfedale Hospital, Newall Carr Road, Otley LS21 2LY
- Pay and Display car parking on site
- The South entrance closes at 7pm, the North at 11pm
- The site access barrier is locked at 11.30pm
- At the weekend there is only access through the North entrance, the South entrance remains locked throughout the weekend.

Safety and Alarms

- Generator on site that kicks-in within 15 seconds to support priority sockets, lifts, fire equipment and nurse calling system
- Frequent Blackstart generator tests are undertaken
- New fire alarm system in place – tested weekly by LTHT and quarterly by the alarm company
- Zone plans are on display in all corridor areas
- The alarm sound is intermittent if the issue is in another part of the building, constant if close by.

Bilberry and Heather Wards

- LCH area comprises Bilberry and Heather Wards

- Up to 30 patients across the two wards (includes two enhanced care beds on Bilberry ward)
- Bed bays are divided by gender
- A number of patients may require a hoist to move in and out of bed
- Average length of stay is around 28 days, however it can be up to 6 weeks
- Bedside oxygen supplies
- Up to two bariatric patients can be accommodated

Evacuation

- LTHT Fire evacuation cards are in place
- There are 4 lifts (2 at the North and 2 at the South entrances) each can accommodate a bed, however these are not to be used during an evacuation
- There are 3 staircases (one at each entry point and a middle staircase for evacuation purposes only) with frequently maintained Ski pads\Evacuation chairs – 4 on each floor
- Oxygen cylinders are available if required to support patients during an evacuation (CQC recommend the large cylinders on trolleys, however smaller ones are also available including in the crash bags)

Exercising

- Fire drills undertaken led by LTHT – most recent 05/11/2024

Training

- New starter induction includes fire alarm, evacuation arrangements and zone orientation
- Mandatory Fire Training

Outstanding actions for EPRR:

1) MOU to be developed between LTHT and LCH to include:
    - escalation process
    - emergency contact arrangements\numbers
    - arrangements\process for the relocation of patients to Day Unit, Ward 1 - 1st Floor
    - operating times of other services within the building ie Day Unit as above
    - availability of OOH support due to reduced overnight staffing (x5 HCAs and 3 nurses)

2) BCP in place and escalation route to be agreed in line with LTHT BCP\Evacuation Plans

3) Hub focused tabletop exercise to take place in Spring 2025

4) Arrangements for onward transportation\relocation of patients if a full evacuation is required

5) Review the tripartite MOU with Prince Henry's School in Otley.

Leeds Community Healthcare NHS Trust

Wharfedale Hub

Emergency Evacuation Action Card

Actions:

Upon the alarm sounding\an instruction to evacuate:

1) In the event of a fire alarm the Fire Service will automatically have been contacted

2) Senor nurse\most senior member of staff to check the fire panels (nurses' station on Bilberry ward, doctor's office on Heather ward)

3) Ward staff to prepare patients and begin lateral evacuation away from the hazard to the 'safe' side of the unit (Bilberry or Heather) including accessing oxygen cylinders for patients if required

4) Where appropriate some patients will be moved from their beds into wheelchairs to assist with the evacuation and to make it possible to use wheelchair taxis should a full evacuation be necessary

5) Ward staff to liaise with LTHT Clinical Site Manager regarding relocation of patients to Ward 1, first floor if there is capacity, or elsewhere on site.

6) Two members of staff from other areas in the hospital will deploy to assist in the evacuation (this will not currently happen at night as the Hub is the only service operating between 11pm and 8am)

7) Senior member of staff to contact Wharfedale Clinical Site Manager to alert them to the evacuation and obtain additional information regarding the type of incident and the nature\scale of the response required

8) Senior Manager and\or On-call Manager (0845 2657599) to be made aware at the earliest opportunity.

LCH EPRR Manager
05/11/2024

Appendix 4

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare

FINAL
Incident Response Plan

Version 12
October 2024

1. This document is part of a suite of Emergency Preparedness, Resilience and Response (EPRR) plans which have been developed to provide the framework by which Leeds Community Healthcare NHS Trust will respond to specific incidents\events.
2. This document must be read and applied in conjunction with LCH incident specific plans and service level Business Continuity Plans as appropriate.
3. An electronic copy of the latest version of this document is available in the On-call channel on MS Teams and the Trust H:Drive.
4. All On-call managers are asked to familiarise themselves with the contents of the LCH EPRR documentation.
5. In the event of an emergency, to contact the On-Call Manager please ring:

0845 2657599

Please note: All approved and ratified policies and procedures remain in place until there is notification of an amended policy or procedure by the EPRR Team.

Document details:	Leeds Community Healthcare NHS Trust Incident Response Plan
Version:	Final Version
Persons / committees consulted:	External: Partner organisations in West Yorkshire Internal: LCH On-call Managers\Exec Directors LCH Communications Team LCH EPRR Testing & Learning Group Trust Leadership Team LCH Business Committee
Approved by:	Trust Leadership Team
Date approved:	September 2024
Ratified by:	LCH Business Committee
Date ratified:	September 2024
Title of originator / author:	Emergency Planning Manager
Title of responsible committee / group (or Trust Board):	LCH Trust Board
Title of responsible Director:	Executive Director of Operations (Accountable Emergency Officer)
Date issued:	
Review date:	September 2025
Frequency of review:	Annual Review in line with NHSE EPRR Core Standards
Target audience:	All staff
Copies available from:	Emergency Planning Manager
Where is previous copy archived (if applicable)	H:Drive
Amendment Summary:	

Change History

Version	Changes Applied	By	Date
1.0	Initial Draft	Emma Lydon	05/01/2011
1.1	Further development	Emma Lydon	14/01/2011
1.2	Further development	Emma Lydon	21/01/2011
1.3	Further development following consultation with Denise Gibson	Emma Lydon	25/01/2011
1.4	Acronyms and minor amendments	Emma Lydon	04/02/2011
1.5	Amendments made	Emma Lydon	14/02/2011
1.6	Further development following consultation with Denise Gibson	Emma Lydon	18.02.2011
1.7	Amendments made	Nicola Annakin	11/04/2011
1.8	Amendments & update	Emma Lydon	25/07/2011
1.9	Updated Control Centre details	Emma Lydon	15/08/2011
1.10	Updated WY Contact Details	Emma Lydon	29/09/2011
1.11	Update following QGRC meeting	Emma Lydon	
1.12	Updated contacts	Emma Lydon	04/11/2011
1.13	Updated Liaison Officer section	Emma Lydon	14/11/2011
1.14	Mass Casualties Appendix added & Board comments	Emma Lydon	23/11/2011
1.15	Annual Review	Emma Lydon	03/10/2012
1.16	Minor update following consultation with Sam Prince	Emma Lydon	04/01/2013
2	Review following NHS Organisational change	Emma Lydon	April 2013
3	Annual review & update	Emma Lydon	May 2014
4	Annual review and update	Emma Lydon	February 2016
5	Complete review and refresh of plan including new How To Guides and Action Cards	Emma Lydon	June 2017
5.1	Minor updates following review	Emma Lydon	Nov 2017
5.2	Contacts updated	Emma Lydon	July 2018
6	Annual review. Updated on call details. Update partner organisation details. Updated contact centre details, with focus on only 2 sites. Transfer of responsibilities for incidents lasting more than 12 hours and added supplementary action cards for silver command action cards. Changes also made to the access to the control room and keys	Dominic Mullan Dominic Mullan	Sept 2019 Sept 2019
7	Section 5.1 updated Loggist details Section 5.1 Updated Resilience Manager from Emma Lydon to Dominic Mullan Section 5.2 added Crime Stoppers and Counter Terrorist contact details.	Dominic Mullan	May 2020

Version	Changes Applied	By	Date
8	Section 5: Contact details updated and expanded to include new organisations Governance arrangements updated to reflect the role of the new Integrated Care Board References to Public Health England updated to the UK Health Security Agency (UKHSA) throughout Updated Resilience Manager from Dominic Mullan to Rebecca Todd Appendix E: Critical Services: Updated LIDS to CDAT (Community Discharge Assessment Team) Little Woodhouse Hall removed List revised to include: ToC (Transfer of Care Hub) Health Case Management Hannah House CAMHS Crisis CAMHS Mindmate SPA	Rebecca Todd	September 2022
8	Donna Ryan removed from contact list	Rebecca Todd	Oct 2022
8	Updated list of trained Decision Loggists	Rebecca Todd	Dec 2022
8	Updated On-call Number for the WY ICB	Rebecca Todd	April 2023

Version Control:

Date	Version	Author	Changes/ Reason	Documents Replaced (if any)
June 2024- August 2024. Final V10 agreed August .	9.0 – 10.0	Rebecca Todd EPRR Manager	Document updated in line with NHS England EPRR Framework guidance and other national best practice arrangements	LCH Major Incident Plan – V9- V10

Incident Response Plan Review Schedule

The Incident Response Plan will be updated continually in line with new\updated legislation, guidance and learning from incidents. The plan will be re-issued annually.

As an electronically distributed file any amendments will be notified by the complete replacement of the file that is held by plan holders rather than by the issuing of incremental paper amendments.

Within LCH the plan will be stored electronically in both the EPRR folder, and the electronic On call folder. There will also be a hard copy available in the Incident Co-ordination Centre.

Externally, the Incident Response plan has been shared with the EPRR Lead at the Integrated Care Board with the view that a library of plans can be made available to all Trusts.

The next review of the Leeds Community Healthcare Incident Response Plan is scheduled for September 2025

LCH Incident Response Plan Sign-off

The Incident Response Plan for Leeds Community Healthcare NHS Trust has been formally signed-off by the Leeds Community Healthcare NHS Trust Board as fit for purpose.

_____

Chief Executive

_____

Date

_____

Chair of the Board

_____

Date

Please familiarise yourself with this plan prior to the management of an incident.

If you are using this plan in response to an on-going incident, please refer to the How To Guides and Action Cards found at the back of this plan.

Contents

1. Introduction

The NHS has a duty to protect and promote the health of the community. It is therefore essential that Leeds Community Healthcare NHS Trust (LCH) has plans in place to respond to any incident which may impact on the health of the community, regardless of size, nature, locality or duration. LCH has a statutory requirement under the Civil Contingencies Act 2004 (CCA) to ensure relevant plans are in place.

The Trust's emergency planning arrangements, including this Incident Response Plan (IRP), are aligned with local, regional and national emergency planning arrangements. NHS England will co-ordinate the NHS response to major incidents and emergencies for the local and regional area. Local co-ordination will be led by the WY Integrated Care Board (ICB) working closely with NHS England. Leeds City Council, in conjunction with the UK Health Security Agency, will co-ordinate the local response to public health outbreaks, incidents and emergencies. All local provider plans have been produced to be cohesive, flexible and follow the same regional and national guidelines.

2. Aim

The purpose of this plan is to provide a framework to enable the Trust as a provider of healthcare services in Leeds to respond to the impact of a major incident. This response plan is intended to be flexible enough to meet the demands of a range of circumstances, and regardless of the nature of the incident the basic principles and procedures set out should be followed.

3. Scope

The LCH Incident Response Plan (IRP) is a generic plan which can be applied to all types of incident. LCH staff who cover on-call or who are likely to fulfil roles as Strategic (Gold)\Tactical (Silver) Commander or within the Incident Co-ordination Team (ICT) should familiarise themselves with the content of this plan. In the event of a major incident, the 'How To' guides and Action Cards should be used as a guide to managing the incident, rather than using the plan in its entirety.

This plan should be used in conjunction with the Trust's On-Call procedures, the Trust-wide Business Continuity Plan, service level Business Continuity Plans and any relevant subject specific plans. The Trust has both a 1st and 2nd on-call Manager available 24/7 underpinned by a comprehensive On-call manual as well as a suite of incident specific and business continuity plans. The 2nd On-Call Manager will fulfil the role of Strategic or Tactical Commander in the event of a major incident. The 1st On-call manager will provide support and maintain a decision log if the incident takes place outside normal working hours.

4. Training and Exercising

Under the CCA all NHS organisations are required to adhere to the following exercising schedule as stated in the NHS core standards for Emergency Preparedness, Resilience and Response Framework (v3, July 2022) to ensure that this plan is fit for purpose:

- A communications test of the Incident Response Plan at least once every six months
- An annual desk-top exercise of the Incident Response Plan
- A live exercise of the plan at least once every three years (unless the plan has been activated during this period)

- A command post exercise every three years.
- The plan is underpinned by an organisational risk assessment on the impact of a major/ critical incident – which will be reviewed and updated at least annually or following incidents, activations and testing.

5. Contacts

5.1 Incident Co-ordination

Name	Contact Number	Note
LCH Switchboard	0113 2208500	White Rose Park staff hub 8am to 5pm
LCH On-Call Manager	0845 2657599	Available 24/7 – both Manager (1st) and Exec Director (2nd) on-call
Strategic \ Tactical Commanders - contact numbers can be found in the Trust On-call rota		
Logging – out of hours the 1st on-call Manager will support\log for the 2nd OCM		

Role	Name	
Decision Loggist (in-hours only)	Jess Brooke-Stead	Andrew Stephenson
	Claire Grey-Sharpe	Rebecca Todd
	Alison Keighley	Wendy Warriner
	Neil Rooney	Anita Simey
IT Manager (in-hours only)	Martin Harris	
Resilience Manager (in-hours only)	Rebecca Todd	

5.2 Contact details for Partner Organisations – In-Hours

Local Police	Emergency	999 / 101
NHS	Medical advice	111
Environment Agency Hotline	Reporting environmental emergencies and incidents	0800 807060
Transco/Gas	Emergency contact ie leaks etc	0800 111 999
National Grid	Emergency contact ie power outage etc	105
Yorkshire Water	Emergency contact ie burst pipes etc	03451 242424
Leeds City Council	Reporting emergencies	0113 222 4444
Leeds City Council	Reporting flooding	0113 3760499
Leeds Office of the NHS West Yorkshire ICB (Integrated Care Board)	Commissioning of Acute and Planned Care Services	0113 221 7777
Leeds Teaching Hospitals NHS Trust	Provider of Acute Services	0113 2433144
Leeds Community Healthcare NHS Trust	Provider of Community Services	0113 220 8500
Leeds & York Partnership NHS Foundation Trust	Provider of Mental Health Services	0113 855 5000
Crime Stoppers	Reporting Crimes	0800 555 111
Police Anti-terrorist hotline	Terrorist Incident (immediate threat to life or property)	999 or 0800 789 321

5.3 Contact Details for Partner Organisations – Out of Hours

Organisation	On-call arrangements	Contact details
Leeds Teaching Hospital Trust	Switchboard (all initial contacts via switchboard)	0113 2432799
	On Call	0113 2432799
Local Care Direct	Duty manager (from 18:30 -08.30 weekdays and 24-hour cover weekends and Bank Holidays)	01484 487272
	Minor Injury Unit (MIU) – Wharfedale (08:00 – 23:00 except Christmas Day)	Via the LCD Duty Manager 01484 487272
	Minor Injury Unit (MIU) – St George's (08:00 – 23:00 except Christmas Day)	Via the Duty Manager 01484 487272
YAS	ROC (Regional Operations Centre)	0300 330 0299
111	24/7 Supervisor Line	0300 330 5407
One Medical Group	Shakespeare Walk In Centre (08:00 – 20:00)	07843 802888 (on-call)
Leeds City Council	LCC Contact Centre (ask for Emergency Planning)	0113 2224444
	Adult Social Care Emergency Duty Team	0113 3780644
Leeds Community Healthcare	On-call manager	0845 2657599 (select 1st on-call)
Leeds and York Partnership	On-call manager	0113 8555000 (ask for on-call)
NHS England	North East & Yorkshire Region – Director on-call	0113 539 7037
UKHSA (previously HPA)	Ask for the Duty Public Health Specialist for West Yorkshire	0300 303 0234
GP Confederation Extended Access	Operational On-call	0113 8873899
NHS West Yorkshire ICB – Leeds Office	ICB On-call	0345 646 0788

Date Checked - August 2024

6. Organisational Roles and Responsibilities in a Major Incident

6.1 Leeds Community Healthcare

- Maintain Business Continuity with a focus on admission avoidance and early discharge from hospital.
- If required, meet health care needs in evacuation centres
- If required, provide mass treatment/vaccination
- Co-ordinate and meet the health care needs of patients discharged early from hospital
- Utilise psychological support (either own Trust or contracted service) – Leeds Mental Wellbeing Services
- Support the UK Health Security Agency (UKHSA)/Local Authority in implementing health protection measures, outbreak response
- Ensure continuation of essential routine health care of the general population (affected or not by the incident).

6.2 NHS England

- Lead the mobilisation of the NHS in the event of an emergency
- Work together with the UK Health Security Agency and the local Integrated Care Board, where appropriate, to develop joint response arrangements
- Ensure integration of plans across the region to deliver a unified NHS response to incidents, including ensuring the provision of surge capacity
- Maintain capacity and capability to co-ordinate the regional NHS response to an incident 24/7.

6.3 NHS West Yorkshire ICB (Integrated Care Board)

- Support NHS England in discharging its EPRR functions and duties locally, including the co-ordination of the local health economy during incidents
- Maintain service delivery across the local health economy to prevent business as usual pressures and minor incidents within individual providers from becoming significant or major incidents. This could include the management of commissioned providers to effectively co-ordinate increases in activity across their health economy which may include support with surge in emergency pressures.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination; and
- Co-operate with other local responders to enhance co-ordination and efficiency.

6.4 UK Health Security Agency (UKHSA)

- Deliver public health services including, but not limited to, surveillance, intelligence gathering, risk assessment, scientific and technical advice, and microbiology services to emergency responders, Government and the public during emergencies at all levels
- Participate in and provide specialist expert public health input to national, sub-national and WY LHRP planning for emergencies
- Maintain UKHSA's capacity and capability to co-ordinate regional public health responses to emergencies 24/7.

6.5 Leeds Teaching Hospitals Trust

- Treat incoming patients affected by a major incident
- Plan for the rapid expansion of capacity of A&E facilities and supplementary staffing
- Consider the need to remodel triage and increase treatment capacity at the scene
- Maximise bed availability and free up capacity with primary and community care partners
- Suspend elective surgery (if necessary)
- Plan for accelerated and temporary discharge of patients from acute beds
- Trigger security measures to control and reduce access to protect capacity
- Activate command and control procedures

6.6 Leeds & York Partnership NHS Foundation Trust (LYPFT)

- Provide support to victims of an incident, including NHS staff
- Provision of staff
- Provision of facilities
- Provision of capacity
- Provision of equipment

As a Mental Health and Learning Disability Trust, LYPFT also have specific responsibilities in the event of a major incident including:

- Link with partner organisations locally in co-ordinating services
- Support the provision of psychological and mental health care in conjunction with partner organisations
- Advise on the long-term effects of trauma on casualties associated with the incident
- Ensure that mental health patients involved in an incident are discharged home with appropriate support in the community.

6.7 Yorkshire Ambulance Service (YAS)

The Ambulance Service is primarily responsible for the alerting, mobilising and coordinating at the scene all primary NHS resources necessary to deal with any incident, unless the incident is an internal health service incident.

Ambulance trusts have specific responsibilities in terms of alerting NHS organisations in the event of a civil emergency and/or major incident. These are to:

- Immediately notify, or confirm with police and fire controls, the location and nature of the incident including identification of specific hazards, for example, chemical, radiation or other known hazards
- Alert the most appropriate receiving hospital(s) based on local circumstances at the time
- Alert the wider health community as the incident dictates.

In addition, YAS are also responsible for:

- Providing clinical decontamination of casualties and supporting mass decontamination
- Making provision for the transport of the Medical Emergency Response Incident Team (MERIT) if this is an agreed function for that Ambulance Service.

6.8 GP Confederation (GPs\Primary Care)

- Voluntary involvement in the treatment of minor injuries and general health treatment
- Keeping up to date with locally or nationally issued public health advice
- Awareness of disease presentations associated with biological release
- Ensure the UK Health Security Agency is informed when a disease presentation is suspected
- Provide medical assistance at rest centres, vaccination centres and other treatment areas
- Assist with service provision to patients from practices directly affected
- Assist colleagues from affected practices
- Balance major incident role with the business continuity of the practice.

7. Terms and Definitions

7.1. Types of Incident

In the NHS, incidents are classed as either:

- **Major Incident**
  A major incident is an event or situation with a range of serious consequences which requires an immediate response from one or more of the emergency services. It can also be any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties as to require special arrangements to be implemented.

- **Critical Incident**
  A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may be\have been harmed or the environment may not be safe requiring special measures and support from other agencies to restore normal operating functions.

- **Business Continuity Incident**
  A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed\winter pressures)

Each of the above will impact upon NHS service delivery and may undermine public confidence and require contingency plans to be implemented. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration and response, particularly where this may be due to internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.

There are a number of types of incident, including:

- **Business continuity/internal incidents** – fire, disruption to utilities, significant equipment failure, hospital acquired infections, violent crime
- **Big bang** – a serious transport accident, explosion, or series of smaller incidents
- **Rising tide** – a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action

- **Cloud on the horizon** – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action
- **Headline news** – public or media alarm about an impending situation, reputation management issues
- **Chemical, biological, radiological, nuclear (CBRN)** – CBRN terrorism is the actual or threatened dispersal of CBRN material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent
- **Hazardous materials (HAZMAT)** – accidental release of hazardous materials
- **Cyber-attacks** – malicious attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality
- **Mass casualty** – typically events with casualties in the 100s where the normal major incident response must be augmented with extraordinary measures.

7.2. Activation

To avoid confusion regarding the different stages of activation, all NHS organisations should adopt the following standard messages regarding both critical and major incidents:

- **Major incident – standby**
  This alerts the NHS that a significant incident/major incident may need to be declared. Significant incident/Major incident standby is likely to involve the participating NHS funded organisations in making preparatory arrangements appropriate to the incident, whether it is a ‘big bang’, a ‘rising tide’ or a pre-planned event

- **Major incident declared**
  This alerts NHS funded organisations that they need to activate their plan and mobilise additional resources

- **Major incident cancelled**
  This message cancels either of the first two messages at any time.

- **Major incident stand down**
  All receiving hospitals are alerted as soon as all live casualties have been removed from the site. Where possible, the Ambulance Incident Commander will make it clear whether any casualties are still en-route while ambulance services will notify the receiving hospital(s) that the scene is clear of live casualties, it is the responsibility of each NHS funded organisation to assess when it is appropriate for them to stand down.

7.3. Command and Control

There are a number of different terms used when describing the levels of command and control. These are:

- **Strategic (Gold) Command**
  The multi-agency Executive-level management of an incident affecting more than one organisation. Sets strategic priorities\direction to be delivered by organisational tactical (silver) command.

- **Tactical (Silver) Command**
  Responsible for directly managing an organisation's response to an incident. To interpret and deliver the strategy set by Strategic (Gold) command including the allocation of resources and coordination of tasks. Tactical command should oversee and support, but not be directly involved in the operational response.

- **Operational (Bronze) Command**
  Those responsible for carrying out the actions and tasks agreed at Tactical (Silver) command. Locality-based, dealing directly with either the incident itself or the impact of the incident on the organisation.

7.4 Situation Reporting (SITREPS)

During a Major or Critical Incident it will be necessary for information to be gathered from relevant Business Units and Corporate Teams to provide a view of how they are coping with the incident. A situation report or 'Sitrep' will be used for that purpose, a template is at Appendix E.

Sitreps will be provided at set times by a Senior Manager on behalf of the Business Unit or Team and returned to the Incident Co-ordination Team until regular service is resumed. Depending on the nature of the incident, additional sitreps may be required, this will be communicated via briefings by the Incident Commander. All fields in the template must be completed. If there is nothing to report, or the information request is not applicable a NIL or N/A return should be submitted.

The AEO or nominated Deputy will appoint staff to obtain and submit the requested data, together with a lead to authorise each submission. If present the AEO will quality assure the content of the Sitrep.

7.5 Information Cascade

It is essential that all messages given are specific; particular attention is drawn to the following:

• This is/is not an exercise:
  - State whether this is a REAL incident",
  - Or: Commence communication with "the exercise name".

State of alert - every person called needs to know what is expected of them eg:

- "Remain on standby, but do nothing now,"
- "Take action, but remain in situ,"
- "Come to work" - where and in what capacity.
- Level of cascade to involve - Clinical Services, must have in place cascade systems and capable of mobilising large numbers of staff. The Incident Commander, in conjunction with the first-in-line contacts, need to clarify exactly how many staff they wish to involve and at what level of seniority.

Messages - Particularly during working hours, the person answering the call may not necessarily be the person required. Messages should not be left if the person required is not available. It is essential that the Incident Co-ordination Team has feedback that an individual can respond / not respond as requested.

If an individual cannot be spoken to directly, the caller should not leave a message, but say they will try someone else. If a message must be left, the person should be asked to call the ICC back within 5 minutes or to cancel the message.

8. Procedures

8.1. Activation and Alerting Mechanisms

In most cases LCH, along with other local health organisations, will be informed of a major incident in Leeds by the WY Integrated Care Board (ICB). This will usually be via the LCH On-call number, however there are additional channels through which information might be received including LCH reception, media reports, emergency messaging systems (such as Leeds Alert), email or through partner organisations. Depending on the nature of the incident, other responding organisations may declare an incident when there is no impact on wider health partners or service delivery.

Regardless of how the information is received the activation of the LCH Incident Response Plan will take place when:

- an incident has occurred that has the potential to impact LCH's ability to maintain essential service delivery\critical functions, and
- where it may be necessary to establish command and control arrangements to co-ordinate a Trust response and recovery.

If the 1st On-Call Manager is notified of a major incident or an issue which has the potential to become a major incident this should immediately be escalated to the 2nd On-Call manager.

The decision to activate this plan and\or declare a major incident will be taken by the Chief Executive or Strategic\Tactical Commander.
See How To: Declare a Major Incident guide in Appendix A.

If the decision is taken to declare a Major Incident, the Chief Executive or Incident Commander should ensure that the Chair of the Board is made aware.

The 2nd On-call manager:

- has full authority to respond to an incident on behalf of the Chief Executive
- may be required to prioritise or cancel some services and redeploy staff
- may be required to approve financial payments to cover immediate needs.

If a major incident is declared, this command-and-control arrangement supersedes normal management structures and reporting arrangements.

If another organisation(s) declares a major incident but the impact of the incident is not significant enough to warrant LCH standing up a response, the Chief Executive or Incident Commander (Strategic or Tactical) should put the Trust on standby and monitor the situation as it develops. If a decision is taken for LCH to declare a major incident this must be communicated to our partner organisations.

The Incident Commander will also decide whether it is necessary to establish an Incident Co-ordination Team (ICT) and\or open an Incident Co-ordination Centre.
See How To: Establish an Incident Co-ordination Team in Appendix B.

8.2. Liaison Officer

The Incident Commander may consider deploying a Liaison Officer to attend another organisation's Incident Co-ordination Centre where appropriate. This would enable and enhance joint working between impacted organisations and improve information flows. Depending on the nature of the incident it may be necessary to deploy more than one Liaison Officer.

Any request to attend LTHT's Incident Co-ordination Centre must be made through the LCH Incident Control Commander leading the response direct to the LTHT Commander. Access to the LTHT Co-ordination Centre will not be granted without production of an LCH photo identification card.

8.3. Emergency Co-ordination Centre (ICC)

Leeds Community Healthcare has two pre-identified ICCs which may be used during any incident response, however any other LCH facility may be used which meets the required space and communication requirements. The decision to open an ICC rests with the Trust's Incident Commander. In most circumstances the secondary ICC will only be utilised if the primary co-ordination centre is inaccessible ie where access is denied due to the location of the incident eg flooding.

Specific ICC functions may locate in adjacent areas enabling the ICT to remain focused on managing the incident without the distraction of mobile phones, emails etc. These areas may be:

- **Incident Management**
- **Communications & Support**

The LCH primary ICC is the Boardroom, Ground floor, Building no 3 at White Rose Park. Hard copies of Emergency Planning documentation are stored in the Emergency Planning Cupboard in the Boardroom on the ground floor office area.

Depending on the location, scale and nature of the incident it may be necessary to use the secondary ICC which is at Chapeltown Health Centre. Other locations may be used as required.

The two ICC bases will be equipped with the following:

- Paper copies of all Trust EPRR policies and plans in case of disruption to IT services
- Log books
- Stationery
- AV equipment (to enable virtual meetings to take place)

See How To Guide: How to Establish an Incident Co-ordination Centre in Appendix C.

8.4. Incident Co-ordination Team Agenda

The aims and objectives of the Incident Co-ordination Team will differ depending on the scale and nature of the incident. Regardless of this, meetings should be scheduled at regular intervals and in-hours both a Loggist and a note taker should be present. Outside normal working hours, the role of the Loggist will be taken by the 1st On call manager.

A proposed ICT agenda can be found at **Appendix D**.

Regardless of whether an ICT is running continuously, regular meetings should continue to take place to maintain an overview of the agenda.

The ICT must maintain a focus on the strategic overview, and it is important to ensure that there is a common understanding of the situation between all team members.

Joint Emergency Service Interoperability Programme (JESIP) is a set of principles designed to encourage and support partnership working to improve the way organisations work together when responding to incidents to save lives and reduce harm. Learning from major incidents such as Grenfell Tower and the Manchester Arena terrorist attack has led to the development of a set of principles designed to enable emergency responders, including the NHS, to respond to incidents in a co-ordinated way. These principles comprise communication, co-ordination, joint understand of risk, joint decision making, shared situational awareness, a common language and the capture and sharing of learning (debrief) following an incident.

Commanders should adopt the Joint Decision Model (JDM) to help bring together the available information, reconcile objectives and make effective decisions together. The JDM is incorporated into the ICT agenda in **Appendix D**.

8.5. Threat and Risk Decision Making Template (Appendix E)

This template outlines the key information\data which may be required\requested at the Incident Co-ordination Team meeting.

8.6. Communication

It is essential that a clear and co-ordinated approach to communications is taken. This ensures staff, the public and partner organisations are fully aware of the situation. Messages MUST be consistent with those coming from partners locally and nationally. The Head of Communications will play an integral part in the Strategic\Tactical Command and media liaison for major incidents will be co-ordinated by them in collaboration with strategic partners.

A plan will be developed to inform Trust staff of the situation as early as possible with regular updates.

The ICC will organise an MS Teams meeting or Teleconference with relevant Managers at an early stage in the process to ensure that communication to staff is clear.

Communications with stakeholders and a plan for joint communiqués, if appropriate, will be developed.

The Head of Communications will ensure that messages about the incident are conveyed to relevant media providers and regular updates are provided. If appropriate a Press Conference will be organised as soon as possible.

It is important to establish whether the incident has been declared a city-wide Major Incident and which agency is taking the lead in media briefing. The Head of Communications will clear all Trust media statements with that agency.

In some circumstances a Joint Strategic Co-ordinating Group will be activated; it is important that its associated media communications team is aware of all NHS media statements to ensure there is no conflict in joint response statements.

In such cases, copies of Trust media statements should be forwarded to WYICB and the Media Briefing Centre.

When the incident is related specifically to Trust Services, the Head of Communications will liaise with the media directly, keeping the Police, NHS, other NHS Trusts and Social Services, etc. informed.

Professional ethics and protection of individuals' privacy and dignity must be maintained.

The Head of Communications will consult with the AEO or Executive Lead in the Incident Co-ordination Centre to determine the extent and detail of information to be released. As a general principle, information should not be withheld unreasonably, especially if its release could help to prevent damaging rumours or errors arising.

8.6. Recovery

Depending upon the nature and impact of the incident, the Incident Commander should give early consideration to establishing a Recovery Team. The function of this team is to co-ordinate the recovery effort and restore the Trust to business as usual. The list of essential services should be used to prioritise the order for service recovery.
See Appendix F: LCH Essential Services.

More detailed information regarding LCH essential (C1) services can be obtained from the Trust Emergency Planning and Resilience Manager.

Membership of the Recovery Team will depend upon the specific incident, however staff may be drawn from those members of the Incident Co-ordination Team not involved in the incident response.

8.7. Legal Advice

Elements of the response to any major incident may involve actions and policy decisions which may have legal implications. The Incident Commander may also require advice on any specific aspects of the incident and response which could create legal liabilities for the Trust. This should be considered as part of the decision-making of the ICT during the co-ordination of the incident.

Engaging solicitors can be an expensive budgetary commitment, therefore the Trust must ensure that solicitors are contacted by designated people and for specific purposes when in-house knowledge and expertise has been exhausted.

The need for legal advice out of hours is rare and staff requiring legal advice should, in the first instance, use the on-call procedure.

Leeds Community Healthcare contract Hempsons for in-hours legal advice. Contact details as below:

Hempsons: 01423 522 331

In-hours should the Solicitor advise that they are unable to supply services due to a conflict of interest please contact the Procurement Manager for advice on alternative providers.

8.8. Training requirements

All staff with a role in the Incident Co-ordination Team (ICT) will require training in line with national standards. Action cards have been provided in Appendix F-H, however this does not replace formal training requirements.

8.9. Communications

In the event of a major incident, it is vital that clear and effective communication is maintained with staff, stakeholders, service users, the public, other responding agencies and the media.

There will be a formal situation reporting process throughout any major or critical incident. The Trust's formal situation reporting will be managed by the Business Intelligence team. A process flowchart has been produced to explain the steps required.

The media and the public may contact the Trust for information about the incident. Social media will be used to broadcast messages and share information in an emerging situation. It is therefore important to ensure accurate and appropriate information is provided.

To assist in the operational duties associated with maintaining good internal and external communication during a major incident a pack of Communications Action cards has been developed and is available in the Supporting Information folder in the On-call folder on H:Drive.

Paper copies are also available in the Emergency Planning cupboard in the Boardroom at White Rose Park.

9. Supporting Documentation

- Adverse Weather Plan
- Cyber Incident Response Plan
- Infectious Diseases Plan
- New & Emerging Pandemics Plan
- Evacuation and Shelter Plan
- Lockdown Plan
- Protected Individuals Plan (VIPs\high profile patients and visitors)
- CBRN (Chemical, Biological, Radiological and Nuclear) Plan
- Service level Business Continuity Plans
- LCH Crisis Comms Pack \ WY Comms & Media Guidance
- EPRR Policy and Business Continuity Management Process

Appendix A

How to declare a major incident

What is a Major Incident?

- Any occurence that presents serious threat to the health of the community, disruption to Trust services or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations

Major Incident Standby

•Decision to be made by the Incident Commander
•This alerts colleagues that a Major Incident may need to be declared
•Involves making preparatory arrangements appropriate to the incident

Major Incident Declared

•Decision to be made by the Incident Commander
•Alert partners that the Incident Response Plan has been activated and an LCH response has been triggered
•Inform the Trust Chair
•NHS England North East and Yorkshire regional on call: 0113 539 7037
•NEY Regional Operations Centre: 0113 539 7045 (team) or 07730375263 (direct)

Major Incident Stand Down

•Decision to be made by the Incident Manager
•Alert partners that LCH is no longer operating a Major Incident response

Action Required

•Escalate/De-escalate using normal escalation channel via the ICB
•Ensure staff are informed where appropriate
•Inform NHSE/ICB that Major Incident status has been stood down

Appendix B

How to Establish an Incident Co-ordination Team (ICT)

What is an ICT?

- The team responsible for managing the LCH reponse to an incident
- Roles fulfilled by LCH staff

When to call an ICT

- Decision to be made by the 2nd On-call Director\Incident Commander
- When the response required to manage the incident is greater than can be managed by the On-call manager and\or specialist advice is required
- When an Emergency Co-ordination Centre has been established to manage the incident response

Roles within an ICT

- Incident Commander (usually 2nd On-Call Manager\member of Exec Team)
- Operational Manager/Deputy Incident Commander (usually 1st On-Call Manager)
- Loggist
- Support Team
- Comms Manager
- IT Manager (if apropriate)
- Resilience Manager

How to establish an ICT

- Incident Commander to decide what roles/representatives are required depending on the scale and nature of the incident
- If the decision is made to establish an ICT, a Loggist should attend
- Establish the Incident Co-ordination Team

Appendix C

How To Establish an Incident Co-ordination Centre (ICC)

What is an ICC?

- A location used for the co-ordination of the LCH response to an incident

When to open an ICC

- Decision to be made by the Incident Commander \2nd On call
- When the response cannot be managed via remote communications

Primary Co-ordination Centre

- Ground Floor Boardroom, Building 3, White Rose Park, Millshaw Park Lane, Leeds LS110DL
- Reception: 0113 220 8500
- Boardroom Landline: N\A
- OOH Access: White Rose Park Site Security Team – **(0113) 3877777**
- Personal access cards are required at all times to open the main entrance doors and to gain access from the car park
- Documentation: Emergency Planning Cupboard in the Boardroom at White Rose Park.

Secondary Co-ordination Centre

- Chapeltown Health Centre
- Annex entrance door code 4510
- 1st Floor hot-desking room
- Staircase door code 253

Alternative Locations

- Any location which meets the space and communications required to manage response
- Any of the locations below can be accessed out of hours:
- Bramley Clinic
- Burmantofts HC
- Halton Clinic
- Holt Park HC
- Hunslet HC
- Horsforth Clinic
- Kirkstall Clinic
- Morley HC
- Otley Clinic
- Pudsey HC
- Rothwell HC
- Seacroft Clinic
- Woodsley Road HC
- Meanwood HC
- To access call Profile Security on (0113) 3839036 and use the password 'Golfball'

Emergency Co-ordination Centre

LCH Primary Emergency Co-ordination Centre - White Rose Park - OOH Access
The LCH designated Emergency Co-ordination Centre is the Boardroom on the Ground Floor of the Staff Hub – White Rose Park - Building 3 (see diagram below).

Address: Building 3, White Rose Park, Millshaw Park Lane, Leeds LS110DL

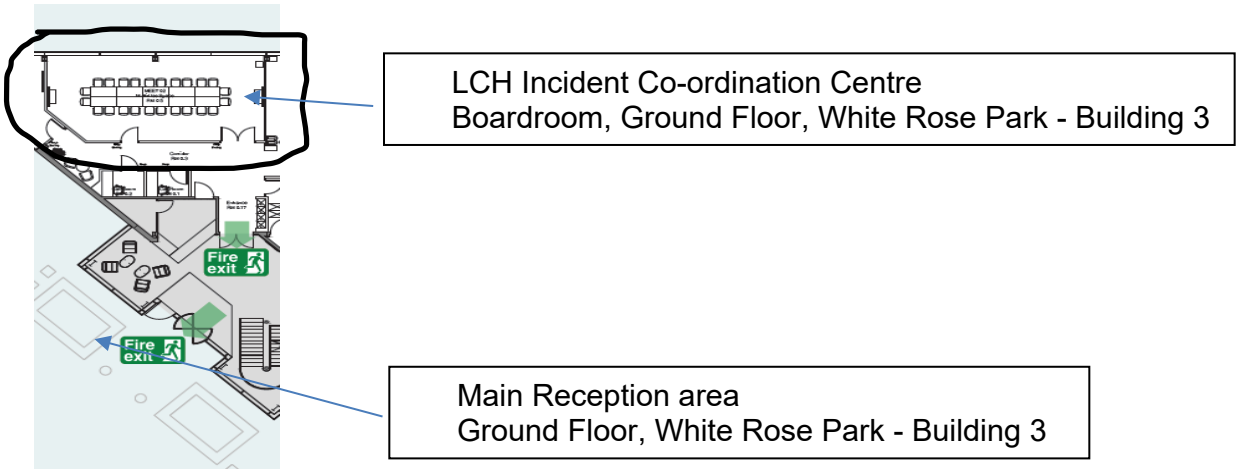
LCH Reception number (08:00 – 17:00) - **(0113) 2208500**

The hours of operation are between 08:00 to 17:00, Monday to Friday. The main front (revolving) door to Building 3 is open between 07:00 and 19:00, Monday to Friday.

Personal access cards are required at all other times to open the main entrance doors and to gain access from the car park.

White Rose Park Site Security Team (Out of Hours access) – **(0113) 3877777**

Emergency Planning documentation and hard copies of plans are stored in the Emergency Planning Cupboard in the Boardroom, Ground Floor – Building 3, White Rose Park.



Backup Emergency Co-ordination Centre – Chapeltown Health Centre

Appendix D

Incident Co-ordination Team Agenda

Incident Response

In line with the NHSE Principles of Health Command Strategic and Tactical training the Trust will adopt the JESIP joint working principles to co-ordinate an incident response.

Joint Decision Model (JDM)

The Joint Decision Model ensures that the incident is under constant review and that the response is appropriate should the incident escalate.

Joint Decision Model

The Incident Commander should revisit the cycle continually throughout the incident as new information becomes available\ the situation develops.

Proposed Meeting Agenda

MEETING:	**Leeds Community Healthcare NHS Trust (#) | Incident Name**		
VENUE:	Click or tap here to enter text.		
DATE:	Click or tap to enter a date.	**TIME:**	

The agenda below is a suggested agenda and should be adapted accordingly by the Chair prior to the meeting.

Ref	Item	Lead
1.	**Introductions** • Welcome and Introductions • Apologies	Chair
GATHER INFORMATION AND INTELLIGENCE		
2.	**Purpose of Meeting**	Chair
3.	**Minutes and Actions of the Previous Meeting (if applicable)**	Chair

4.	**Situation Report** • Impact Summary (inc cross boundary issues) • Plan Activation Level	Chair / All
5.	**Forward Look** • Anticipated Future Impacts (inc cross boundary issues) • Anticipated Plan Activation Level	Chair
ASSESS RISKS & DEVELOP A WORKING STRATEGY		
6.	**Risks and Impacts (patients, staff, the public, infrastructure etc)**	All
7.	**Action Required**	All
CONSIDER POWERS, POLICIES AND PROCEDURES		
8.	**Plans, Policies, and Procedures** • Relevant LCH supporting documentation	All
IDENTIFY OPTIONS AND CONTINGENCIES		
9.	**Options and Contingencies** • Evacuation • Resources (staffing and equipment) • Protecting buildings and infrastructure • Mutual Aid • Authorisation of Expenditure • Other	All
10.	**Communications** • Patient, staff Communication • Stakeholder \ partner Communication to include WY ICB • Public Communication	Comms Lead
11.	**Escalation of Risks** • Is an Incident Co-ordination Team required? • Is an Incident Co-ordination Centre required? • Risks to Escalate • Is this a Major Incident?	Chair
REVIEW OF ACTIONS (allow at least 10 minutes for this section)		
12.	**Review of Actions \ Decisions**	Chair / Loggist
13.	**Any Other Business**	Chair
14.	**Future Meetings** • Review of Group Membership • Date / Time / Venue of Next Meeting	Chair

Appendix E

Threat and Risk Decision Making Model Template

INFORMATION	ACTION
Information \ Intelligence	
Risk Assessment Risk to patients, staff, public etc.	
Working Strategy Maximise the capacity of staff by working systematically and effectively in partnership	
Policies, consider: Health and Safety Act, Civil Contingencies Act, Human Rights Act, Equality Act,	
Tactical Options / Plans Consider plans already in place	
Check Against Strategic Aim	

INFORMATION	ACTION
Decision(s) Made When, by whom, organisation	
Agree Time to Review Strategy and Actions	

Additional Comments:

Appendix F

LCH Critical Services

- Neighbourhood Teams including Nights
- Cardiac
- Stroke Team
- Child Protection
- YOI – Adel Beck, Wetherby
- Police Custody
- CIVAS
- Respiratory Team
- Diabetes
- HHIT (Homeless Health Inclusion Team)
- QPD Clinical Governance
- Infection Control
- Safeguarding
- CLASS
- Bed Bureau
- CDAT (Community Discharge Assessment Team)
- ToC (Transfer of Care Hub)
- SPUR (Single Point of Urgent Referral)
- Health Case Management
- Hannah House
- CAMHS Crisis
- CAMHS Mindmate SPA (Single Point of Access)
- LMWS
- Recovery Hubs including Wharfedale

Appendix G

Incident Commander (Strategic\Tactical) Action Card

Role:

- To establish and maintain overall control and co-ordination of the Trust's response to an incident
- To determine the strategy and tactical actions for how the Trust will manage the incident

Responsibilities:

- Gather as much information about the incident as possible to determine scale and nature
- Establish if any other responding organisation has declared a Major Incident
- Determine the\any impact on LCH and any risks that need to be mitigated/ escalated
- Set response priorities for LCH

Actions (if appropriate):

- Start and maintain an Incident Log of any actions considered and/or taken. OOH 1st on-call to support 2nd on-call with logging until an ICT and Loggist are in place if appropriate. Ensure the log is mantained throughout the incident and that actions, decisions and rationale are recorded
- Declare Major Incident (see How To: Declare a Major Incident)
- Establish an Incident Co-ordination Centre (ICC) - see How To: Establish an ICC
- Establish an Incident Co-ordination Team (ICT) - see How To: Establish an ICT
- Prepare a situation briefing for the ICT
- Establish arrangements for situation reporting in line with national/ local requirements.
- Inform the Chief Executive and Chair
- Link with other organisations as necessary leading on the decisions around additional resources, overtime, agency and mutual support to other organisations.
- Consider reducing the risks of reducing normal service operations to support the incident.
- Consider establishing a Recovery Team to support business continuity and manage the restoration to normality. If an incident is expected to last more than 12 hours put in place arrangements to transfer responsibilities to another incident commander and back-up ICT if required.
- When the incident is concluded, declare Major Incident Stand Down.
- Ensure the decision log has been reviewed and signed off.

Appendix G

Loggist Action Card

Role:

- To maintain a timely and accurate record of:
- all key decisions made by the Incident Co-ordination Team (ICT)
- all actions taken by the ICT
- all actions considered and rejected by the ICT
- all requests for information

Responsibilities:

- To attend the Incident Co-ordination Centre (ICC) where possible
- To use the log books provided in the ICC (if available) or create a log as appropriate
- Ensure that the log records are all present and roles fulfilled
- Include named responsibility for specific actions
- Include rationale for decisions made/rejected

Actions at the end of your shift:

- Review documentation and liaise with the Incident Manager to ensure accuracy of records
- Ensure the log book and any other paperwork is signed off and handed to the Incident Commander or nominated representative
- Provide a handover to new loggist if required

Appendix H

Operational Manager action card

Role:

- To implement a local sit rep process if required
- Represent service/ Directorate/ Business unit in information gathering/ analysis and decision making

Responsibilities:

- To attend the Incident Co-ordination Centre (ICC) as required
- Provide local summaries of risks/ issues and mitigations

Actions:

- Ensure that detailed situation reports are available for discussion/ dissemination
- Take action and contribute to decision making around priorities
- Communicate decisions from the ICT to all services under their control, and ensure any decisions are actioned

Appendix i

Emergency Planning Situation Report (Sit Rep)

This Situation Report is to be completed by the General Manager or a Senior Manager deputising for them in each Business Unit\Corporate Service Team. Please return this to the Incident Commander by 10.00hrs daily until usual service is resumed. In the event of an IT outage please use this template as a structure to phone in the information to ?
Note: Please complete all fields. If there is nothing to report, or the information request is not applicable, please insert NIL or N/A.

Business Unit\Coporate Team:		**Date:**	
Name & Role (completed by):		**Time:**	
Mobile Telephone number:			
Email address:			

Type of Incident	**eg Severe Weather**
Have you experienced any serious operational difficulties eg travel to community service users, staff unable to attend for duty, requests for assistance.	
Impact on services and patients:	
Have you invoked Business Continuity Plans?, *including any planned reduction in services and any rescheduled appointments etc.*	

Impact on other service providers		
Mitigating actions taken		
Additional comments		
Staff Unable to attend work Please list job roles and numbers:	**Role**	**Number unable to attend**
	•	
	•	
	•	
	•	

Appendix 5

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

FINAL

Business Continuity Policy \ Statement and Management System (BCMS)

1. This document is part of a suite of Emergency Preparedness, Resilience and Response (EPRR) plans which have been developed to provide the framework by which Leeds Community Healthcare NHS Trust will respond to specific incidents\events.
2. This document must be read and applied in conjunction with the LCH Incident Response Plan, incident specific plans and service level Business Continuity Plans as appropriate.
3. An electronic copy of the latest version of this document is available in the On-call channel on MS Teams and the Trust H:Drive.
4. All On-call managers are asked to familiarise themselves with the contents of the LCH emergency documentation.
5. In the event of an emergency, to contact the On-Call Manager please ring:

0845 2657599

Issue Date	01/10/2024	Review Date	01/10/2027

Contents

1 INTRODUCTION

This policy sets out the specific requirements for establishing and maintaining effective Business Continuity Plans (BCPs) and associated planning arrangements across Leeds Community Healthcare (LCH).

2 PURPOSE

The Civil Contingencies Act (2004), Health & Social Care Act (2012) and Health Care Act (2022) require NHS funded organisations to have adequate measures in place to remain resilient. This includes a need to instil business continuity arrangements to ensure that LCH is prepared for any service disruption, internally and externally, which threatens the continued delivery of our commissioned services. By taking a proactive approach to business continuity, the Trust can prioritise, deliver and support the critical healthcare systems and services that our stakeholders and community rely upon, in so far as is reasonably practicable.

The NHS England EPRR Core Standards require the Trust to have in place a policy which includes a statement of intent to undertake business continuity. That intent also includes a commitment to adopt a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.

3 SCOPE

This policy applies to all LCH staff. It is to be read in conjunction with the Emergency Plans on the H:Drive and the MS Teams On-call Channel, and falls within the remit of the Trust's EPRR arrangements.

For the purposes of this policy a business continuity incident is an event or occurrence that; disrupts (or might disrupt) LCH's normal service delivery below acceptable predefined levels and where special arrangements need to be implemented until services can return to an acceptable level.

4 EPRR CORE STANDARDS

Implementation of this policy ensures that LCH maintains compliance with the following NHS England EPRR Core Standards:

- Standard 44. The organisation has a policy which includes a statement of intent to undertake business continuity and is committed to a Business Continuity Management System (BCMS) which is aligned to ISO standard 22301.
- Standard 45. The organisation has established the scope and objectives of their BCMS, specifying the risk management process and how that will be documented.
- Standard 46. The organisation annually assesses and documents the impact of service disruption through Business Impact Analysis (BIA).

- Standard 47. The organisation has BCPs in place for the management of incidents, detailing how the individual service or organisation as a whole will respond, recover and manage during disruptions to:
    - People
    - Information and data
    - Premises
    - IT and Infrastructure
    - Suppliers and Contractors.
- Standard 48. The organisation has in place procedures where the testing and exercising of BCPs is undertaken at least annually or following organisational change or as a result of learning from any untoward incidents.
- Standard 49. The organisation annually certifies that they are compliant with the Data Protection and Security Toolkit.
- Standard 50. The BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of exercises and any corrective actions are annually reported to the Trust Board.

5 RESPONSIBILITIES, DUTIES AND ACCOUNTABILITY

5.1 Accountable Emergency Officer (AEO)

The Accountable Emergency Officer will:

- Be accountabile to the Trust Board for ensuring a suitable and robust Business Continuity Policy is in place.
- Provide a strategic lead on business continuity matters ensuring they are discussed at the LCH Senior Leadership Team.
- In conjunction with the EPRR Manager, ensure this policy is reviewed every 3 years to ensure it remains relevant, suitable and appropriately in line with EPRR Core Standards.
- Provide post incident reports to the Senior Leadership Team, Business Committee and Trust Board as required.
- Commission internal audit reviews at least once ever 3 years and provide subsequent reports to the Senior Leadership Team, Business Committee and Trust Board as and when audits are undertaken.

5.2 EPRR Manager

The EPRR Manager will:

- Ensure the Business Continuity Policy is reviewed every three years to ensure it is aligned to ISO standard 22301.
- Ensure the Business Continuity Policy is approved by the Senior Leadership Team and ratified by the Business Committee (a sub-committee of the Trust Board).
- Ensure the EPRR Risk Register is presented to the Senior Leadership Team at least annually, to provide the basis for risk assessments within individual service BCPs.
- Liaise with staff at all levels to assist with their understanding of the requirements of this policy.
- Co-ordinate the process for the annual testing, exercising and updating of BCPs, identifying the named individual as the author responsible for each service BCP.
- Provide all plan authors with guidance on how to update their BCP.
- Provide a BCP template for use across all service areas.

- Where required, assist BCP authors to complete their plans, including the completion of a Business Impact Assessment (BIA).
- Ensure that all BCPs contain action cards to address risks identified in the EPRR Risk Register and EPRR Core Standards.
- Review updated service BCPs, checking for completeness and alignment with other LCH planning arrangements, prior to approval of the BCP for use.
- Collate and store BCPs within EPRR Team records and archives, ensuring that the latest version of each BCP is available for use on the H:Drive and On-Call MS Teams Channel.
- Will, when notified of any incidents where BCPs have been activated, request/ perform a formal or informal post-incident debrief if required, and provide appropriate recommendations for agreement at the Trust Learning and Exercising Group.
- In consultation with the AEO, ensure that business continuity matters are included on the Trust Risk Register where appropriate.
- Liaise with individual services to agree suitable dates for the exercising of their BCPs.
- Liaise with the LCH Data Protection Officer and Informatics department to assist with the annual certification of compliance with the Data Protection & Security Toolkit.
- Co-operate and assist with any internal audit of the BCMS system.

5.3 Directors

Directors will:

- Where required seek assurance from Deputy Directors/General Managers and/or Service Managers that BCPs are being completed to meet BCMS requirements, and exercises undertaken to test business continuity arrangements.
- Undertake any actions required in terms of strategic support to services during untoward incidents. This may include the use of the LCH Incident Response Plan to make strategic decisions on service priority, escalate or declare an incident, source mutual aid from external sources and liaise with partner organisations.
- Provide feedback as part of a post-incident debrief.
- Provide feedback as required following receipt of an internal audit report.

5.4 Service Managers/Leads

Service Managers or Leads will:

- Make appropriate checks to ensure that BCPs are suitable, proportionate and completed as appropriate.
- Liaise with the EPRR Manager to place business continuity issues on the appropriate risk register if required.
- Ensure suitable representation and attendance at the Trust Learning and Exercising Group and provide feedback to teams and services as appropriate.
- Ensure managers and staff are aware of the location and content of their BCP and the requirement to participate in exercises.
- Follow the action cards contained within the BCP in the event of a business continuity incident.
- Provide feedback as required in any post-incident debrief.

5.5 Service BCP Authors

BCP authors will:

- Ensure BCPs are completed in line with the procedures listed in section 6.
- Act as the Business Continuity Lead for the service for which they have developed the BCP.
- Review their BCP on an annual basis, ideally in line with post-exercise actions. Earlier review should be undertaken as necessary, eg after an incident or due to changes to the service\operating procedures.
- Share the BCP with the team\staff prior to each review requesting feedback and input to form updates.
- Ensure business continuity is discussed as a regular agenda item at team meetings.
- Following a business continuity incident ensure that lessons learned are included in an updated version of the BCP within 4 weeks.
- Ensure that electronic and paper copies of the BCP are stored in a suitable location that is known and accessible.
- Ensure that all service staff are aware of the location(s) of the BCP.
- Ensure that new members of staff are made aware of their BCP as part of their induction training.
- Act as the first point of contact for all business continuity matters within the service, including the provision of Situation Reports (Sitreps) when plans are invoked.
- Assist the EPRR Team with the development and delivery of service BCP exercises.
- Follow the action cards contained within the service level BCP in the event of a business continuity incident.
- Provide feedback as required in any post-incident debrief.

5.6 All Staff

All staff will:

- Know the location of the BCP for their service and have some knowledge of its contents.
- Co-operate with the BCP author in updating the plan.
- Inform the BCP author and/or their line manager of any circumstances which may require alterations to the BCP ie changes of process, new Standard Operating Procedures etc.
- Participate in exercises as required by the Service Manager, EPRR Manager or Senior Management.
- Follow the action cards contained within the BCP in the event of a business continuity incident.
- Provide feedback as required in any post incident debrief.

5.7 Trust Senior Leadership Team

The Senior Leadership Team will:

- Approve the business continuity policy and associated documents and contingency plans. Responsibility for the final ratification of these documents lies with the Business Committee, a sub-committee of the Trust Board.
- Oversee the implementation and management of the BCMS.

- Ensure learning from incidents and exercises is captured and monitored to completion for the continuous improvement of EPRR arrangements.

6 PROCEDURE AND IMPLEMENTATION

6.1 Procedure

All BCPs will be updated at least annually by the service BCP Author. The final draft of the updated BCP will be forwarded to the EPRR Manager for checking and verification of contents. Once both the BCP Author and EPRR Manager are satisfied that all EPRR and business continuity requirements are met the final version of the BCP will be signed-off as being approved for use.

If the service undergoes reorganisation or changes its function or operating procedures in such a way as to significantly affect the effectiveness and validity of the BCP, the Author is to ensure the BCP is amended and submitted to the EPRR Manager for sign-off within one calendar month of any changes made.

6.2 Implementation

Once an updated BCP is approved for use the EPRR Manager will notify the author in writing, advising that the service should destroy all previous versions of the BCP and distribute copies of the latest version within the service as required. The EPRR Manager will ensure the new version is uploaded to the H:Drive and the On-call MS Teams channel for use by LCH incident response staff during business continuity or other emergency incidents.

6.3 Plans or Policies to be read in Conjunction with BCP

BCPs may be activated due to a variety of reasons which may impact on the continued delivery of services. In addition to the Trust Incident Response Plan, which outlines the Trust's command and control arrangements for the management of a range of incidents, the Trust also holds separate plans for the following specific risks:

- Adverse Weather (including heatwave, flooding, winter)
- Pandemic
- Infectious Disease
- Fuel disruption
- Evacuation and Shelter

Copies of all emergency and business continuity plans and policies are available on the H:Drive or on the On-call MS Teams channel.

6.4 BCP Contents

All BCPs will follow an approved template and include the name of the service on the cover. The 'intelligence' section will describe the service's location(s), operating hours, names and contact details of the service management hierarchy and the critical functions provided by the service.

Each BCP contains action cards specific to the service to address each of the following risks in line with the International Standard ISO 22301:

- Loss of staff.
- Loss of premises/facilities.
- Loss of IT systems.
- Loss of communications systems.
- Loss of supplies.
- Loss of fuel or travel issues.

If the service has any other systems or equipment that is vital to the continued delivery of their critical functions then additional action cards for those aspects are also to be included in the BCP.

Contingencies to address the impact of each risk should be included in the action cards contained within the service BCP. It is the responsibility of the BCP Author to ensure that those contingencies remain relevant to the service and its functions.

Full contact details of any essential suppliers/contractors/service providers should include: email, landline telephone, mobile telephone and full address with postcodes.

Contact details contained within each BCP should be those used in relation to work duties only and listed in the order of preference that they should be used. Absolutely no personal contact details should be included in the BCP (see section 6.6 for staff contact details).

6.5 Business Impact Assessment (BIA)

BCP Authors must assess the impact of the risks at 6.4 on their service critical functions for a period of up to one day, one week and over one week. The impact of disruption may be None, Minor, Moderate, Major or Catastrophic. The impact assessments should also include timescales on how long any loss could be endured before becoming unrecoverable (ie Maximum Tolerable Period of Disruption). Additionally, the BIA should highlight any priority for recovery of service and show the Recovery Time Objective (RTO) to enable business functionality to be restored without an unacceptable break in continuity of service delivery.

The EPRR Manager can provide assistance to BCP Authors on completion of the BIA as part of their annual review.

6.6 Staff Contact Details

In order to meet GDPR and Information Governance requirements contact details for all service staff should be recorded separately from the BCP itself. This is because the BCP, once published, will be a publicly available document and therefore must not contain personal details for staff members.

6.7 Exercise and Review

Service BCP exercises are held annually and aligned with the principles of ISO 22301 to uphold and validate BCMS requirements. Exercises will be conducted in conjunction with the EPRR Manager to ensure consistency across the entire Trust. These exercises will be designed to test the BCP operational functionality, to raise awareness and confidence of individual staff members, and to assess further training requirements. They will also provide insight as to how local and Trust-wide contingency plans inter-link to achieve an integrated response in the management and recovery of untoward events.

The outcomes and any suggested improvement actions from each BCP exercise will be reported to Service Managers/Leads and their respective Senior Leadership Team representative. The service will debrief\provide feedback on the exercise and ensure updates on actions are completed by the relevant BCP Author in collaboration with the Service Manager. Any corrective or improvement actions will be reviewed by the Trust Learning and Exercising Group prior to completion.

The Trust Learning and Exercising Group holds responsibility for monitoring any improvement actions resulting from exercises or live incidents until they are satisfactorily completed. The Group chair will then provide assurance of BCMS effectiveness to the Trust Board through the Business Committee.

7 EQUALITY IMPACT ASSESSMENT

The Trust has no intent to discriminate and endeavours to develop and implement policies that meet the diverse needs of our workforce and the people we serve, ensuring that none are placed at a disadvantage over others. Our philosophy and commitment to care goes above and beyond our legal duty to enable us to provide high-quality services. Our Equality Analysis and Equality monitoring is a core service improvement tool which enables the organisation to address the needs of disadvantaged groups. The aim of Equality analysis is to remove or minimise disadvantages suffered by people because of their protected characteristics.

An impact assessment has been undertaken to consider the need and assess the impact of this Procedural Document and is evidenced at Appendix B.

8 TRAINING NEEDS ANALYSIS

Individual services are responsible for ensuring that all staff are aware of their service-level business continuity plan, its location and any roles/responsibilities they might have within the plan in the event a Business Continuity incident is declared.

Business Continuity Leads within services are responsible for the maintenance of the plan and for ensuring that all members of the team/service are aware of the actions and procedures to be followed in the event of a service disruption and where they can view the most up-to-date version of the plan. This should also be incorporated into induction when a new member of staff joins the team.

Each service has a named Business Continuity Lead whose details are available in the Business Continuity Plan. It is the responsibility of the Business Continuity Lead to ensure that all staff within their service have received appropriate training to enable them to follow the BCP in the event of an incident. This training may take a number of forms including:

- Sharing the plan and any roles and responsibilities at a team brief
- Specific training for individuals based on identified responsibilities detailed in the plan

It is important that staff fully understand the need for BCM as well as their role in response to any Emergency Preparedness Response and Recovery (EPRR) incident.

The Trust is committed to high quality targeted training and effective communication to support this procedural document and recognises that training capacity can fluctuate and will depend on resources available. As such, based on an assessment of capacity and risk, the training needs analysis will identify the high priority groups for training.

The introduction of this Business Continuity Management System will include a continuous process of refresher training on business continuity as local continuity plans are annually updated or as services are re-configured. Incident response training will be an integral part of On-call workshops and validated through a programme of validation exercises.

9 MONITORING COMPLIANCE AND EFFECTIVENESS

Criteria	Evidence identified to indicate compliance with policy	Method of monitoring ie how/where will this be gathered?	Frequency of Monitoring	Lead responsible for monitoring
Duties	Review of Business Continuity Policy, Incident Response Plan, Trust-wide Business Continuity and related emergency plans	Published Trust policies and plans via EPRR Team	Every 3 years	EPRR Manager
	Live record of all service BCPs	H:Drive \ On-call MS Teams Channel	Continuous	EPRR Team
	BCP exercise programme	Service BCP exercise report and action plan	Annually	BCP authors and EPRR Manager
	Consultation with members of the Learning and Exercising Group, share learning and best practice	Minutes of Learning & Exercising Group	Quarterly	Accountable Emergency Officer (as Chair)
	Compliance with NHS England EPRR Core Standards	EPRR Self Assessment	Annually	EPRR Manager
Reporting	Validation reports (exercises) and incident reports (real events)	All reports to Trust Learning & Exercising Group, and escalated to Senior Leadership Team if necessary	As required	EPRR Manager
	EPRR report	Trust Board	Annually	EPRR Manager

10 REFERENCES TO EXTERNAL DOCUMENTS

- The Civil Contingencies Act 2004
- The Health and Social Care Act 2012
- The Health and Care Act 2022
- National Occupational Standards (NOS) for Civil Contingencies – Skills for Justice
- PAS 2015: Framework for Health Services Resilience
- PAS 200: Crisis Management guidance and good practice

- ISO 22301 & ISO 22313: Business Continuity Management Systems – Requirements
- NHS England Emergency Preparedness Framework
- HM Government (2007) Data Protection and Sharing – Guidance for Emergency planners and Responders
- The Freedom of Information Act 2000
- The Data Protection Act 1998
- NHS England Core Standards for EPRR
- Local Health Resilience Partnership Risk Register

11 ASSOCIATED INTERNAL DOCUMENTATION

- Incident Response Plan
- Trust-wide Business Continuity Plan
- Other scenario-specific LCH response plans
- Locality & service level Business Continuity Plans for individual LCH service areas

12 DOCUMENT PRODUCTION DETAILS – APPENDIX A

Title:	Business Continuity Policy
Version:	Version 1.0 (initial version)
Name and Title of Responsible Director:	Sam Prince, Chief Operating Officer (Accountable Emergency Officer)
Name and Title of Responsible Deputy Director/ General Manager:	Peter Ainsworth, Operations Support Manager
Name and Title of Author:	Rebecca Todd
Title of Responsible Committee / Group (or Trust Board):	LCH Learning & Exercise Group Senior Leadership Team Business Committee Trust Board
Persons/Groups/Committees consulted:	External: Internal: Accountable Emergency Officer (AEO) Directors, Deputy Directors and General Managers Assistant General Managers and Heads of Service Learning & Exercising Group
Service User, Patient and Carer consultation:	None as not applicable to this policy.
Target Audience:	All Leeds Community Healthcare staff
Approved by:	Business Committee
Date Approved:	October 2024
Ratified by:	LCH Trust Board
Date Ratified:	*Insert the date of the meeting at which the Policy document was ratified for implementation in dd/mm/yyyy format, e.g. 12/04/2017.*
Date Issued:	August 2024
Review Date:	August 2027
Frequency of Review:	3 yearly or as required due to organisational or legislative changes
Copies available from:	H:Drive, On-call MS Teams Channel, EPRR Manager
Where is previous copy archived (if applicable):	Not applicable – initial version
Amendment Summary:	Nil – new document

Amendment detail:

Amendment number	Page	Subject
1		*Insert description of amendments made to the Policy document since its last review if required.*
2		*Insert description of amendments made to the Policy document since its last review if required.*
3		*Insert description of amendments made to the Policy document since its last review if required.*

APPENDIX B

Relevant National Occupational Standards for Civil Contingencies and Required Training Interventions

In June 2022 NHS England issued revised training requirement for NHS incident command staff and those who may support an incident. A formal training course – Principles of Health Command has been devised that will be standard across the NHS. This will be delivered to all three levels of command – Strategic, Tactical and Operational.

The three skills for justice competencies for incident command are:

SFJ CCA G1 Respond to emergencies at the strategic level	All those on Executive\2nd on call
SFJ CCA G2 Respond to emergencies at the tactical level	All those on 1st on call
SFJ CCA G3 Respond to emergencies at the operational level	Operational Managers

The new initiative also directs that support staff are included in EPRR training - the following roles are indicated in the NHS England document.

- Ward staff
- Specialist service staff
- Pharmacy
- Pathology
- Security
- Supplies
- Porters
- Administration
- Communications, including switchboard.
- Human Resources

The following tables are replicated from the NHS England document *Minimum Occupational Standards for Emergency Preparedness, Resilience and Response (EPRR) (Version 1.0 June 2022)*

Skills For justice NOS	Chief Executive Officer	Accountable Emergency Officer	Strategic Commander	Tactical Commander	Operational Commander	EPRR Specialist / Adviser	Business Continuity Lead	Comms Officer	Command Support Role	On Call staff	Loggist
SFJ CCA A1 Work in cooperation with other organisations	O	O	M	M	M	M	M	M	O	M	-
SFJ CCA A2 Share information with other organisations	O	O	M	M	M	M	O	M	O	M	
SFJ CCA A3 Manage information to support civil protection decision making	-	-	M	M	M	M	-	O	O	M	O
SFJ CCA B1 Anticipate and assess the risk of emergencies	-	O	M	M	M	M	-	-	-	-	-
SFJ CCA C1 Develop, maintain and evaluate emergency plans and arrangements			O	O		M			O		
SFJ CCA D1 Develop, maintain and evaluate business continuity plans and arrangements		O	O	O	O	M	M				

Skills For justice NOS	Chief Executive Officer	Accountable Emergency Officer	Strategic Commander	Tactical Commander	Operational Commander	EPRR Specialist / Adviser	Business Continuity Lead	Comms Officer	Command Support Role	On Call staff	Loggist
SFJ CCA D2 Promote business continuity management		M				M	M	O			
SFJ CCA E1 Create exercises to practice or validate emergency or business continuity arrangements						M	M				
SFJ CCA E2 Direct and facilitate exercises to practice or validate emergency or business continuity arrangements						M					
SFJ CCA E3 Conduct debriefing after an emergency, exercise or other activity		O	M	M	M	M	M		O	O	
SFJ CCA F1 Raise awareness of the risk, potential impact and arrangements in place for emergencies			O	O		M	M	M			
SFJ CCA F2 Warn, inform and advise the community in the event of emergencies	O		M	O	O	M		M			

Skills For justice NOS	Chief Executive Officer	Accountable Emergency Officer	Strategic Commander	Tactical Commander	Operational Commander	EPRR Specialist / Adviser	Business Continuity Lead	Comms Officer	Command Support Role	On Call staff	Loggist
SFJ CCA G1 Respond to emergencies at the strategic level	O	O	M			M				M	
SFJ CCA G2 Respond to emergencies at the tactical level				M		M				M	
SFJ CCA G3 Respond to emergencies at the operational level					M	M	O			M	
SFJ CCA G4 Address the needs of individuals during the initial response to emergencies			O	M	O	M			O	M	
SFJ CCA H1 Provide on-going support to meet the needs of individuals affected by emergencies			M	M	O	M				O	
SFJ CCA H2 Manage community recovery from emergencies	M	O	M	O	O	M				O	

Key: O – optional for the role (to be developed through CPD)

M – Mandatory for the role

APPENDIX C

Definitions	
BC	**Business Continuity** Strategic and tactical capability of the organisation to plan for and respond to incidents and business disruptions in order to maintain business operations at an acceptable predefined level.
BCM	**Business Continuity Management** Holistic management process that provides a framework for building organisation resilience with the capability of an effective response that safeguards the interests of its key stakeholders and reputation.
BCMS	**Business Continuity Management System (BCMS)** Is a management system that establishes, implements, operates, monitors, reviews, maintains and improve business continuity.
BCP	**Business Continuity Plan** Provides documented procedures that guide the organisation to respond, recover, resume and restore to a pre-defined level of operation following disruption.
EPRR	**Emergency Preparedness Response and Resilience** The process by which NHS organisations maintain a robust capability to plan for and respond to incidents or emergencies that could impact on health or services to patients.
ISO	**International Standardisation for Organisation** ISO certification certifies that a management system has all the requirements for standardisation and quality assurance, ISO is an independent non-governmental, international organisation that develops standards to ensure the quality, safety and efficiencies of services and systems.

APPENDIX D

EQUALITY IMPACT ASSESSMENT (EQIA)

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. Consideration must be given to any potential impacts that the application of this policy/procedure might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender, and sexual orientation).

Declaration: The potential impacts on the application of this policy/procedure have been fully considered for all nine protected groups. Through this process I ~~have~~ / have not identified any potential negative impacts for any of the nine protected groups.

Print name:

Job title:

Date:

If any potential negative impacts are identified the Diversity Team must be contacted for advice and guidance: email:

*Delete as appropriate

PLAN CHECKLIST (NOT AN APPENDIX AND WILL BE REMOVED FROM FINAL VERSION OF POLICY WHEN ISSUED)

To be completed and attached to any draft version of a procedural document when submitted to the appropriate group/committee to support its consideration and approval/ratification of the procedural document.

This checklist is part of the working papers.

Title of document being newly created / reviewed:		Yes / No
1.	**Title**	
	Is the title clear and unambiguous?	*Yes*
	Is the procedural document in the correct format and style?	*Yes*
2.	**Development Process**	
	Is there evidence of reasonable attempts to ensure relevant expertise has been used?	*Yes*
3.	**Content**	
	Is the Purpose of the document clear?	*Yes*
4.	**Approval**	
	Does the document identify which committee/group will approve it?	*Yes*
5.	**Equality Impact Assessment**	
	Has the declaration been completed?	*Yes*
6.	**Review Date**	
	Is the review date identified?	*Yes*
	Is the frequency of review identified and acceptable?	*Yes*
7.	**Overall Responsibility for the Document**	
	Is it clear who will be responsible for co-ordinating the dissemination, implementation, and review of the document?	*Yes*

Author Approval			
The Author should complete, sign and date this Policy Document Compliance Checklist to show they have applied it.			
Author	Rebecca Todd, EPRR Manager	Date	October 2024
Signature	Signed electronically		

Appendix E

NHS
Leeds Community Healthcare
NHS Trust

Title: *enter service/team name*

Business Impact Analysis (BIA)

&

Risk Assessment

Directorate/Business Unit:	
BIA Owner (Head of Service?):	
BIA Contact (Service Manager?):	
Date Completed:	
Document Version and Status:	
Author:	
Sign-Off/Approval of Completed BIA: (Head of Service/Service Manager)	*Enter signature/name/date*

Use of this template

The Business Impact Analysis template provides a documented evaluation process for determining continuity and recovery priorities, objectives and targets for your service. This stage in the process will provide the basis for your service BCP.

A Business Impact Analysis must be completed prior to developing a Business Continuity Plan.

Please note: This template is designed for all service types, multiple service areas or individual services. There may be sections which are not applicable to all services, in these instances ensure N/A is entered as appropriate. Managers should determine and agree the scope of the BIA prior to progressing.

For further information, guidance or queries relating to Business Continuity Management should be made to the Emergency Planning & Business Continuity Manager:

lcht.emergencyplanning@nhs.net

1. Service Details

The table below should be completed to include the general details of the service and its function.

Name of Service/Business Unit/Team:
•
Directorate/Business Unit:
•
Number of Staff within Service:
•
Who are the main stakeholders – partner organisations, patients, service users, staff, the public:
•
Main Functions of the Service:
•

2. Service Criticality Assessment

All services are important; however criticality is not based on importance, but on a combination of the potential impact on the service should a loss, interruption or disruption occur **and** recovery timescales which together reflect criticality i.e. the services where disruption would have the greatest impact in the shortest timescale.

The following table should be completed by a manager or officer responsible for, or with a good understanding of the service to be assessed. Enter Yes or No depending on your response to the questions. When answering, consider the wider impact of the loss, interruption or disruption to the service would have on service users, customers, the community, partners, other services etc.

Question: If the service or function was disrupted…	**Yes**	**No**
Would there be an impact on public health Consider the impact on the health, safety and wellbeing of service users		
Would there be an impact on staff welfare Consider the impact on the health and welfare of LCH or contracted staff		
Would there be an impact on security Consider the impact on the safety, accessibility and usability of premises		
Would there be a financial impact Consider payment of staff and suppliers, and fulfilling contractual payments		
Would there be a reputational impact Consider the impact on credibility and public perception of the service and media interest		

If disrupted, how quickly would it need to be recovered	**Within 0-24hrs**	**Within 24-48hrs**	**Within 48hrs-1wk**	**Within 1wk-1month**

3. Establishing Key Requirements

The purpose of establishing key requirements that support delivery of the service is to help understand the impact that a loss, interruption or disruption to such requirements might have on the service and to inform development of appropriate continuity arrangements for each key requirement.

*The following table should be completed by a manager or officer responsible for, or with a good understanding of the service. Enter the key requirements focusing on those that are **essential** in supporting the delivery of the service.*

Requirements	Key Requirements (essential to maintain service delivery)
People List the number of staff normally required to run the service business as usual. The list should include managerial, clinical and non-clinical staff and any specific or specialist roles	•
Buildings/Premises/Work Environment List the buildings currently occupied by the service. The list should also include all work environments occupied by staff within this service eg home working, mobile working, patient homes	•
Information & Communication Technology List the key ICT requirements to support the service including telephony.	•
Information & Data List the essential electronic or paper-based information or data	•
Equipment & Consumables List key equipment and consumables, including PPE and specific medical equipment	•
Key Suppliers & Partners List the key suppliers and partners that support the service internally and externally.	•
Transportation List any vehicles used, including use of personal vehicles, to deliver the service	•

4. Risk Assessment

A risk assessment is a process of estimating the likelihood of an incident occurring and how severe the consequences would be. It will identify, analyse and evaluate the risk or threat of disruptive incidents to the service and its key requirements (as identified in Section 3 above). This will inform decision-making about effective actions for 'managing risks' i.e. avoiding, removing, reducing, improving, and controlling risks.

*Each risk should be individually assessed using the risk matrix chart below and a rating for each risk identified (**L**ow, **M**edium, **H**igh or **V**ery **H**igh). Every risk/threat calculated as High or Very High should be addressed in the Business Continuity Plan. The impact of risks will vary from service to service. There are a number of risks which would have a High or Very High rating for every service and should be identified in each service BCP as a minimum. These are:*

- Loss of staff\staff shortage
- Loss of Buildings/Premises/Work Environment
- Loss of ICT Technology - loss of access to data\information
- Supply chain failure
- Utility Failure
- Severe Weather
- Fuel Shortage

Probability
1. Rare
2. Unlikely
3. Possible
4. Probable
5. Almost Certain

Impact
1. Insignificant
2. Minor
3. Moderate
4. Major
5. Highly Significant

IMPACT					
5	*H*	*H*	*VH*	*VH*	*VH*
4	*H*	*H*	*H*	*VH*	*VH*
3	*M*	*M*	*H*	*H*	*H*
2	*L*	*L*	*M*	*M*	*M*
1	*L*	*L*	*L*	*L*	*L*
	1	*2*	*3*	*4*	*5*

PROBABILITY

For the risks identified as requiring treatment (ie High or Very High) the service should consider proactive measures that can be taken or controls which can be put in place in order to reduce the likelihood of disruption, shorten the period of disruption, and/or limit the impact of the disruption to the service and its key requirements.

Using the following table, list the threats that could cause disruption to the service. Include the potential impact and Risk Rating. Consider and enter the risk treatments or controls that can be taken.

Ref	Risk/Threat & Potential Impact	Rating (L,M,H,VH)	Risk Treatment\Mitigating Actions (actions to reduce or control the risk)
001	Loss of staff\staff shortage		•
002	Loss of Buildings\premises\work environment		•
003	Loss of ICT Technology - loss of access to data\information		•
004	Supply chain failure		•
005	Severe Weather		•
006	Fuel Shortage		•
007	Additional Service Specific Risks		•
008			•

5. Approval & Next Steps

The manager responsible for the service should approve the completed BIA to ensure that the content is appropriate and a true reflection of the service. The output from the BIA and Risk Assessment can now be used to inform the development of a Business Continuity Plan to:

- Understand the C1 elements of the Trust's services
- Protect the most critical functions\elements
- Stabilise, continue, resume and recover the critical elements of services/functions
- Understand any key requirements, supporting resources and dependencies\inter-dependencies
- Mitigate, respond to and manage any impact on service delivery.

Appendix F

NHS
Leeds Community Healthcare
NHS Trust

Title: *enter service/team name*

Business Continuity Plan (BCP)

Directorate/Business Unit:	*Enter directorate/business unit name*
BCP Owner (Head of Service?):	*Enter name* *Office telephone number* *Mobile number* *Email address*
BCP Contact (Service Manager?):	*Enter name* *Office telephone number* *Mobile number* *Email address*
Date Completed:	*Enter date*

Document Version and Status:	*Enter v0.00* *Draft or Final*
Author:	*Enter name* *Office telephone number* *Mobile number* *Email address*
Date of Next Review:	*Enter date*

Distribution List

Managers and staff issued with a hard copy of the BCP need to be listed on the following table. This is to ensure that when changes to the electronic version are made, hard/paper copies are produced and re-issued to ensure all managers and staff have the latest version to hand.

Name	Electronic/Hard Copy	Position

Change History

Each time a change is made to this document the version number should be revised (ie v1.0), along with the date the change was made, the name of the person making the change, a brief description of the change and the location.

Version	Date	Author	Location and Description of Change

Plan Training

Each service is responsible for the training of staff in the implementation of the plan ensuring that all members of the team/service are aware of the actions and procedures to be followed in the event of service disruption and where the latest version of the plan is located.

Staff/Team	Trained by	Date

Exercise History

Each service is responsible for ensuring that the plan is fit for purpose through regular testing, exercising and verification of the procedures included within the plan.

Exercise Type (eg live, desktop)	Date

BCP Sign-Off

The Plan Owner (Head of Service) and Service Manager should sign-off the completed template to confirm that the contents of the BCP are appropriate to meet the needs of the service.

Sign-Off of the Business Continuity Plan	
Plan Owner (HoS)	*Enter signature/date*
Service Manager	*Enter signature/date*

Date of Next Review/Test/Exercise

The purpose of review and exercise is to ensure that the service's business continuity arrangements, competence and capability remains effective, fit for purpose and up to date. All changes impacting the service need to be considered with regard to business continuity arrangements as the changes may trigger revisions to the BCP. The service is responsible for planning, arranging and performing testing and exercising of this BCP. As a minimum, it is recommended that services undertake a complete review of the BCP at least annually or when there is significant change in premises, personnel, process or organisational structure and when an exercise or incident highlights deficiencies.

Date of Next Review/Test/Exercise	
Date due	*Enter date*
Person responsible	*Enter name, position, and contact details*

Use of this template

This BCP template is designed to support services in developing continuity arrangements in order to manage and respond to a disruptive incident and maintain key critical functions and services as identified through the completion of the Business Impact Assessment (BIA).

A Business Impact Assessment/Risk Assessment should be completed prior to developing a BCP.

This template is designed for all service types/functions. There may be sections which are not applicable to all services, in these instances please ensure N/A is entered in order to demonstrate that the particular element/scenario had been considered.

For further information, guidance or queries relating to Business Continuity Management please contact the Emergency Planning & Business Continuity Manager:

lcht.emergencyplanning@nhs.net

An electronic copy of the completed/updated BCP should be sent to the Emergency Planning Manager at the email address above and a copy will be retained in the On-call Folder on the LCH H:Drive and uploaded to MS Teams for secure storage.

1.INTRODUCTION

Upon completion of the Business Impact Assessment stage of the Business Continuity process a number of scenarios have been determined as being 'High' or 'Very High' risks for this service. This document contains the information required, and actions to be taken, to manage and mitigate the impact and effect of these risks.

1.1 PURPOSE AND SCOPE

The purpose and scope of the BCP should be brief and clearly defined so that it can be understood by those who will put the plan into action ie whether the plan covers individual or multiple services and functions. The purpose and scope should include a brief description of the service(s) to be maintained and any elements of service provision not included and why.

1.2 Major incidents

A BCP is not designed to replace the Trust's other EPRR planning documents such as:

1.3 Incident Response and Incident specific plans

The Trust has developed policies and plans for the key incidents that may affect business continuity:

- Emergency Preparedness, Resilience and Response Policy & Business Continuity Management Process
- Adverse Weather Plan
- Cyber Incident Response Plan
- Fuel Disruption Plan
- CBRN (Chemical, Biological, Radiological and Nuclear) Plan
- Incident Response Plan
- New & Emerging Pandemic Plan
- Infection Prevention Control Policy
- Policy for Management of Communicable Disease Outbreaks in Community Care Settings
- Mass Treatment and Countermeasures
- Evacuation & Shelter
- Lockdown
- Security Plan

These plans should complement the BCP wherever it is appropriate to do so. Copies can be obtained from the EPRR Manager or General Managers.

1.4 Objectives

The objective(s) of a BCP can be strategic, tactical or operational. All NHS organisations have a duty to put in place continuity arrangements to ensure they can maintain continuity of key services in the face of disruption from identified local risks and minimise the impact of disruption upon the local community through planning effectively for the continuance and/or recovery of services during or following an emergency or disruption.

2 Activation

The process by which a BCP is invoked, including clear criteria to justify activation, needs to be documented and allow the BCP to be invoked in the shortest possible time following an incident or a disruption to service delivery. The description of the process should be brief and quickly enable confirmation of the nature and extent of the disruption, the control and containment of the situation, whilst supporting timely communication with those required to provide a response.

2.1 Activation Criteria

The Business Impact Assessment (BIA) identified the following risks or threats that, if realised, would form the criteria for activation of the Business Continuity Plan: *The risks listed below must be addressed in every service BCP, there may be more risks/threats to add which are applicable to individual services, depending upon the results of the BIA*

- Capacity and demand issues including staff shortages (pandemic issues/ severe weather/ EU Exit/ industrial action/ mutual support to other services/ organisations) or excessive demand.
- Loss of Building/Premises/Work Environment
- Loss of Information and Communications Technology (including telephony)
- Utility Failure
- Severe Weather
- Fuel Shortage
- Supply issues
- Lone working/ violence and aggression against staff

2.2 Activation Procedure

In the event of the activation of this plan, the manager or officer responsible for activation should take the following actions:

- Access or have sight of the BCP and associated appendices/plans
- Establish the impact of the incident on the service and initiate the recording of entries and assignment of actions into the Incident Log
- Continually assess the impact of the incident on the service (see Joint Decision Model)
- Contact key personnel as appropriate, advising them of the incident and requesting any support required
- Update the Head of Service and other staff/managers as appropriate if the disruption is likely to have an impact on service delivery

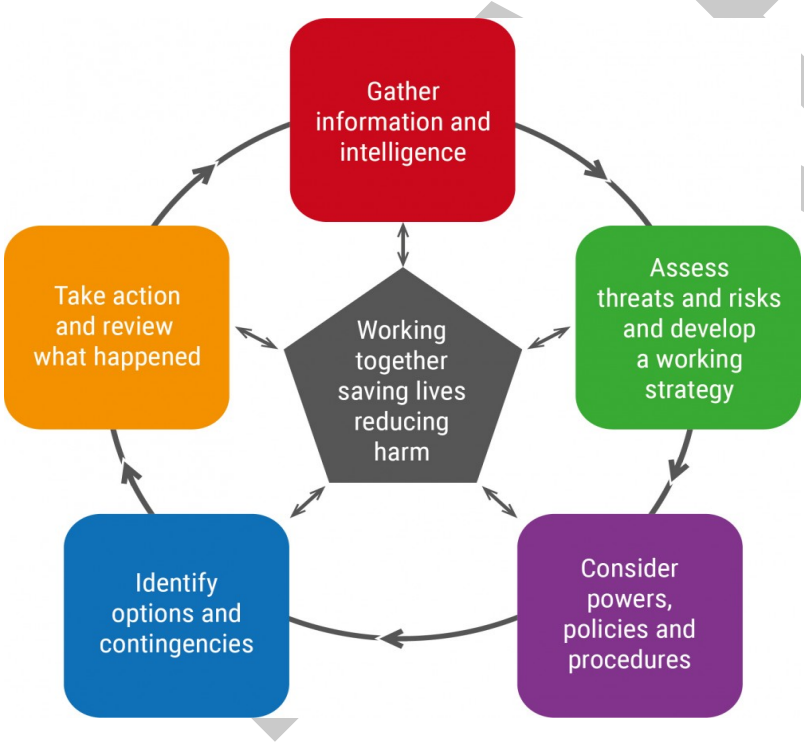
- Monitor the situation and provide regular status reports to the Head of Service
- Take control of the incident and agree the functions and workload to be prioritised and recovered first
- Oversee the response or recovery effort until the service is fully recovered

If required, initiate escalation of the incident via the Head of Service - in hours to the Trust Leadership, out of hours the On-Call Manager.

2.3 Decision Making \ Working Together

Joint Emergency Service Interoperability Programme (JESIP) improving the way we work together when responding to incidents to get better at saving lives and reducing harm

JESIP Principles
Communicate, co-ordinate, jointly understand risk, shared situational awareness, capture and share learning (debrief)



Joint Decision Model

Continually revisit the cycle throughout the incident and as\when new information becomes available or the situation changes

3 Procedures for Responding to and Recovering from a Disruptive Incident

The following sections outline the procedures for responding to a disruptive incident and how the service will maintain and/or recover its activities and critical functions within the recovery timescales identified in the Business Impact Assessment and in line with any potential impact of the risks/threats highlighted in section 2.1 above.

3.1 Capacity and Demand issues

There are a number of incidents which could result in the loss of staff. These include:

- Sickness (inc Pandemic diseases such as flu or Covid)
- Loss of staff due to national policy decisions such as immigration/ EU Exit etc
- Requests from other services/ organisation for mutual support
- Recruitment issues of key staff
- Severe Weather
- Industrial Action

Excessive demand can also be a reason why services might struggle to deliver aspects of the service.

All services have established processes for dealing with any capacity and demand issue which may affect service delivery, including:

- Daily reporting against Operational Performance Escalation Levels (OPEL) – see Appendix 4 for definitions
- Classification of service elements in to Critical 1, Critical 2, Critical 3 categories
- Creation of a log of skills, knowledge and experience required to maintain critical services
- Action list linked to OPEL triggers
- Optional use of mutual aid support (buddying or pathway agreements with other organisations)
- Decision modelling to rank the options of responding to a significant capacity/ demand issue

Example

The table below shows an example each service will need to populate to reflect their critical services\elements

C1	C2	C3
Suspension of this element of the service would result in immediate risk to the health of a significant number of patients	Suspension of this element of the service would result in immediate risk to the health of a smaller number of patients	Suspension of this element of the service would not result in immediate risk to the health of patients
This element of the service is critical to maintaining patient flow	Elements of the service are critical to maintaining patient flow	This element of the service is not critical to maintaining patient flow
This element of the service is critical to maintaining core business functions	Elements of the service are critical to maintaining core business functions	This element of the service is not critical to maintaining core business functions

Service to adapt following tables as required

Procedures for responding to and recovering from Staff Shortages			
No	**Action Required**	**Target Time (hours or days)**	**Responsibility**
1			
2			
3			
4			
5			
6			
7			
8			

Covid Action List (an example)

OPEL Level	Internal Action
OPEL 1	**reduce referrals** **reduce demand** **create internal capacity**
	improve internal flow
	increase outflow **greater coordination**
	Consider support available internally to support any services under pressure
	Identify what activity can be brought forward; maintain caseload review
	Monitor current situation
OPEL 2	**reduce referrals** **reduce demand** **create internal capacity**
	improve internal flow
	increase outflow
	greater coordination
	Cancel routine work (C3) in line with prepared decision modelling where required to maintain capacity for essential (C2 and C3) work

	Support requested from Buddy services
	Contact Class for support
	Consider cancelling all non-essential training & meetings
	If required, request for overtime, extra hours & volunteers to rearrange annual leave to provide extra capacity
	maintain caseload review
	All appropriate actions at Level 1 completed
	Daily sit-rep reporting of position by affected services/ teams
	Bronze service-level review as required to manage situation and take action to avoid further escalation - at Head of Service Level
OPEL 3	**reduce referrals** **reduce new cases** **create internal capacity** **increase outflow** **improve internal flow** **greater coordination**
	All appropriate actions at Level 2 completed
	Consider support from alternative services across all BUs to support service delivery and ensure all essential activity can be carried out
	Request for overtime, extra hours & volunteers to rearrange annual leave to provide extra capacity
	Where appropriate, introduce measures to boost and maintain staff morale (e.g. lunches, massage therapy, comms)
	Defer statutory and mandatory training

	Defer appraisals and 1:1s unless high risk
	Where appropriate, cancel all meetings not immediately required for the provision of safe services
	Suspend C2 and C3 services in line with prepared decision modelling
	maintain caseload review; target available senior capacity to ensure maximum flow
	Bronze business unit-level review as required to manage situation and take action to avoid further escalation - at General Manager Level
	Continue daily sit-rep submission for affected services
OPEL 3 Escalating	**reduce referrals**
	reduce new cases
	create internal capacity
	improve internal flow
	increase outflow
	greater coordination
	All appropriate actions at Level 3 completed
	Consider only accepting referrals from priority sources focussed on C1 services
	Contact Redeployment team for support
	Use of other staff within LCH (not including core services) with correct skill set to meet presenting need where appropriate
	All colleagues with a clinical registration to be available to support essential services and critical functions if required
	Inform commissioners of current issues and ask for support – initiate partner support where agreements are in place
	Suspend all appraisals and training.

	Major Incident status on standby
	Daily Silver Command and Control meetings - led at Director level
OPEL 4	**reduce referrals** **reduce new cases** **create internal capacity** **improve internal flow** **increase outflow** **greater coordination**
	All appropriate actions at Level 3 Escalating completed
	Declare Major Incident and establish Gold Command and Control – daily meetings chaired by Chief Executive. Exec Team and General Managers to attend
	Activate MIP
	Establish Recovery Team
	Establish Emergency Management Team to manage situation and coordinate actions
	Contact all partners to provide support for essential service delivery

Mutual Aid requirements (optional)

OPEL level	Support from	Agreed actions/ support
OPEL 2		
OPEL 3		
OPEL 3 Escalating		
OPEL 4		

If service decision modelling has been undertaken, include a summary of the actions/ priority actions here.

5.1. Loss of Buildings/Premises/Work Environment

A disruptive incident could cause a partial or complete loss of a building or working environment. The information captured in the BIA, and in Appendix 1 of this plan, will have identified the current buildings and locations used by this service. Consideration needs to be given to identifying alternative locations\building options to ensure that the service can be transferred and maintained in the event of an emergency or incident.

Recovery Locations	
'Walk to' Alternative Site	**'Remote' Alternative Site**
Provide details of alternative premises which can be utilised by staff within walking distance of original premises *Include name, address and contact number or site*	*Provide details of all other appropriate alternative premises which can be utilised by staff* *Include name, address and contact number of site*

Procedures for responding to and recovering from Loss of Building			
No	**Action Required**	**Target Time (hours or days)**	**Responsibility**
1			
2			
3			
4			
5			
6			

Other Considerations/Dependencies/Requirements

5.2. Loss of ICT\Technology

Some services may be heavily dependent upon ICT\ technology to deliver their services. The information captured in the BIA will have identified the technology that is required to support the service. Consideration needs to be given to the impact that the unavailability of ICT\technology would have on the service if the incident lasts for a number of days.

The following table should be completed to identify and record the immediate, urgent, routine and pending timescales for recovery of ICT technology (for example, landline telephony, mobile telephony, SystemOne, NHS Mail, access to drives)

ICT Application, Hardware/Software, Telecoms			
Immediate Recovery within 0-24 hrs	**Urgent** Recovery within 24-48 hrs	**Routine** Recovery within 48-1 week	**Pending** 1 week – 1 month+

Procedures for responding to and recovering from Loss of ICT Technology			
No	**Action Required**	**Target Time (hours or days)**	**Responsibility**
1			
2			
3			
4			
5			
6			

Other Considerations/Dependencies/Requirements

5.3. Utility Failure

Failure of one or more of the utilities (gas, water, electricity) at any given building/location may impact on service delivery. There may be an increased impact on those services responsible for providing patient care from a fixed base. Consideration should be given to the response/action required to manage the impact of such an incident should it last for a significant length of time.

The table below should be completed with details of all premises used by the service, along with the relevant estates management company who can be contacted in the event of a utility failure.

Service Site	Estate Management Company

Procedures for responding to and recovering from Utility Failure			
No	**Action Required**	**Target Time (hours or days)**	**Responsibility**
1			
2			
3			
4			
5			
6			

Other Considerations/Dependencies/Requirements

5.4. Severe Weather

Periods of severe weather have the potential to cause disruption to services in a number of ways including staff shortages, travel difficulties (impacting on staff travel to and from work), staff conducting patient visits, and increased demand. Business continuity plans should be developed in line with the Trust's Business Continuity Arrangements for Winter document which provides details of a number of contingency plans which can be adopted by services to mitigate the effects, and the Staff Special Leave Policy.

Procedures for responding to and recovering from Severe Weather			
No	**Action Required**	**Target Time (hours or days)**	**Responsibility**
1			
2			
3			
4			
5			
6			

Other Considerations/Dependencies/Requirements

5.5. Supply issues

Service delivery can be put at risk if key supplies are not available, ie PPE, drugs, dressings etc. To mitigate this risk all services should develop minimum stock levels for their key supplies. They should also identify alternative products/suppliers for the essential supplies the service is reliant upon.

Disruption to supplies can happen at any time, but specifically as a result of transport disputes (industrial action), trade issues (EU Exit) or supply issues (raw material shortages/ distributer breakdown).

Services should develop plans to ensure that actions are put in place to attempt to secure additional supplies, and to ration existing supplied.

Ensure that, as a minimum, the critical functions of a service are maintained.

Procedures for responding to and recovering from Supply Issue			
No	**Action Required**	**Target Time (hours or days)**	**Responsibility**
1			
2			
3			
4			
5			
6			

Other Considerations/Dependencies/Requirements

5.6. Fuel Shortage

A shortage of road fuel, whether local or national, could have an adverse impact on LCH service delivery, it's staff and patients. This could result in the inability of a service to maintain normal levels of service delivery. The severity of the impact will be influenced by its cause, geographical extent and duration. A fuel shortage could result in potential impacts for a number of stakeholders including staff, patients, support services (eg LCES) and suppliers. Consideration should be given to what actions can be taken to ensure that, as a minimum, the critical functions of a service can be maintained.

Procedures for responding to and recovering from Fuel Shortage			
No	**Action Required**	**Target Time (hours or days)**	**Responsibility**
1			
2			
3			
4			
5			
6			

Other Considerations/Dependencies/Requirements

5.7. Lone working, violence and aggression

Services are required to complete a risk assessment of the key risks affecting the service including the safety and security of staff whilst performing their duties. These risks may include the working environment, lone working, or the challenges of a certain client\patient group.

Mitigating plans should be put in place to reduce these risks as much as possible, however despite these plans, occasionally a member of staff may find themselves in an unsafe situation which may require a service response to ensure staff safety and maintain business continuity.

The use of the PeopleSafe App for those lone working in the community with an LCH mobile is now mandatory. All lone workers are required to check in at the start of their shift (or high-risk activity), log the duration of their shift/activity and then check out at the end of the shift/activity. In the event a staff member doesn't check out at the end of their shift/activity an escalation process will begin. This may result in the Alarm Receiving Centre at PeopleSafe contacting the on-call manager to identify that a member of staff has not checked out after their last shift.

All services and teams should have an individual escalation process and their own SOP on the use of PeopleSafe. Service level Business Continuity Plans must also be updated accordingly. PeopleSafe hold personal details and next of kin information for every staff member using the app. They can also see the live GPS location of staff checked into the app.
NB - It is the responsibility of the member of staff using the App to ensure PeopleSafe have their most up to date contact numbers and next of kin details.

Staff are provided with training on how to use the app and the available functions by PeopleSafe. This is a prerequisite to using the app and a mandatory requirement for all roles assessed as high risk.

Please note:

- PeopleSafe do not routinely contact the Police as part of their escalation, the decision to involve the Police will generally fall to the LCH on call manager.
- PeopleSafe will only contact the Police if they believe a member of staff is in danger.
- The contact number for the PeopleSafe Alarm Receiving Centre is: 0203 7500998. Staff have been requested to save this number as a contact on their mobile phone.

5.8. Scenario

There may be additional risks/threats in addition to those already addressed above, or as identified during the Risk Assessment phase. Services should ensure that procedures for each individual risk are addressed here.

No	Additional Risk\Threat	Mitigating Actions
1.		
2.		
3.		
4.		
5.		

6. Appendix 1 – Service Site details

The table below should be completed to include details of all sites/premises used by the service and its staff.

Service/Staff Locations	
Site 1 *Include name of premises, address and contact telephone number*	**Site 2** *Include name of premises, address and contact telephone number*
Site 3 *Include name of premises, address and contact telephone number*	**Site 4** *Include name of premises, address and contact telephone number*
Site 5 *Include name of premises, address and contact telephone number*	**Site 6** *Include name of premises, address and contact telephone number*

7. Appendix 2 – Service Staff Details

The table below should be completed to include the contact details of all essential staff within the service. A decision may be made to include all staff within the service to ensure that, in the event of a business continuity incident, all staff can be contacted.

This section must be frequently reviewed and details updated as required.

Name	Title	Base	Contact Number

8. Appendix 3 – Key Contacts

An up to date and comprehensive contact list is essential for responding to and managing an emergency or disruption and to ensure the overall effectiveness of the BCP. This list should include details of anyone who would play a key role in responding to the incident, along with those who would need to be informed such as partner organisations.

Name or Organisation	Contact Number	Email Address
LCH On-Call Manager	0845 265 7599	n/a
IT Helpdesk	0113 8433133	computer.helpdesk@nhs.net

9. Appendix 4 – OPEL levels

OPEL Local health and Social Care System NHS England Definitions

The Trust has adopted the National OPEL escalation framework. NHS providers across West Yorkshire have adopted OPEL which enables partners to better understand the level of operational demand across the local health and social care system.

Operational Pressure Escalation Levels		
OPEL 1	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.	Business as usual, no support or intervention required (overview at Local A&E Delivery Board)
OPEL 2	The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS England and NHS Improvement colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.	Operational pressures being managed at a local A&E Delivery Board with awareness or support as appropriate at DCOs/DIDs level.
OPEL 3	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms	Increased pressures, DCOs/DIDs actively involved as appropriate according to local arrangements and requirements. Regional teams aware of situation and involved where required. National team notified if necessary
OPEL 4	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.	DCOs/DIDs actively involved in support/intervening to ensure escalation can be stood down as quickly as possible, with regional involvement and support from National teams as appropriate

LCH OPEL Criteria/indicators

All services (clinical and some non-clinical) will report their operational performance escalation levels on a daily basis (Monday to Friday). This will be captured by the Trust's Business Intelligence team and the individual service scores will be extrapolated into an overall Trust OPEL level that is shared daily on a citywide basis (see Appendix 1 for an example).

The Business intelligence team will also circulate the summary OPEL performance report on a daily basis on a Business unit/ Departmental level.

Escalation within the service

The definitions of OPEL levels are as follows. LCH has added an additional level in to the national system (Opel 3e), to reflect the range of severity between Opel 3 and 4.

	OPEL Level				
Trigger	**OPEL 1**	**OPEL 2**	**OPEL 3**	**OPEL 3 esc.**	**OPEL 4**
OPEL Level Description	All services are running a normal service	There are some pressures within services. These are being managed through routine business continuity arrangements.	There are pressures within service. These are being managed through additional internal business continuity and mutual aid arrangements	There are significant pressures within services. Internal and external mutual aid actions in place.	To be determined depending on the situation

10. Incident Log

This Incident Log should be used to record key information, especially in regard to decisions made during any disruption or emergency. The log can then be used to assess how effective an incident response has been and to highlight any gaps in process or amendments required to the plan.

Incident: *provide a brief outline of the incident*			
Date	**Time**	**Information/Decisions/Action**	**Owner**

Appendix 6

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

FINAL ADVERSE WEATHER PLAN

1. This document is part of a suite of Emergency Preparedness, Resilience and Response (EPRR) plans which have been developed to provide the framework by which Leeds Community Healthcare NHS Trust will respond to specific incidents\events.
2. This document must be read and applied in conjunction with the LCH Incident Response Plan, incident specific plans and service level Business Continuity Plans as appropriate.
3. An electronic copy of the latest version of this document is available in the On-call channel on MS Teams and the Trust H:Drive.
4. All On-call managers are asked to familiarise themselves with the contents of the LCH emergency documentation.
5. In the event of an emergency, to contact the On-Call Manager please ring:

0845 2657599

Please note: All approved and ratified policies and procedures remain in place until there is notification of an amended policy or procedure by the EPRR Team.

Document details:	Leeds Community Healthcare NHS Trust Adverse Weather Plan
Version:	Final Version
Persons / committees consulted:	External:ICS colleagues ICB Internal: LCH Communications Team LCH Workforce LCH EPRR Testing & Learning Group Trust Leadership Team LCH Business Committee
Approved by:	Trust Leadership Team
Date approved:	October 2025
Ratified by:	LCH Business Committee
Date ratified:	October 2025
Title of originator / author:	Emergency Planning Manager
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Where is previous copy archived (if applicable)	N\A
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Amendment number	Section	Subject

Version Control:

Date	Version	Author	Changes/ Reason	Documents Replaced (if any)
June 2024	1.0	Rebecca Todd EPRR Manager	Newly merged document	Heatwave Plan and Severe Weather Plan merged in line with the new UKHSA Adverse Weather and Health Plan 2024\25

Table of Contents

1. Introduction and Overview

1.1. Scope

Over recent years the UK has seen an increase in the number of emergencies\incidents related to adverse weather such as flooding, severe winters and heatwaves. This has been recognised nationally and in 2023 the UK Health Security Agency (UKHSA) produced a new Adverse Weather and Health Plan brings together current guidance on weather and health. The health effects of adverse weather events are well documented as they become more intense and frequent due to climate change. This plan builds on the previous Heatwave and Cold Weather Plans for England and on existing measures being taken by the government and its agencies, NHS England and local authorities to protect individuals and communities from the health effects of adverse weather and to build community resilience.

This has highlighted the need to ensure that health and social care undertake planning in partnership to mitigate the risks posed by adverse weather events. Adverse weather incidents such as severe cold, flooding and excessive heat could lead to a high number of casualties or fatalities placing pressures on health and social care services.

This plan outlines the planning and response arrangements for all services provided by Leeds Community Healthcare NHS Trust for all types and scales of weather event. The plan can be referenced in support of the Leeds Community Healthcare Incident Response Plan if a Trust command structure has been established. Service level Business Continuity Plans also contain actions to support safe service delivery during periods of extreme weather.

1.2 Aim

The aim of this plan is to provide a framework which enables Leeds Community Healthcare to prepare for, respond to and recover from adverse weather incidents which have the potential to affect the safe delivery of services provided by the Trust and the wider Leeds health and social care community.

1.3 Objectives

The objectives of this plan are to:

- Highlight the risks that could impact on Leeds Community Healthcare's ability to maintain safe service delivery
- Provide definitions and understanding of the categories of adverse weather
- Define the types of warnings and alert criteria used by the Met Office, the Environment Agency and the Flood Forecasting Centre
- Define warning and alert notification mechanisms for Leeds Community Healthcare
- Outline the actions of Leeds Community Healthcare staff in dealing with adverse weather incidents
- Define the response and co-ordination arrangements between Leeds Community Healthcare and partner agencies for the management of adverse weather incidents
- Provide details of the mechanism in place to ensure that accurate and timely weather information is communicated in line with established warning and informing arrangements
- Define actions to be considered to enable Leeds Community Healthcare to recover post incident.

1.4 Planning Assumptions

1.4.1 **West Yorkshire Community Risk Assessment.** For this plan, Leeds Community Healthcare has referenced the West Yorkshire Community Risk Register (CRR) which identifies 7 adverse weather-related hazards which could lead to disruption across the region. These hazards are identified below in Figure 1.

Reference in CRR	Risk Area	Risk Rating
R93-MO	Storms	High
R91-MO	Low Temperatures and Heavy Snow	High
R81-DEFRA	Coastal Flooding	Very High
R82-DEFRA	Fluvial Flooding	Very High
R83 - DEFRA	Surface Water Flooding	High
R90-MO	Heatwave	High
R84-DEFRA	Drought	Medium

Figure 1 – West Yorkshire Community Hazards with Adverse Weather.

The local impacts of the above risks are captured within individual Local Authority plans.

1.5 **Threats**

With the exception of those hazards considered in Figure 1, there are no known additional threats relating to adverse weather.

1.6 Supporting Plans and Arrangements

This plan complements LCH's existing Emergency Preparedness, Resilience and Response plans and business continuity arrangements.

Additionally, this plan should be read in conjunction with:

- UKHSA Adverse Weather and Health Plan – Protecting Health from Weather Related Harm 2023-2024

1.7 Adverse Weather Warning Services

- Met Office National Severe Weather Warning Service – heat health and cold health alerts – June\November 2023
  Details of the services provided by the Met Office are contained at Annex A to this plan.

1.8 Flood Warnings

Details of the warnings provided by the Environment Agency and Flood Forecasting Centre (including flood maps) are contained at Annex B to this plan.

2 Activation and Co-Ordination

2.1 Activation

2.1.1 Met Office, Environment Agency, Flood Forecasting Alerts / Warnings Summary
The above specialist organisations provide warnings and supplementary advice services and information concerning adverse weather and have established alert/warning systems to warn Category 1 (Emergency services, Local Authorities and NHS Bodies) and Category 2 Responders (Utility companies, Transport) when adverse weather can be expected to enable organisations to prepare. The alert/warning levels are outlined at Annex C.

2.1.2 Notification Arrangements. The flow chart at Annex D shows the notification arrangements that will be used when weather warnings/alerts are issued from any of the specialist organisations.

2.2 Command, Control and Co-ordination

2.2.1 In the event of a serious weather incident Leeds Community Healthcare will establish its standard command, control and co-ordination arrangements as detailed in the Trust's Incident Response Plan.

2.2.2 Leeds Community Healthcare will look to the Integrated Care Board (ICB), WY Local Resilience Forum (LRF) and local partner organisations to co-ordinate any wider multi-agency response to a severe weather incident.

2.3 Supplementary Advice

The following organisations provide supplementary advice and information services concerning adverse weather:

- Local Authority (LA): Leeds City Council use DTN (weather based operational intelligence - Weather - DTN) as an electronic notification system, to assess local risk and the need for gritting during ice and snow conditions system.
- Met Office – Public Weather Service (PWS).: Met Office PWS Advisors are available to the emergency planning community to provide support for emergency responders to assess the risk in their particular areas from predicted or ongoing severe weather events and to put preparations in place to mitigate the impact.
- Met Office – Hazard Manager: The Met Office has a web-based service called 'Hazard Manager', which is available on a 24/7 basis. The purpose of the service is to help responders prepare for and respond to emergencies that are caused by the weather. The website acts as a one-stop shop information source allowing responders to access services such as Flood Forecasting and CHEMET in one place. How to access the Hazard Manager service - Met Office
- Environment Agency – River Levels Service: The Environment Agency monitor river levels across the UK and provide access to river and sea level data, to enable people within flood risk areas to be better informed and decide what actions to take as the water levels change. Flood alerts and warnings - GOV.UK (check-for-flooding.service.gov.uk)

2.4 Local Weather Information

Travel and winter gritting information for roads and paths (including grit bins) can be found at:
Ice and snow clearing (leeds.gov.uk)

BBC Local weather updates
Radio Leeds - Listen Live - BBC Sounds

Local Travel Information with live updates for any area selected can be found at:
Up to date local travel information:
Connecting Leeds Travel Info (@LeedsTravelInfo) / X (twitter.com)
Profile / X (twitter.com)

2.5 Met Office weather information

UK weather warnings - Met Office

3 Organisational Roles and Responsibilities

3.1 Preparation Levels \ Warning & Informing Arrangements

The national table of the levels of alert for adverse weather are below.

- The heat health alert system operates from 1st June to 15th September
- The cold health alert system operates from 1st November to 30th March.
- Out of season alerts may still be issued if impacts from adverse weather on health are expected:

Green	No alerts will be issued, business as usual
Yellow (Response)	These alerts cover a range of situations. These alerts may be issued during periods of heat/cold which would be unlikely to impact most people but could impact on those most vulnerable people.
Amber (Enhanced Response)	This alert indicates that weather impacts are likely to be felt across the whole health service, with potential for the whole population to be at risk.
Red (Emergency Response)	This alert indicates significant risk to life for even the healthy population.

Fig 2 – national table of alerts

The Trust through both EPRR and Comms is signed up to receive Met Office and Health alerts. Warning and informing arrangements will be in line with the Communications Lead Action Card at Annex C.

3.2 Role Specific Action Cards

Each phase has specific actions which are to be undertaken by certain individuals within the Trust. The action cards for specific roles are located as follows:

- Emergency Planning Manager (see Action Card 1).
- On-Call Manager/Incident Control Team Lead (see Action Card 2).
- Communications Lead (see Action Card 3).
- Heads of Service/Operations (see Action Card 4).

Each card details the actions to be undertaken for each level of escalation due to severe weather needs.

3.3 Staff Duties and Responsibilities

The Trust recognises that during periods of adverse weather employees may face great difficulties, not only in attending their place of work but also in returning home and stresses that the delivery of services to client groups is of paramount importance. This will be the basis for decisions taken by managers regarding attendance (or continued attendance) at work.

3.4 Manager responsibilities

It is the manager's responsibility to ensure critical services are maintained and that the situation is fairly managed by negotiating with each team member to ensure the priority of patient needs are balanced against individual staff needs.

Managers should also ensure that Business Continuity Plans for their services are up to date and reflect adverse weather.

3.5 Staff Responsibility

All staff should ensure that they know the whereabouts and the content of their service business continuity plan particularly around adverse weather.
All employees have a duty to make every reasonable effort to attend their place of work and complete their scheduled duty hours.

Where a member of staff attends late due solely to adverse weather, pay should not be unreasonably withheld.

Where an employee cannot attend their work base, they should notify their manager of their absence in accordance with established practice (the timescale for notification of this should be the same as sickness absence – within 1 hour of their normal starting time). See LCH Special Leave Policy for further details.

3.6 Working at other bases

Where staff are prevented from attending their regular work base they may, with the permission of their manager, attend a base nearer to their home.

Staff should not unreasonably refuse requests to work at an alternative more accessible base or undertake duties different to those they would normally undertake.

Should the weather conditions lessen throughout the day then the employee will be expected to attend their normal base at their manager's request.

3.7 Working from Home

Any staff working from home should continue to do so. Where staff are unable to access their usual work base it may be possible, with the permission of their manager and depending on service requirements, to work from home where appropriate if they are not required to work from an alternate base closer to their home.

3.8 Travel to and from work

Where worsening weather conditions impact staff travel home from work their manager may exercise their discretion to authorise them to leave work early or to redeploy to a different work-base to maintain service delivery, however this should only be in **extreme circumstances**.

- In extreme circumstances managers should refer to the LCH Special Leave Policy (ie if someone's home was flooded).
- Before making any decision, it should be up to each individual manager to consider any advice given by the Emergency Planning Team, Police and the Met Office.
- If an employee cannot get to work by car (if that is their usual method), for instance side roads are icy, they should use public transport to get to work (if this is operating).

- If staff are travelling by car in adverse cold weather conditions, the Trust recommends that they carry some of the following in their vehicle:

  - Warm clothes
  - Boots
  - Shovel
  - De-icing equipment
  - Tow rope
  - Torch
  - Hi-visibility Jacket
  - First Aid Kit
  - Hazard warning triangle
  - Fire extinguisher
  - Blanket

3.9 **Transportation of essential staff in adverse weather (including community visits) Manager responsibilities to include:**

- Utilising non-essential staff within the organisation with 4x4 vehicles as appropriate.
- Contacting the West Yorkshire 4x4 Volunteers – details contained within service level Business Continuity Plans.

If the above two options have been exhausted, consider utilising the following organisations linking with the Emergency Planning Team:

- St John Ambulance
- Red Cross
- Local Authority

3.10 Staff unable to return home

In the case of staff being unable to return home due to extreme weather circumstances the Trust will be responsible for ensuring suitable accommodation is provided until such time they can do so, this will be coordinated by the Incident Control Team.

Inpatient staff may be able to be accommodated on the unit that they work on temporarily and if not, then a suitable alternative will be found as above.

4 Adverse Weather At Risk Groups

Certain individuals are particularly at risk during both cold and hot weather, and can include the following:

- Over 65 years old
- Frail
- Pre-existing chronic medical conditions such as heart disease, stroke or TIA, chronic obstructive pulmonary disease or diabetes, kidney disease and Parkinsons disease
- People with mental ill-health that reduces individuals' ability to self-care including dementia
- People with learning difficulties
- Pregnant women
- Limited mobility or otherwise at risk of falls

- Young children under the age of 5 years
- Living in deprived circumstances
- Living in homes with mould
- Fuel poverty (needing to spend 10% or more of household income on heating)
- Elderly people living on their own
- People who are housebound or otherwise low mobility
- Homeless or people sleeping rough
- Other marginalised groups

5 At Risk Premises

Within Leeds Community Healthcare's remit there are a very limited number of premises that during heavy rainfall risk being flooded, or access impacted as follows:

Premises		Flood Warning Area
Hospital	Wharfedale Hospital	Infrequent issues with closure of the bridge which dissects the town of Otley requiring a 45 minute detour\alternative route
Health Centres and clinics	Wortley Beck Health Centre	Minimum risk of flooding to the property, considered marginal as there has never been an incidence of flooding since the building was built. Decant arrangements are covered within the Health Centre's Business Continuity Plan

Temperatures within Leeds Community Healthcare premises should be maintained below 26ºC to reduce risk to vulnerable groups.

6 Leeds Community Healthcare Emergency Planning Documents

6.1 This Plan forms part of a suite of emergency documents which support contingency measures and planning across the Trust whilst providing a robust framework to enable the Trust to respond to events.

6.2 The Leeds Community Healthcare EPRR Policy, Business Continuity Management System and service level Business Continuity Plans make up the suite of emergency documents which enhance contingency measures and planning across the Trust.

6.3 Plans for specific emergencies are activated as appropriate in tandem, where appropriate, with the activation of the Incident Response Plan. These specific plans would include; pandemic, industrial action, adverse weather (inc heatwave, snow, ice and flooding), fuel crisis and civil unrest.

7 References

LCH supporting documents:

EPRR Policy and BCMP
Incident Response Plan
Service Level Business Continuity Plans

8 Other Supporting Guidance:

The Civil Contingencies Act 2004
The Health and Care Act 2022
UK Health Security Agency Adverse Weather Plan – updated November 2023
Leeds City Council Severe Weather Plan
West Yorkshire Resilience Forum Adverse Weather Plan
PAS 2015: Framework for Health Services Resilience
PAS 200: Crisis Management guidance and good practice
ISO 22301 & ISO 22313: Business Continuity Management Systems – Requirements
NHS England EPRR Framework (V3) – July 2022
HM Government (2007) Data Protection and Sharing – Guidance for Emergency planners and Responders
West Yorks Resilience Forum - Community Risk Register
HM Government - National Risk Register – 2023 Edition (Natural and Environmental Hazards 48-53)

Annex A - WARNING SERVICES

Met Office Weather Warning Services

The Met Office operates a weather warning system which is designed to let people, businesses, emergency responders and governments know what weather is in store and what the impacts of that can be. These warnings are impact based which means meteorologists work based on its potential impact on people alongside other factors such as time of day, year, regions affected etc which could make the weather particularly impactful in practice. These warnings are designed to let people know that there is a potential impact in their location and should make them think about what steps can be taken to minimise the chances of disruption.

UK weather warnings - Met Office

National Severe Weather Warning System (NSWWS)

The Met Office operates a National Severe Weather Warning Service on the same link, which provides two types of warning; “Warnings” are issued up to 24 hours ahead, and “Alerts” are issued more than 24 hours ahead.

The warnings will be issued for: Rain, Thunderstorms, Wind, Snow, Lightning, Ice, Extreme heat, Fog.

The combination of likelihood and impact will be measured against a matrix to give each warning a colour:

Green	No alerts will be issued, business as usual
Yellow (Response)	These alerts cover a range of situations. These alerts may be issued during periods of heat/cold which would be unlikely to impact most people but could impact on those most vulnerable people.
Amber (Enhanced Response)	This alert indicates that weather impacts are likely to be felt across the whole health service, with potential for the whole population to be at risk.

Red (Emergency Response)	This alert indicates significant risk to life for even the healthy population.

Fig 3 – Adverse weather alerts

Specialist Organisation – Warnings Summary

Alert Level	Met Office Heat Health Watch	Met Office Cold Weather Watch	Met Office Severe Weather Warning Service	Environment Agency	Flood Forecasting
Green Level 1	**Summer preparedness and long-term planning.**	**Winter preparedness and long-term planning.**	**No Severe Weather Forecast** 	**No warning**	**Very Low** – Minimal disruption *<20% likelihood of flooding*
Yellow Level 2	**Alert and readiness.** *60% chance of temperatures being high enough on at least two consecutive days to have significant effect on health.*	**Alert and readiness.**	**Be Aware** 	**Flood Alert** – flooding possible. Be prepared 	**Low** – Minor disruption. *20-40% likelihood of flooding*
Amber Level 3	**Heatwave Action required**. *Declared when Met Office confirms that threshold temperatures have been reached in any one region or more.*	**Severe Weather Action required.**	**Be Prepared** 	**Flood Warning** – Flooding is expected. Immediate action required. 	**Medium** – Significant disruption. *40-60% likelihood of flooding*

Red Level 4	**Emergency Response.** *Declared when a heatwave is so severe and/or prolonged heatwave affecting sectors other than health*	**Emergency Resonse** *Exceptionally severe weather or threshold temperatures breached for more than six days.*	**Take Action** 	**Severe Flood Warning** – Severe Flooding. Danger to Life. 	**High** – Severe disruption. *60% or greater chance of flooding.*

Weather Impact Table for Emergency Responders including Key Messages

Impact Level	Very Low	Low	Medium	High
Impact and advice associated with **Extreme Heat Key Messages**	N/A	N/A	Adverse health effects experienced by those vulnerable to extreme heat. Some changes in working practices and daily routines may be required Some heat-sensitive systems and equipment may fail, leading to power cuts and the loss of other services to some homes and businesses Some delays to road, rail and air travel, with potential for welfare issues for those who experience long delays. More people visiting coastal areas, lakes and rivers leading to risk of water safety incidents.	Adverse health effects experienced by all, not just limited to those most vulnerable to extreme heat, leading to serious illness or danger to life. Changes in working practices and daily routines will be required. Failure of heat-sensitive systems and equipment with loss of power and other essential services, such as water, electricity, gas or mobile phone services. Delays on roads and road closures, along with delays and cancellations to rail and air travel, with significant welfare

				issues for those who experience even moderate delays. Significantly more people are likely to visit coastal areas, lakes and rivers leading to risk of water safety incidents.

Impact Level	Very Low	Low	Medium	High
Impact and advice associated with ***RAIN Key Messages***	A few places will have flooding of low-lying land and susceptible roads. A few transport routes affected. Road conditions affected with spray and some standing water in a few places.	Some flooding of homes and businesses and susceptible roads. Some transport routes and travel services affected. Some journeys require longer travel times. Road conditions affected by spray and standing water. Short term disruption to utilities and services in some places.	Flooding of homes and businesses. Danger to life from fast flowing/deep water. Damage to buildings/ structures. Transport routes and travel services affected. Longer journey times expected. Some road closures. Difficult road conditions due to spray and standing water. Interruption to utilities and services. Some communities temporarily inaccessible due to flooded access routes.	Widespread flooding of homes and businesses. Danger to life from fast flowing/deep water. Extensive damage to and/or collapse of buildings/ structures. Transport routes and travel services disrupted for a prolonged period. Long travel delays. Widespread road closures. Dangerous driving conditions due to spray and standing water. Prolonged disruption to or loss of utilities and services. Communities become cut off for a prolonged period, perhaps several days, due to flooded

Impact Level	Very Low	Low	Medium	High
Impact and advice associated with ***WIND Key Messages***	Loose debris blown around. A few transport routes affected by difficult driving conditions. Instances of spray and large waves affecting coastal routes, sea fronts and coastal	Some transport routes and travel services affected. Some journeys require longer travel times. Some disruption to road, rail, air and ferry transport. Difficult driving conditions for high-sided vehicles on prone routes, such as cross winds on exposed or high-level roads. A few power interruptions. Coastal routes, sea fronts and coastal communities affected by spray	Injuries and danger to life from flying debris Some structural damage, such as slates dislodged from roofs. Transport routes and travel services affected. Longer journey times expected. Disruption to road, rail, air and/or ferry transport. Closure of some susceptible and key routes (eg some vulnerable bridges). Interruptions to power and/or other utilities and services. Casualties and danger to life from large waves/beach material being thrown onto coastal routes, sea fronts and coastal communities.	Widespread danger to life from flying debris. Widespread structural damage eg roofs blown off, mobile homes overturned, power lines brought down. Transport routes and travel services affected for a prolonged period. Long travel delays. Closure of main bridges, road and rail networks in many areas, and significant disruption to air and ferry transport. Widespread and prolonged disruption to power, and/or other utilities and services. Danger to life from large waves/beach material being thrown onto coastal route, sea fronts and coastal communities.

Impact Level	Very Low	Low	Medium	High
Impact and advice associated with ***FOG*** ***Key Messages***	Limited travel disruption with difficult travel conditions mostly confined to a few prone routes. A few road traffic collisions.	Difficult driving conditions with slower journey times. Some road traffic collisions. Passengers delayed with short-term closure of airports.	Difficult driving conditions with long journey times. Road traffic collisions. Passengers delayed and/or stranded at airports and/or ferry terminals.	Crashes/ collisions caused by weather
Impact and advice associated with ***SNOW*** ***Key Messages***	A few transport routes affected	Some transport routes and travel services affected. Some journeys require longer travel times.	Transport routes and travel services affected. Longer journey times expected. Some stranded vehicles and passengers, with disruption to rail, road and air services. Interruptions to power and/or other utilities and services. Some rural communities temporarily inaccessible due to deep snow or snow drifts.	Transport routes and travel services affected for a prolonged period. Long travel delays. Large numbers of stranded vehicles and passengers with widespread disruption to rail, road and air services. Widespread and prolonged interruptions to power and/or other utilities and services. Rural communities cut off for a prolonged period, perhaps several days, due to deep snow or snow drifts.

Impact Level	Very Low	Low	Medium	High
Impact and advice associated with ***ICE*** ***Key Messages***	A few transport routes affected by ice on some untreated roads, pavements and cycle paths. Limited travel disruption with difficult conditions mostly confined to a few prone routes.	Some injuries from slips and falls. Some transport routes and travel services affected with some ice on untreated roads, pavements and cycle paths, but road networks generally open. Some road traffic collisions.	Casualties with risk to life. Injuries from slips and falls. Transport routes and travel services affected by widespread black ice. Some road closures and some only passable with care. Untreated pavements and cycle paths impassable. Some travel disruption with longer journey times and road traffic collisions. Interruptions to power and/or other utilities and services.	Widespread risk to life. Casualties and injuries from slips and falls. Transport routes and travel services affected by sudden formation of black ice across whole communities with roads pavements and cycle paths becoming instantly impassable. Widespread disruption to road, rail and air transport with frequent road traffic collisions. Widespread interruptions to power due to power line icing, leading to impacts on telecommunications.

Impact Level	Very Low	Low	Medium	High
Impact and advice associated with ***THUNDERSTORMS*** ***Key Messages***	A few places will have flooding, usually lasting an hour to a few hours at most. A few local transport routes may be affected with difficult driving conditions. Very short-term disruption to power and/or other utilities and services in a few places.	Some flooding of homes, businesses and susceptible roads lasting several hours in places. Some damage to buildings/ structures from flooding and/or lightning. Some transport routes and travel services affected. Some journeys require longer travel times. Road conditions affected by spray and standing water and/or hail. Short-term disruption to power and/or other utilities and services in some places.	Flooding of homes and businesses. Danger to life due to sudden deep/fast flowing water. Damage to buildings/ structures from flooding and/or lightning, hail, strong winds. Transport routes and travel services affected quickly by flooding. Longer journey times and cancellations. Difficult road conditions due to spray, standing water and/or hail, sudden gusty winds. Interruption to power and/or other utilities and services. Some communities temporarily inaccessible due to flooded access routes.	Widespread flooding affecting homes and businesses. Danger to life due to sudden fast flowing/deep water. Injuries from hail. Casualties and danger to life from lightning strikes. Extensive damage to buildings/ structures from flooding and/or lightning, hail, strong winds. Transport routes and travel services affected by flooding for a prolonged period with long travel delays and rapidly changing/deteriorating conditions. Dangerous driving conditions due to spray, standing water and/or hail, sudden gusty winds. Prolonged disruption to or loss of power and/or other utilities and services. Communities become cut off for a prolonged period, perhaps several days, due to flooded access routes or damage to road infrastructure.

MET OFFICE

	LEVEL 1 Be Aware/prepared	LEVEL 2 Take action to reduce impacts and disruption	LEVEL 3 Take Action to reduce risk to life and to mitigate disruption	Stand down/ recovery
ALL WEATHER TYPES				
ALL WEATHER TYPES	• Consider the use of Resilience Direct. • The Met Office will issue warnings of severe weather up to 7 days ahead, based on a risk matrix system using a sliding colour code. Once issued, the warning will be updated as, and when necessary • The warnings are issued to CAT 1 and 2 responders by email or other means and are also available on the Met Office website. • Depending upon the circumstances consider emailing responders with a "local outlook" covering the potential impact of the weather forecasted.	Continue standby actions plus the following: • Weather warnings will continue to be updated, reflecting the level of expected impacts. • The Met Office will endeavour to give at least 2 hours' notice of the event. • The warnings will be issued by email or other means to CAT 1 and 2 responders, and they will be available on the Met Office website. • Depending on the time of day an email may follow giving additional more localised detail of the circumstances. • The Met Office Advisor is available during normal working hours to offer advice on the latest meteorological information available. The Advisor is also available to participate in multi-agency teleconferences. • The Hazard Manager website is available on a 24/7 basis during a severe weather incident. • EMARC (Environment Monitoring and Response Centre) provide out of hours cover and can pass on contact details for the on-call Advisor.	• As Level 2	• The Met Office will continue to issue bespoke forecasts for as long is necessary during the recovery phase. • Attend multi-agency debrief meetings.
SPECIFIC WEATHER TYPES **Consider the all-weather actions above, plus the following**				
HEATWAVE / EXTREME HEAT	• No additional action required	• No additional action required	• No additional action required	• No additional action required
COLD WEATHER	• No additional action required	• No additional action required	• No additional action required	• No additional action required
SNOW **ICE**	• No additional action required	• No additional action required	• No additional action required	• No additional action required
	• No additional action required	• No additional action required	• No additional action required	• No additional action required

MET OFFICE				
	LEVEL 1 **Be Aware/prepared**	**LEVEL 2** **Take action to reduce impacts and disruption**	**LEVEL 3** **Take Action to reduce risk to life and to mitigate disruption**	**Stand down/ recovery**
FOG				
WIND	• No additional action required	• No additional action required	• No additional action required	• No additional action required
RAIN **THUNDERSTORMS** **LIGHTNING** **FLOOD ALERTS/WARNINGS** **FLOOD GUIDANCE STATEMENTS**	• No additional action required	•	•	•

UK HEALTH SECURITY AGENCY

	LEVEL 1 Be Aware/prepared	LEVEL 2 Take action to reduce impacts and disruption	LEVEL 3 Take Action to reduce risk to life and to mitigate disruption	Stand down/ recovery
ALL WEATHER TYPES				
ALL WEATHER TYPES	• Consider activating relevant internal plans • Consider the use of Resilience Direct • Maintain a watching brief of the weather and / or flood alerts and cascade as required to internal staff Consider implementing Business Continuity Plans	Continue stage 1 actions plus the following: • Continue to work with partner agencies, providing advice as required • Communicate public health messages to the public and partners • Participate in multi- agency command, control and coordination arrangements • Make advice available to public and professionals in affected areas	• Continue stage 1 and stage 2 actions	• Consider actions required to return to business as normal • Collate all records and logs and store accordingly • Conduct a debrief with all key staff who participated during the incident • Attend multi-agency debrief if appropriate • Develop an action log of lessons learnt • Review and amend internal plans and contribute to West Yorkshire LRF Severe Weather plan in line with lessons learnt • Participate in Recovery Groups that maybe established by external partners if appropriate
SPECIFIC WEATHER TYPES Consider the all-weather actions above, plus the following				
HEATWAVE / EXTREME HEAT	• Make advice available to public and professionals in affected areas	Continue stage 1 actions plus the following: • Make advice available to public and professionals in affected areas • Continue to monitor syndromic and mortality surveillance for inclusion within weekly reporting	• Continue stage 1 and stage 2 actions	• Make advice available to public and professionals
COLD WEATHER	• Make advice available to public and professionals in affected areas • Routinely monitor syndromic, influenza, norovirus and mortality surveillance data	Continue stage 1 actions plus the following: • Make advice available to public and professionals in affected areas • Continue to monitor syndromic, influenza, norovirus and mortality surveillance data	• Continue stage 1 and stage 2 actions	• Make advice available to public and professionals
SNOW **ICE**	• No additional actions required	• No additional actions required	• No additional actions required	• No additional actions required
FOG	• No additional actions required	• No additional actions required	• No additional actions required	• No additional actions required
WIND	• No additional actions required	• No additional actions required	• No additional actions required	• No additional actions required

UK HEALTH SECURITY AGENCY				
	LEVEL 1 **Be Aware/prepared**	**LEVEL 2** **Take action to reduce impacts and disruption**	**LEVEL 3** **Take Action to reduce risk to life and to mitigate disruption**	**Stand down/ recovery**
RAIN **THUNDERSTORMS** **LIGHTNING** **FLOOD ALERTS/WARNINGS** **FLOOD GUIDANCE STATEMENTS**	• No additional actions required	• Assess the risks to health from the flood incident and provide health protection advice to the NHS and local responders • Jointly with Directors of Public Health, issue appropriate public health advice in liaison with local authority Environmental Health services	• Continue stage 2 actions	• Assess the risks to health from the flood incident and provide health protection advice to the NHS and local responders • Jointly with Directors of Public Health, issue appropriate public health advice in liaison with local authority Environmental Health services

NHS ENGLAND

	LEVEL 1 / YELLOW Response (early)	LEVEL 2 / AMBER Enhanced Response	LEVEL 3 / RED Emergency Response	Stand down/ recovery
ALL WEATHER TYPES				
ALL WEATHER TYPES	• Monitor forecast • Consider potential impacts on ability to respond to incidents, both within NHSE and across the NHS • Alignment of response with neighbouring ICBs and LRFs	Continue actions as per Yellow / Stage 1 plus the following: • Work in collaboration with ICBs to ensure that local providers of NHS commissioned care have the capacity and capability to deliver their function • Hold health and social care services to account for taking appropriate actions as per action cards in response plans to ensure preparedness. • Support TCG/SCG as appropriate	Continue actions as per Amber / Stage 2 plus the following: • Coordinate mutual aid when requested by health and social care providers. • Implementation of national emergency response arrangements by central government. • All level 3 responsibilities must be maintained unless advised to the contrary. • If Major Incident declared, advise NHSE National Team of LRF activation	• Attend Strategic Recovery Group. • Monitor health system pressures for any delayed impacts on health conditions or delivery of services
SPECIFIC WEATHER TYPES **Consider the all-weather actions above, plus the following**				
HEATWAVE / EXTREME HEAT	• Monitor forecast • Consider potential impacts on ability to respond to incidents • National NHSE may brief internal staff • Alignment of response with neighbouring ICBs and LRFs	Continue actions as per Yellow / Stage 1 plus the following: • Review adverse weather plans for heatwave implications and consider regional actions. • Work in collaboration with ICBs to ensure that local providers of NHS commissioned care have the capacity and capability to continue to deliver their functions • Hold health and social care services to account for taking appropriate actions as per local and regional plans to ensure preparedness. • Support TCG/SCG as appropriate	Continue actions as per Amber / Stage 2 plus the following: • Coordinate mutual aid when requested by health and social care providers. • Implementation of national emergency response arrangements by central government. • All level 3 responsibilities must be maintained unless advised to the contrary. • If Major Incident declared, advise NHSE National Team of LRF activation	• Attend Strategic Recovery Group. • Monitor health system pressures for any delayed impacts on health conditions
COLD WEATHER	• Monitor forecast • Consider potential impacts on ability to respond to incidents • Alignment of response with neighbouring ICBs and LRFs	Continue actions as per Yellow / Stage 1 plus the following: • Support TCG/SCG as appropriate • Review adverse weather plans for cold weather implications and consider regional actions. • Work in collaboration with ICBs to ensure that local providers of NHS commissioned care have the capacity and capability to continue to deliver their functions • Hold health and social care services to account for taking appropriate actions as per	Continue actions as per Amber / Stage 2 plus the following: • Coordinate mutual aid when requested by health and social care providers. • Implementation of national emergency response arrangements by central government. All level 3 responsibilities must be maintained unless advised to the contrary.	• Attend Strategic Recovery Group. • Monitor health system pressures for any delayed impacts on health conditions

NHS ENGLAND				
	LEVEL 1 / YELLOW Response (early)	**LEVEL 2 / AMBER Enhanced Response**	**LEVEL 3 / RED Emergency Response**	**Stand down/ recovery**
		local and regional plans to ensure preparedness.		
SNOW **ICE**	• As for Cold Weather above • Alignment of response with neighbouring ICBs and LRFs	Continue actions as per Yellow / Stage 1 plus the following: • Support TCG/SCG as appropriate • Check for impacts on key assets • National NHSE may brief internal staff	Continue actions as per Amber/ Stage 2 plus the following: • If Major Incident declared, advise NHSE National Team of LRF activation	• Attend Strategic Recovery Group.
FOG	• No additional actions required.	• No additional actions required.	• Consider briefing internal staff on travel impacts	• Attend Strategic Recovery Group.
WIND	• No additional actions required.	• No additional actions required.	• Consider briefing internal staff on travel impacts	• Attend Strategic Recovery Group.
RAIN **THUNDERSTORMS** **LIGHTNING** **FLOOD ALERTS/WARNINGS** **FLOOD GUIDANCE STATEMENTS**	• Dial in to Environment Agency teleconferences if convened • Support ICB as required if potential impacts on healthcare premises or potential for evacuation of residents with healthcare needs • Alignment of response with neighbouring ICBs and LRFs	Continue actions as per Yellow / Stage 1 plus the following: • Activate business continuity plans • Stand up further staff to support with a multi-LRF response if required	Continue actions as per Amber/ Stage 2 plus the following: • Consider briefing internal staff on travel impacts • If Major Incident declared, advise NHSE National Team of LRF activation	• Attend Strategic Recovery Group.

NHS WEST YORKSHIRE INTEGRATED CARE BOARD (ICB)

	LEVEL 1 Be Aware/prepared	LEVEL 2 Take action to reduce impacts and disruption	LEVEL 3 Take Action to reduce risk to life and to mitigate disruption	Stand down/ recovery
ALL WEATHER TYPES				
ALL WEATHER TYPES	• Consider activating relevant internal plans. • Consider the use of Resilience Direct. • Ensure health and social providers have arrangements in place to receive and cascade weather and flood alerts. • Maintain a watching brief of the weather and / or flood alerts and cascade as required to health and social care providers and internal staff. • Continue to work with partner agencies, health and social care providers to ensure vulnerable groups are identified and supported. • Communicate public media messages – especially to 'hard to reach' vulnerable groups. • Consider implementing Business Continuity Plans. • Provide support to NHS England as requested. • Increase advice to health and social care workers working in community.	Continue Level 1 actions plus the following: • Consider if West Yorkshire Severe Weather Plan needs to be fully activated • Continue to monitor weather and / or flood alerts. • Review safety of public events. • Establish arrangements under Incident Response Plan as required.	Continue Level 2 actions plus the following: • Support organisations to reduce unnecessary travel. • Mobilise community and voluntary support if deemed necessary. • Activate business continuity plans.	• Stand down incident and communicate stand down to NHS England, health and social care providers. • Consider actions required to return to business as normal. • Collate all incident records and logs and store accordingly. • Conduct a debrief with all key staff who participated during the incident. • Attend multi-agency debrief if established. • Develop an action log of lessons learnt • Review and amend internal severe weather plans and business continuity plans in line with lessons learnt. • Ensure that Incident Co-ordination Centre(s) re-stocked and all equipment is in working order. • Participate in Strategic and / or Tactical Recovery Groups that maybe established by external partners • Review West Yorkshire Resilience Forum Recovery (incl. site clearance) plan.
SPECIFIC WEATHER TYPES Consider the all-weather actions above, plus the following				
HEATWAVE / EXTREME HEAT	• Review Heatwave Plan for England and consider actions within 'action table'. • Work collaborative with NHS England and providers to ensure that local providers of NHS commissioned care have the capacity and capability to deliver their function • Consider the action tables within the Heatwave Plan for England and recast the suggested actions in ways that are most appropriate for local needs.	Continue Level 1 actions plus the following: • Co-ordinate mutual aid when requested by health and social care providers.	Continue Level 2 actions plus the following: • Implementation of national emergency response arrangements by central government. • All level 3 responsibilities must be maintained unless advised to the contrary	• No additional actions required.

NHS WEST YORKSHIRE INTEGRATED CARE BOARD (ICB)

	LEVEL 1 Be Aware/prepared	LEVEL 2 Take action to reduce impacts and disruption	LEVEL 3 Take Action to reduce risk to life and to mitigate disruption	Stand down/ recovery
COLD WEATHER	• Review Cold Weather plan for England and consider actions within 'action table'. • Work collaborative with NHS England and providers to ensure that local providers of NHS commissioned care have the capacity and capability to deliver their function • Consider the action tables and recast the suggested actions in ways that are most appropriate for local needs. • Participate in NHS England Winter teleconferences.	Continue Level 1 actions plus the following: • Co-ordinate mutual aid when requested by health and social care providers.	Continue Level 2 actions plus the following: • Implementation of national emergency response arrangements by central government. • All level 3 responsibilities must be maintained.	• No additional actions required.
SNOW **ICE**	• See cold weather alert section. • Liaise with Local Authorities regarding gritting routes and snow clearing situation to ensure access to critical services health and social care.	• No additional actions required.	• No additional actions required.	• No additional actions required.
FOG	• No additional actions required.	• No additional actions required.	• No additional actions required.	• No additional actions required.
WIND	• No additional actions required.	• No additional actions required.	• No additional actions required.	• No additional actions required.
RAIN **THUNDERSTORMS** **LIGHTNING** **FLOOD ALERTS/WARNINGS** **FLOOD GUIDANCE STATEMENTS**	• No additional actions required.	• No additional actions required.	• No additional actions required.	• No additional actions required.

LOCAL AUTHORITY

	LEVEL 1 Be Aware/prepared	LEVEL 2 Take action to reduce impacts and disruption	LEVEL 3 Take Action to reduce risk to life and to mitigate disruption	Stand down/ recovery
ALL WEATHER TYPES				
ALL WEATHER TYPES	• Assess the information and local impacts on themes including vulnerable individuals, vulnerable establishments, and vulnerable infrastructure. • Consider liaising with the Met Office to obtain further information on local impacts. • Monitor the forecast on Hazard Manager. • Disseminate warnings and alerts to internal services and external partners as required. • Liaise with the Communications Team to arrange for key messages to be issued to members of the public, local businesses, etc. This may include the creation of specific messages or aligning to and sharing messages from partner agencies. • Provide general information and guidance to services, senior management, elected members, and members of the public. • Consider activating relevant internal plans and arrangements. • Consider using Resilience Direct to share information and for mapping. • Consider holding a meeting(s) with key services and local partners to discuss actions required. • Consider opening an incident log. • Ensure appropriate staff and resources are available to respond to any impacts. • Consider staff rotas and staff overtime to respond to any impacts. • Establish an internal, and/or local command structure if appropriate. • Advise service areas to activate their business continuity plans and arrangements, to mitigate against service disruption, and to protect staff, partners, and the public. • Make arrangements to record incurred costs. • Where available, consider access / use of local CCTV systems.	Continue appropriate Level 1 actions, plus the following: • Consider the need to declare a Major Incident. • Attend WYRF command structure meetings (SCG's and TCG's) as appropriate and submit situation reports when requested. • Provide Environmental Health advice to the public. • Consider opening a local ECC and inviting key services and partners to attend. • Consider requesting assistance from local voluntary organisations. • Consider requesting assistance from voluntary organisations affiliated with the WYRF. • Identify vulnerable individuals (e.g. those known to care services and rough sleepers), vulnerable establishments (e.g. schools and care homes), and vulnerable infrastructure (e.g. roads, rail, air, water ways, telecoms and water treatment) in areas at risk, and provide support if appropriate. • Identify appropriate evacuation centres for use if evacuation is necessary. Where residents are likely to be displaced for a protracted period, consider longer term accommodation options such as hotels and local authority housing. • Consider holding meetings(s) with bordering Local Authority district areas (not in West Yorkshire) to agree a joined-up approach to responses where appropriate.	Continue appropriate Level 1 and Level 2 actions, plus the following: • Consider establishing a public helpline if necessary. • Consider establishing humanitarian assistance centres (community hubs) to provide information and practical support to affected members of the public. • Consider making or accepting mutual aid requests in liaison with the Local Authority strategic lead. • Attend regional and national command structure meetings (SCG's and TCG's) as appropriate and submit situation reports when requested. • If active, attend a West Yorkshire ECC. • Activate corporate business continuity plans and arrangements if appropriate.	• Activate local recovery plans and arrangements as appropriate. • Establish a local command structure for the recovery if appropriate. • If active, work under the direction of the WYRF Recovery and Site Clearance Framework. • Attend any WYRF command structure meetings that focus on recovery. • Liaise with the Communications Team to arrange for key messages to be issued to members of the public, local businesses, etc. Communication messages should be based on several themes including practical, financial, and mental health support, and messaging to enable the public to identify their own learning and improve future community resilience. • Undertake a local debrief as appropriate. • Attend the WYRF debrief as if one is arranged. • Consider funding arrangements for the recovery, including the Bellwin scheme.

LOCAL AUTHORITY				
	LEVEL 1 **Be Aware/prepared**	**LEVEL 2** **Take action to reduce impacts and disruption**	**LEVEL 3** **Take Action to reduce risk to life and to mitigate disruption**	**Stand down/ recovery**
SPECIFIC WEATHER TYPES **Consider the all-weather actions above, plus the following**				
HEATWAVE / EXTREME HEAT	• Follow appropriate actions for each alert level in the National Adverse Weather and Health Plan. The plan can be accessed via the .gov website. • Liaise with partners around the supply of water in drought affected areas and for residents on private water supplies.	Continue appropriate Level 1 actions, plus the following: • Ensure event holders consider possible heat mitigations that may be necessary (through the Safety Advisory Group). • Consider advising event organisers of potential additional risks, and where appropriate consider cancelling planned events. Consider utilising event organisers to assist in cascading message to attendees.	Continue appropriate Level 1 and Level 2 actions, plus the following: • Consider suspending or amending the operational hours for front line Service delivery.	• No additional actions required
COLD WEATHER	• Follow appropriate actions for each alert level in the National Adverse Weather and Health Plan. The plan can be accessed via the .gov website.	• Continue appropriate Level 1 actions.	• Continue appropriate Level 1 actions.	• No additional actions required
SNOW **ICE**	• No additional actions required.	• Consider activating 4x4 vehicle plans and arrangements. • Consider additional gritting of roads on high and exposed ground, and roads around critical sites, particularly those that contain vulnerable people, and vulnerable infrastructure. • Consider closing roads on high and exposed ground.	Continue appropriate Level 2 actions, plus the following: • Consider suspending or amending the operational hours for front line Service delivery.	• No additional actions required
FOG	• No additional actions required.	• Consider closing roads on high and exposed ground.	• Continue appropriate Level 2 actions.	• No additional actions required
WIND	• No additional actions required.	• Consider advising event organisers of potential additional risks, and where appropriate consider cancelling planned events.	Continue appropriate Level 2 actions, plus the following: • Consider suspending or amending the operational hours for front line Service delivery.	• No additional actions required
RAIN **THUNDERSTORMS** **LIGHTNING**	• Consider obtaining additional information from the Met Office Advisor, Hazard Manager and / or Environment Agency (Flood Resilience Team / Area Incident Room). • Consider deploying staff to act as "spotters" at known flooding hot spots.	Continue appropriate Level 1 actions, plus the following: • Consider closing roads liable to flooding. • Consider advising event organisers of potential additional risks, and where	Continue appropriate Level 1 and Level 2 actions, plus the following: • Consider suspending or amending the operational hours for front line Service delivery.	• Liaise with key services regarding the collection of flood damaged goods, etc. • Liaise with health partners to ensure that any contamination is managed appropriately through public

LOCAL AUTHORITY				
	LEVEL 1 **Be Aware/prepared**	**LEVEL 2** **Take action to reduce impacts and disruption**	**LEVEL 3** **Take Action to reduce risk to life and to mitigate disruption**	**Stand down/ recovery**
FLOOD ALERTS/WARNINGS **FLOOD GUIDANCE STATEMENTS**	• Liaise with internal services regarding deployment of resources, such as sandbags, clearing of drains, gullies and other preparatory work.	appropriate consider cancelling planned events.		messaging an safe clean up processes. • Investigate flooding from or around non-critical ordinary watercourses or land drainage. • Examine safety of highway, bridges and buildings affected by flooding, storms and lightning and make necessary repairs.

Annex B - FLOODING

Environment Agency - the Environment Agency provides a flood warning service for local rivers which produces three types of warnings as follows:

Alert Level	Description	Impact
No warning in force	No flood alerts or warnings are currently in force. No further flooding is currently expected for your area.	Flood water may still be around and could be contaminated
 Flood Alert	Flooding is possible and you need to be prepared for it.	Flooding of low-lying land and roads is possible.
 Flood Warning	Flooding is expected and that immediate action needs to be taken.	Flooding of homes and business including major road and infrastructure is expected. Possible low risk to life.
 Severe Flood Warning	Severe flooding and danger to life. These are issued when flooding is posing **significant** risk to life.	Flooding is now expected and there is extreme danger to life and property, or severe disruption to communities.

Figure 5

Flood Forecasting Centre - the Flood Forecasting Centre provides Flood Guidance Statements (FGS) for Category 1 and 2 responders to assist them with tactical planning decisions. The FGS assess the risk for all types of natural flooding – river, coastal, groundwater and surface water flooding at a county level. These levels of risk are presented on a coloured risk basis, which can be seen in the table below:

Alert Level	Description	Impact
Very Low	Minimal disruption <20% likelihood of flooding	Generally, no impact, however, they may be isolated and minor flooding of low-lying land and roads. Little or no disruption to travel although wet road surfaces could lead to difficulty
Low	Minor disruption 20-40% likelihood of flooding	Some individual risk for the more vulnerable Localised flooding of land and roads – risk of aquaplaning Localised flooding could affect individual properties Localised disruption to key sites identified in flood plans Local disruption to travel – longer journey times
Medium	Significant disruption 40-60% likelihood of flooding	Flooding affecting properties and parts of communities. Damage to building/structures is possible. Possible danger to life due to fast flowing/deep water. Disruption to key sites identified in flood plans eg Railways, utilities, hospitals, health centres, GP Practices. Disruption to travel is expected. A number of roads are likely to be closed.

High	Severe disruption. 60% or greater chance of flooding	Widespread flooding affecting significant numbers of properties and whole communities. Collapse of buildings/structures is possible. Danger to life due to fast flowing/deep water. Widespread disruption or loss of infrastructure identified in flood plans. Large scale evacuation of properties may be required. Severe disruption to travel. Risk of motorists becoming stranded.

Flood Warnings - the government, in collaboration with the Environment Agency provide a flood warning summary by area or postcode:

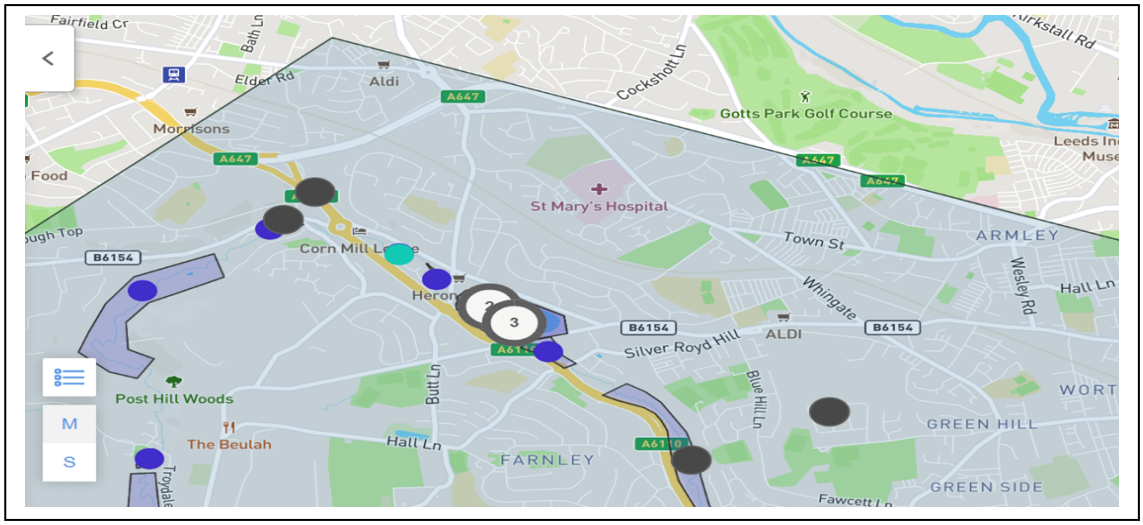
Flood alerts and warnings - GOV.UK (check-for-flooding.service.gov.uk)

Contact the Floodline for advice:

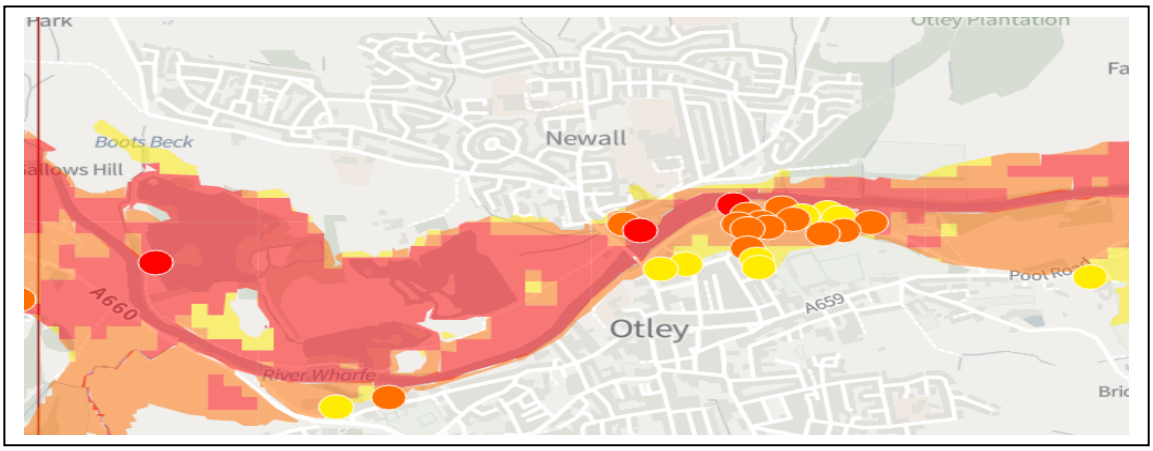
Telephone: 0345 988 1188
Textphone: 0345 602 6340
Open 24 hours a day, 7 days a week

FLOOD MAPS

1. Worley Beck Health Centre, Ring Road, Lower Wortley, Leeds LS12 5SG



2. Wharfedale Hospital - Newall Carr Rd, Otley LS21 2LY

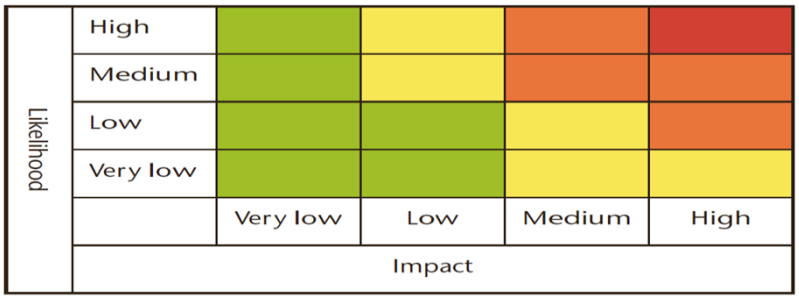


Impact Matrix

There are impact tables for all eight of the severe weather elements.

Likelihood and Impact are plotted onto a Weather Impact Matrix:

Likelihood of impacts occurring



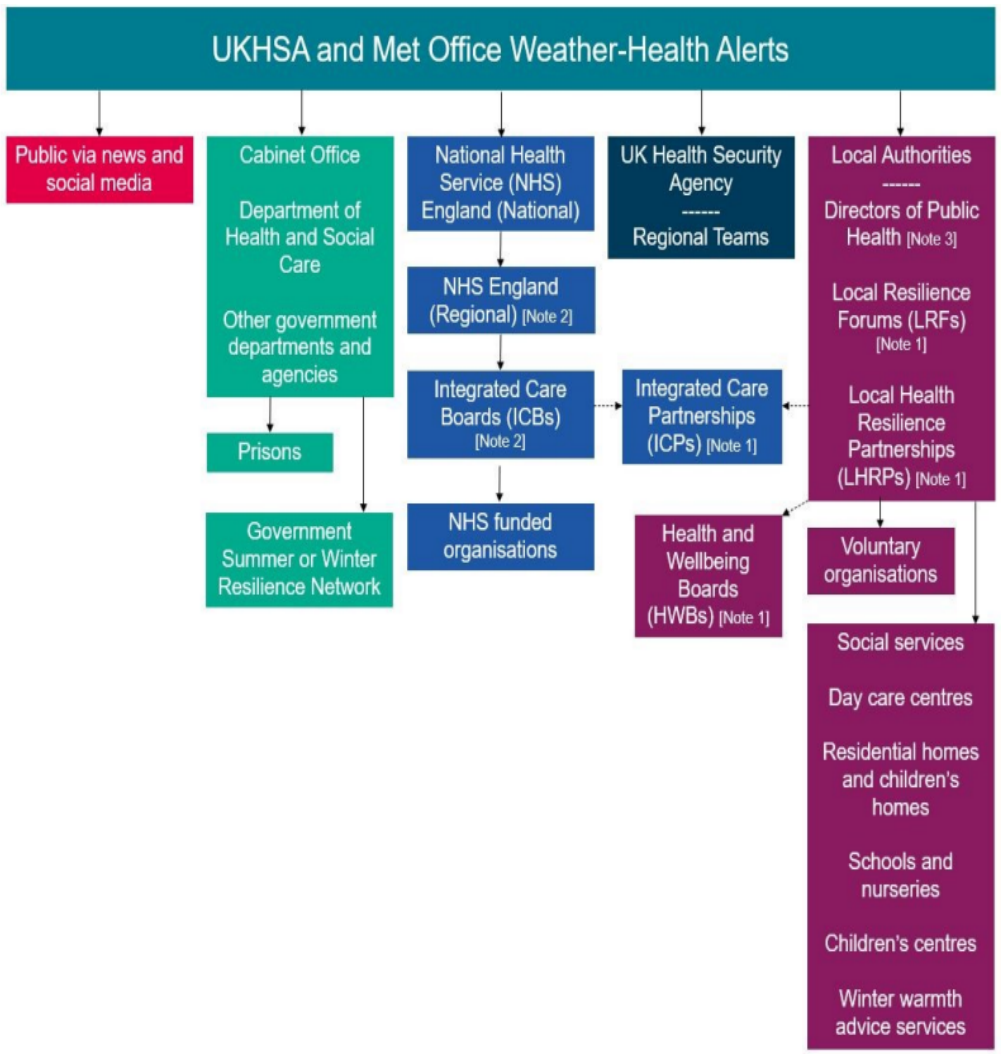
Level of impacts expected

Plotting the Likelihood against the Impact allocates the warning a colour.

The location of the tick in the box is the important element NOT the colour!

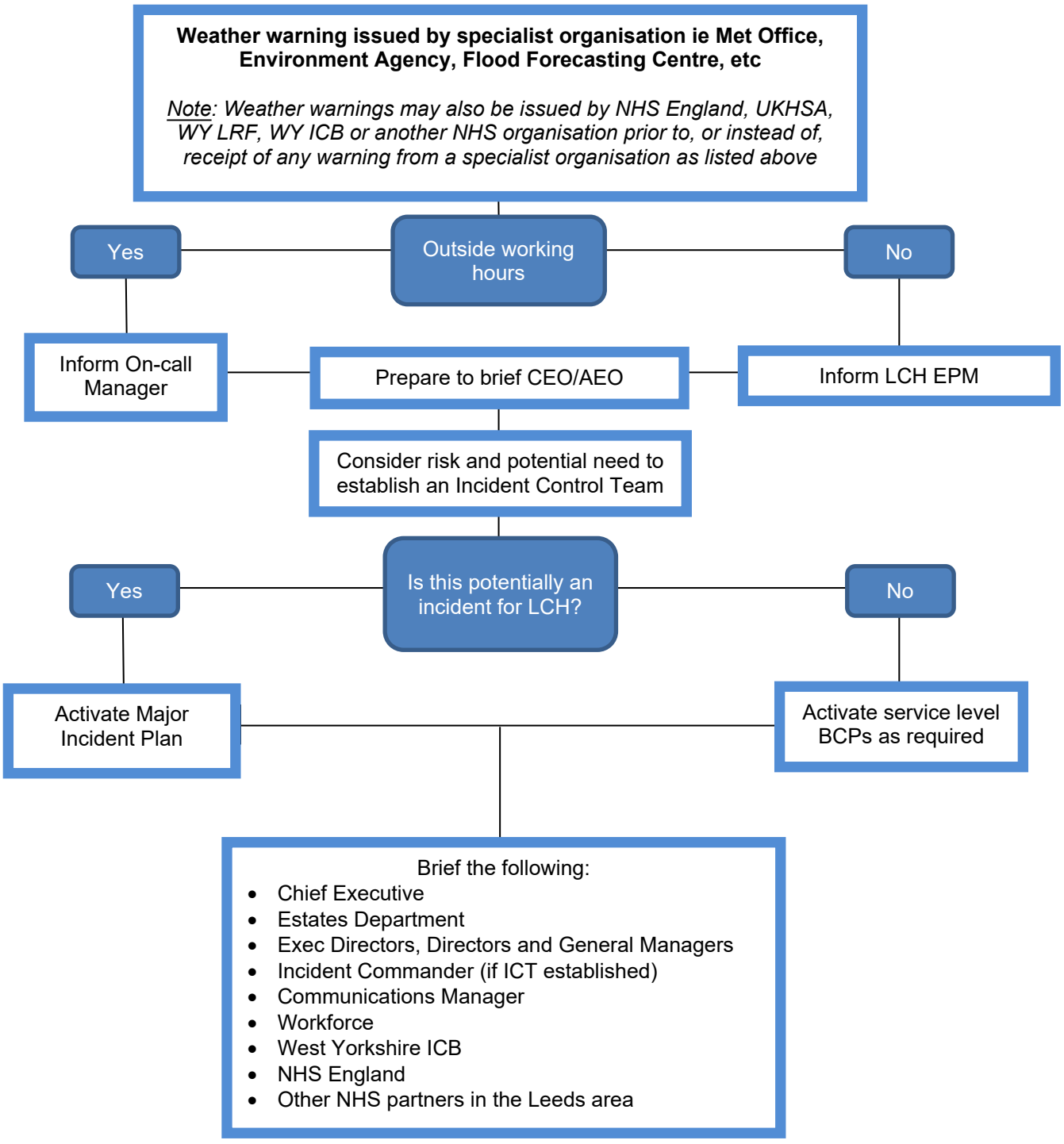
Cascade of Weather Health Alerts

Typical cascade of Weather Health Alerts



UKHSA Adverse Weather Health Plan – April 2023

Cascade System for Adverse Weather Notification



Flowchart 1 – Notification Arrangements

Action Card 1 - Emergency Planning Manager

<table>
<tr><th colspan="3">GREEN / LEVEL 1 ALERT (PREPAREDNESS)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">• Ensure up-to-date arrangements are in place to receive weather and flood alerts and cascade to relevant staff / departments.
• Review any revised guidance and update the LCH Adverse Weather Plan accordingly.
• Distribute relevant guidance from UKHSA, Met Office, Local Authority, via Comms (My LCH).
• Liaise with the WY ICB and partners to enquire if joint surge and escalation meetings are required.
• Liaise with the Communications Team to agree a communication strategy for staff, service users and members of the public to address adverse weather preparedness.</td><td>Heat Wave</td><td>• No additional actions required.</td></tr>
<tr><td>Cold Weather (Snow & Ice)</td><td>• Review the UKHSA Information Card for Cold Weather \Heat Health Alert – Health, social care and local authority organisations and action accordingly.</td></tr>
<tr><td>FGS Flood Risk Assessment: Very Low

No flood alerts in place</td><td>• Identify vulnerable healthcare premises and ensure that appropriate business continuity and response plans are in place.</td></tr>
<tr><th colspan="3">YELLOW / LEVEL 2 ALERT (ALERT AND READINESS)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">Continue actions as per Green/Level 1 Alert, plus the following:
• Maintain a watching brief of the weather and/or flood alerts in conjunction with advice from the Met Office, Public Weather Service Advisor or Hazard Manager, and cascade as required.
• Liaise with ICB and partners to enquire if joint surge and escalation meetings are to be scheduled.
• In conjunction with the Communications Team, co-ordinate advice and information for staff, service users and partner agencies</td><td>Heat Wave</td><td>• No additional actions required.</td></tr>
<tr><td>Cold Weather (Snow & Ice)</td><td>• No additional actions required.</td></tr>
<tr><td>FGS flood risk assessment: Low

Flood Alert in place</td><td>• Maintain a watching brief of the Environment Agency river level information.
• Review specific information in the Flood Alert to assess potential escalation of warning.</td></tr>
</table>

<table>
<tr><th colspan="3">AMBER / LEVEL 3 ALERT (RESPONSE)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">Continue actions as per Yellow/Level 2 Alert, and:
Distribute Commonly Recognised Information Picture (CRIP) messages to Emergency Planning leads.
If activated, work with BDCFT Incident Control Team</td><td>Heat Wave</td><td>No additional actions required.</td></tr>
<tr><td>Cold Weather (Snow & Ice)</td><td>No additional actions required.</td></tr>
<tr><td>FGS flood risk assessment: Medium

Flood warning in place</td><td>Maintain a watching brief of the Environment Agency river level information.
Review specific information in the Flood Warning to assess potential escalation of warning.
Liaise with Estates & Facilities re warning contents, to consider any actions which can be taken to protect vulnerable LCH sites where appropriate as per flood risk action card.</td></tr>
<tr><th colspan="3">RED / LEVEL 4 ALERT (RESPONSE / MAJOR INCIDENT)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">Continue actions as per Amber/Level 3 Alert</td><td>Heat Wave</td><td>No additional actions required</td></tr>
<tr><td>Cold weather (Snow & Ice)</td><td>No additional actions required</td></tr>
<tr><td>FGS flood risk assessment: High

Severe flood warning in place</td><td>No additional actions required</td></tr>
</table>

Action Card 2 - On-Call Manager (may delegate to Tactical Commander)

<table>
<tr><th colspan="3">GREEN / LEVEL 1 ALERT (PREPAREDNESS)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">• Routine preparation actions\warning and informing completed by Emergency Planning Manager\Comms</td><td>Heat Wave</td><td>• No additional actions required</td></tr>
<tr><td>Cold Weather (Snow & Ice)</td><td>• No additional actions required</td></tr>
<tr><td>FGS Flood Risk Assessment: Very Low

No flood alerts in place</td><td>• No additional actions required</td></tr>
<tr><th colspan="3">YELLOW / LEVEL 2 ALERT (ALERT AND READINESS)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">• Alert and readiness actions\ warning and informing completed by Emergency Planning Manager\Comms</td><td>Heat Wave</td><td>• No additional actions required.</td></tr>
<tr><td>Cold Weather (Snow & Ice)</td><td>• No additional actions required.</td></tr>
<tr><td>FGS flood risk assessment: Low

Flood Alert in place</td><td>• No additional actions required.</td></tr>
<tr><th colspan="3">AMBER / LEVEL 3 ALERT (RESPONSE)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">• Liaise with WY ICB to consider the need to convene a joint surge and escalation meeting or teleconference.
• Where a joint surge and escalation meeting is <u>not</u> established, LCH to be represented at city Silver meeting (to include UKHSA and Local Authority representation).
• Participate in multi-agency Silver and wider multi-agency response, if established.
• Work with multi-agency partners to maintain critical health and social care services (referencing the LCH Major Incident Plan).
• Consider setting up an Incident Control Team and appointing an Incident Commander</td><td>Heat Wave</td><td>• No additional actions required</td></tr>
<tr><td>Cold Weather (Snow & Ice)</td><td>• No additional actions required</td></tr>
<tr><td>FGS flood risk assessment: Medium

Flood warning in place</td><td>• Liaise with ICB and Local Authority concerning the identification of vulnerable individuals in areas subject to evacuation, as required.
• Work with ICB to manage continuity of services where premises are affected, if required.
• Work with ICB\Local Care Direct concerning provision of staff at Local Authority rest centres, if necessary.
• Notify Estates & Facilities re content of warnings</td></tr>
</table>

<table>
<tr><th colspan="3">RED / LEVEL 4 ALERT (RESPONSE / MAJOR INCIDENT)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">Continue actions as per Amber/Level 3 Alert and:
If not already established, LCH to link in with joint surge and escalation meetings and/or teleconferences until the situation improves.
Consider the need to declare a Major Incident based on the impact of the weather on the delivery of LCH critical services and the wider health and care system
If not already done so, invoke the LCH Major Incident Plan.</td><td>Heat Wave</td><td>No additional actions required</td></tr>
<tr><td>Cold weather (Snow & Ice)</td><td>No additional actions required</td></tr>
<tr><td>FGS flood risk assessment: High

Severe flood warning in place</td><td>No additional actions required</td></tr>
</table>

Action Card 3 - Communications Lead

<table>
<tr><th colspan="3">GREEN / LEVEL 1 ALERT (PREPAREDNESS)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">• In addition to use of the WY Media Toolkit and the LCH Crisis Comms pack for communications, liaise with the Emergency Planning Manager to develop a communication strategy to promote adverse weather preparedness for staff, services and members of the public.
• Liaise with NHS England, West Yorkshire ICS and other partner agency Communications Teams to ensure that adverse weather preparedness advice is consistent.
• Select pre-prepared\develop media statements to warn members of the public and promote preparedness in regard to adverse weather.
• Discharge standing responsibilities in line with existing emergency response arrangements.</td><td>Heat Wave</td><td>• Respond in line with the arrangements detailed in Section 4.3 of the LCH Adverse Weather Plan.</td></tr>
<tr><td>Cold Weather (Snow & Ice)</td><td>• Respond in line with the arrangements detailed in Section 4.3 of the LCH Adverse Weather Plan.</td></tr>
<tr><td>FGS Flood Risk Assessment: Very Low

No flood alerts in place</td><td>• No additional actions required.</td></tr>
<tr><th colspan="3">YELLOW / LEVEL 2 ALERT (ALERT AND READINESS)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">Continue actions as per Green/Level 1 Alert, plus the following:
• Respond in line with Communications Plan, as appropriate.</td><td>Heat Wave</td><td>• Respond in line with the arrangements detailed in Section 4.3 of the LCH Adverse Weather Plan.</td></tr>
<tr><td>Cold Weather (Snow & Ice)</td><td>• Respond in line with the arrangements detailed in Section 4.3 of the LCH Adverse Weather Plan.</td></tr>
<tr><td>FGS flood risk assessment: Low

Flood Alert in place</td><td>• No additional actions required.</td></tr>
<tr><th colspan="3">AMBER / LEVEL 3 ALERT (RESPONSE)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">Continue actions as per Yellow/Level 2 Alert, plus the following:
• Respond in line with the communications requirements of the LCH Major Incident Plan\Crisis Comms Pack or service level Business Continuity Plans, as appropriate.</td><td>Heat Wave</td><td>• Respond in line with the arrangements detailed in Section 4.3 of the LCH Adverse Weather Plan.</td></tr>
<tr><td>Cold Weather (Snow & Ice)</td><td>• Respond in line with the arrangements detailed in Section 4.3 of the LCH Adverse Weather Plan.</td></tr>
<tr><td>FGS flood risk assessment: Medium</td><td>• No additional actions required.</td></tr>
</table>

	***Flood warning* in place**	
RED / LEVEL 4 ALERT (RESPONSE / MAJOR INCIDENT)		
Actions for all weather types	**Actions for specific weather types**	
Continue actions as per Amber/Level 3 Alert	**Heat Wave**	• Respond in line with the arrangements detailed in Section 4.3 of the LCH Adverse Weather Plan.
	Cold weather (Snow & Ice)	• Respond in line with the arrangements detailed in Section 4.3 of the LCH Adverse Weather Plan.
	FGS flood risk assessment: *High* *Severe flood warning* in place	• No additional actions required.

Action Card 4 - Operational Lead\Head of Service

<table>
<tr><th colspan="3">GREEN / LEVEL 1 ALERT (PREPAREDNESS)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="3">• Ensure up-to-date arrangements are in place to receive weather and flood alerts and cascade to relevant staff / services.
• Ensure staff are aware of their roles and responsibilities in response to adverse weather.
• Provide information regarding adverse weather preparedness to patients and staff.
• Ensure that processes are in place to identify vulnerable individuals at risk from seasonal variations eg extreme heat
• Identify changes that would need to be made to individual care plans due to seasonal variation, particularly for those in high-risk groups (eg initiating daily visits, revisit care plans).
• Work with the families and informal carers of at-risk individuals to ensure awareness of the dangers due to seasonal variations eg extreme heat</td><td>Heat Wave</td><td>• Review UKHSA Hot Weather and Health: guidance and advice – May 2023
Hot weather and health: guidance and advice - GOV.UK (www.gov.uk)
• Distribute UKHSA factsheets Hot Weather and Health: Supporting Vulnerable People to Trust, Beat the Heat to Business Units\Operational staff
• Identify and create cool areas at Hannah House, Wharfedale Hospital and in patients' homes.</td></tr>
<tr><td>Cold Weather (Snow & Ice)</td><td>• Review UKHSA Adverse Weather and Health Plan – Nov 2023
• Review the Cold Weather: Guidance and Advice information cards for health, social care and local authority organisations and action accordingly.
• Share information cards\guidance with Business Units and relevant teams.
• Ensure plans are in place to provide influenza and Covid vaccinations to all front-line staff and encourage vaccination uptake.</td></tr>
<tr><td>FGS Flood Risk Assessment: Very Low

No flood alerts in place</td><td>• Identify vulnerable healthcare premises and services and ensure that appropriate business continuity and response plans are in place.</td></tr>
<tr><th colspan="3">YELLOW / LEVEL 2 ALERT (ALERT AND READINESS)</th></tr>
<tr><th>Actions for all weather types</th><th colspan="2">Actions for specific weather types</th></tr>
<tr><td rowspan="2">Continue actions as per Green/Level 1 Alert, plus the following:
• Maintain a watching brief on the weather and/or flood alerts and cascade as required.
• Anticipate the potential impact of adverse weather on service provision and demand and develop actions as appropriate.
• Ensure that patients who are at high risk from adverse weather have been identified and have visitor/phone call arrangements in place.</td><td>Heat Wave</td><td>• Re-distribute the UKHSA advice (as above) to relevant staff.
• Initiate changes to individual care plans in the event of a heatwave if required.
• When visiting patients check room temperatures to ensure they are in the coolest area of the house with access to cool drinks
• Ensure that cool areas are available and consistently at 26°C or below.
• Prioritise particularly vulnerable individuals to have time in a cool area.
• Obtain supplies of ice/cool water.</td></tr>
<tr><td>Cold Weather (Snow & Ice)</td><td>• Re-distribute UKHSA information card\guidance and advice for Cold</td></tr>
</table>

• Repeat messages on risk and protective measures to staff and patients		Weather – NHS, social care and community and hub staff. • When visiting clients check room temperatures to ensure that clients are warm. • Consider how the forecast weather conditions may impact on service delivery ie snow and icy roads may delay home visits. • Check clients have supplies of food and medication and that they are claiming the benefits to which they are entitled. • Ensure staff are aware of cold weather health risk and can advise patients on how to protect again the cold.
	FGS flood risk assessment: *Low Flood Alert* in place	• No additional actions required.
AMBER / LEVEL 3 ALERT (RESPONSE)		
Actions for all weather types	**Actions for specific weather types**	
Continue actions as per Yellow/Level 2 Alert.	**Heat Wave**	• Implement appropriate protective factors, including regular visits and assistance with cold drinks. • Ensure that discharge planning considers the temperature of accommodation and level of daily care during the heatwave period. • Reduce internal temperatures by turning off unnecessary lights and electrical equipment. • For Hannah House and the Wharfedale Hub consider moving visiting hours to mornings or evenings to reduce the effect of afternoon heat. • Implement daily visits/phones calls for high-risk individuals living on their own.
	Cold Weather (Snow & Ice)	• Consider daily visits/phones calls for high-risk individuals living on their own.
	FGS flood risk assessment: *Medium* *Flood warning* in place	• If required work with the LCH Incident Control Team\City Silver regarding provision of staff to a Leeds City Council rest centre. • If required, work with the LCH Incident Control Team to manage continuity of services where premises are affected.

RED / LEVEL 4 ALERT (RESPONSE / MAJOR INCIDENT)		
Actions for all weather types	**Actions for specific weather types**	
Continue actions as per Amber/Level 3 Alert	**Heat Wave**	• Central government will declare a Level 4 alert if necessary
	Cold weather (Snow & Ice)	• No additional actions required
	FGS flood risk assessment: *High* ***Severe flood warning* in place**	• No additional actions required

Appendix 7

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare

FINAL
Fuel Disruption Plan

Version 0.2
October 2024

1. This document is part of a suite of Emergency Preparedness, Resilience and Response (EPRR) plans which have been developed to provide the framework by which Leeds Community Healthcare NHS Trust will respond to specific incidents\events.
2. This document must be read and applied in conjunction with LCH incident specific plans and service level Business Continuity Plans as appropriate.
3. An electronic copy of the latest version of this document is available in the On-call channel on MS Teams and the Trust H:Drive.
4. All On-call managers are asked to familiarise themselves with the contents of the LCH EPRR documentation.
5. In the event of an emergency, to contact the On-Call Manager please ring:

0845 2657599

Please note: All approved and ratified policies and procedures remain in place until there is notification of an amended policy or procedure by the EPRR Team.

Document details:	Leeds Community Healthcare NHS Trust Fuel Disruption Plan
Version:	Final Version
Persons / committees consulted:	External: Partner organisations in West Yorkshire Internal: LCH On-call Managers\Exec Directors LCH Communications Team LCH EPRR Testing & Learning Group Trust Leadership Team LCH Business Committee
Approved by:	Business Committee
Date approved:	30/10/2024
Ratified by:	
Date ratified:	
Title of originator / author:	Emergency Planning Manager
Title of responsible committee / group (or Trust Board):	LCH Trust Board
Title of responsible Director:	Executive Director of Operations (Accountable Emergency Officer)
Date issued:	
Review date:	September 2025
Frequency of review:	Annual Review in line with NHSE EPRR Core Standards
Target audience:	All staff
Copies available from:	Emergency Planning Manager
Where is previous copy archived (if applicable)	H:Drive
Amendment Summary:	

Version Control:

Date	Version	Author	Changes/ Reason	Documents Replaced (if any)
September 2024	0.1	Rebecca Todd EPRR Manager	Document updated in line with NHS England EPRR Framework guidance and other national best practice arrangements	
October 2024	0.2 (Final)	Rebecca Todd EPRR Manager Peter Ainsworth Operational support manager	Updated following a regional exercise.	0.1

LCH Fuel Disruption Plan Sign-off

The Fuel Disruption Plan for Leeds Community Healthcare NHS Trust has been formally signed-off by the Leeds Community Healthcare NHS Trust Board as fit for purpose.

_____

Chief Executive

_____

Date

_____

Chair of the Board

_____

Date

Contents

Annexe

Action Cards

INTRODUCTION

1.1 The effects of a fuel shortage are likely to increase in impact as the duration of a shortage continues. Leeds Community Healthcare (LCH) delivers the majority of its services in the community and relies on staff using their own transport. In the event of a national fuel crisis LCH will activate the Trust-Wide Business Continuity Plan (BCP), implement service level BCPs to maintain critical service elements, and if necessary, activate the LCH Incident Response Plan.

1.2 The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) state that Trusts must have plans in place to mitigate the effects of a road fuel shortage.

1.3 The Government Department for Energy & Climate Change has a National Emergency Plan for the event of fuel crisis (NEP-F). Within this plan are emergency powers that can be implemented in the event of disruption to fuel supplies to enable the supply of fuel to the emergency services and also utility organisations, some of whom supply the health service. However, this plan will only be activated in extenuating circumstances (not at initial disruption).

1.4 The delivery of critical service elements will be maintained by the Trust for as long as possible in the event of a fuel crisis. In addition, LCH will endeavour to implement measures that will assist in the conservation of fuel, such as car sharing, staggered shift patterns, etc. This will contribute to minimising the disruption nationally.

ALERT & ACTIVATION

2.1 The potential for fuel disruption may present itself as a rising tide scenario, (eg sabotage, fuel contamination) or a cloud on the horizon (eg threat of industrial action). Notification of a potential fuel threat will normally be received from external sources and would affect a greater geographic footprint than that of LCH.

2.2 In the event of any fuel disruption, LCH will convene their Incident Co-ordination Team (ICT) and be flexible and sensitive to transport issues. The Trust's response to a disruption in fuel supply will be proportionate to the scale of the disruption.

- In the event of a short-term or minor fuel disruption, LCH will make all efforts to advise staff in the responsible purchasing of fuel and fuel conservation, as well as providing and maintaining essential communications to staff.

- In the event of a prolonged fuel disruption the ICT will be responsible for managing and co-ordinating the Trust's response and actions. Service BCPs will be activated as required.

- In the event of a major fuel crisis the government may introduce emergency powers and put into action various schemes to both conserve fuel and ensure

that priority services and infrastructure are maintained. Within these schemes are contingencies to evenly distribute certain amounts of fuel to the public, and also ensure that the emergency services have access to fuel to maintain their critical services.

2.3 Contingencies to supply fuel for identified staff using their own vehicle in the course of their work for health and social services may be implemented nationally. This would only occur in extenuating circumstances, therefore in the first instance service level BCPs will be activated.

2.4 There is no provision for fuel to be supplied to staff to get to their place of work. This must be considered by staff, as they may need to make alternative arrangements for getting to work during this period of disruption. Each member of staff has a responsibility to report for work. Similarly, it is made clear in NEP-F that this scheme should not be used to supply fuel to staff for the purposes of getting to work. Staff should be encouraged to conserve fuel for this, car share, walk or utilise public transport.

COMMAND & CONTROL

3.1 **Chief Executive**
Ensure that LCH can effectively respond and manage service disruption as a result of a disruption or crisis in fuel supplies.

3.2 **Accountable Emergency Officer**
The AEO is responsible for receiving notifications from NHS England (via LHRP) declaring a disruption to fuel in the area and will:

- Ensure that business continuity arrangements pay due and proper attention to potential fuel shortages and staff depletion.
- Give advice on impending fuel shortages
- Chair the ICT, with responsibility to manage the Trust response to the fuel crisis.
- In consultation with the Chief Executive, consider whether the Trust should declare a Major Incident.

3.3 **Deputy Directors**
Take the actions shown on Action Card 1.

3.4 **Deputy Director of Estates & Facilities**
Take the actions shown on Action Card 2.

3.5 **Heads of Service**
Take the actions shown on Action Card 3.

3.6 **Service Managers/Team Leaders**
Take the actions shown on Action Card 4.

3.7 **Emergency Planning Manager**
Take the actions shown on Action Card 5.

3.8 **Communications Manager**
Take the actions shown in the Incident Response Plan, Action Card 3.6 and section 4 of this plan.

COMMUNICATIONS

4.1 Care will be taken in communicating with staff during a disruption or potential disruption of fuel. Inaccurate and inappropriate messages to Trust employees may have the effect of creating rumour and causing panic buying. In turn, panic buying of fuel may either create a problem where there was not one or exacerbate an existing problem.

4.2 In the event of a fuel dispute, General Managers\Heads of Service will be briefed regarding any potential fuel disruption through the ICT. They will be advised on the actions LCH may take and distribute messages across their services.

- All communication will be agreed with and co-ordinated by the ICT, via the Head of Communications.
- Pre-prepared messages for this scenario will be available from the Communications team.
- Messages to staff groups will be disseminated through the line management structure and alternative communication methods including MyLCH
- Any correspondence with the media must be conducted through the Communications department.

PLANNING ASSUMPTIONS

5.1 Fuel will be accessible to ensure the delivery of critical services.

5.2 The Trust will work with other organisations in Leeds to maintain similar arrangements and to share resources where appropriate.

MINOR FUEL DISRUPTION

6.1 Short Term

In the event of a potential short-term or minor disruption to the supply of fuel, the Trust will communicate with staff, advising them of responsible actions and disseminating appropriate messages and guidance. This will both assist staff in being more prepared and reinforce the message of responsible fuel purchasing, which will potentially prevent a minor disruption becoming significant.

The messages given to staff in this type of scenario would include:

- Be responsible, buy fuel normally.
- To avoid escalating the issue do not panic buy.
- Drive sensibly to conserve fuel use.
- Where possible avoid using the car.
- Use public transport, walk or cycle.
- Car share where possible (including with other teams and services).
- Prioritise your car use where possible to be able to get to\from work if necessary and ensure that if on call you have enough fuel to last you for the on-call period.

Actions taken by the Trust minimise fuel use will be as follows:

- Promote alternate modes of transport to be utilised where possible, such as public transport, car sharing, walking or cycling.
- Face to face training and non-critical meetings will be deferred.
- Flexible/ hybrid working will be permitted where appropriate to reduce commuting.
- Staff will be encouraged to plan journeys around the shortest overall travel distance.
- A list of electric car volunteers will be prepared.
- Non face to face appointments for patients will be put in place wherever appropriate.

6.2 Elongated Time period

Fuel supplies may require to be accessed through emergency sources. The NEP-F may be activated that would enable LCH to access a limited supply of emergency fuel supplies.

Individual service level BCPs and the LCH Incident Response Plan will be activated as required and overseen by the ICT.

Partner organisations such as the Yorkshire Ambulance service and Leeds city council have access to bunkered diesel fuel. The ICT leads would link with citywide command groups to discuss the possibility of accessing this fuel for staff undertaking essential/ priority visits. Alternatively, Leeds city council could offer a vehicle and driver service/

MAJOR FUEL DISRUPTION

7.1 In the event of a major fuel disruption, the government may be forced to implement emergency powers under the Energy Act 1976. In this instance, special measures may be activated by the Trust in order to maintain services during the disruption.

7.2 In the event of a severe fuel crisis it may be necessary for LCH to suspend non-essential activities to support the continued delivery of critical service elements as outlined in the LCH Incident Response Plan and the Trust-wide BCP.

MAXIMUM PURCHASE SCHEME (MPS)

8.1 Under emergency powers the government may issue a scheme to limit the public to a maximum of 15 litres of fuel per visit to a petrol station. This should enable staff to be able to travel to and from work. Staff will need to prioritise on journeys that are non-essential and should be encouraged to use their vehicles responsibly. Staff will be expected to conserve fuel as far as possible to ensure that they can get to and from work at all times.

EMERGENCY SERVICES SCHEME (ESS)

9.1 Under emergency powers the government may implement the Emergency Services Scheme (ESS). In this scheme, designated petrol stations will supply fuel to vehicles with an emergency service logo, including NHS vehicles. This will allow vehicles owned by the Trust to be supplied with fuel.

9.2 In such an event, Temporary Fuel Logos will be issued to some services and staff. However, issue will be strictly limited to those services where car use is essential to the delivery of care, and then only for those who drive vehicles that do not already have NHS logos.

It is likely that the number of Fuel logos the Trust receives will be lower than the number of staff that would require access to fuel. LCH provides some critical 24/7 services therefore it may be necessary to use this scheme to ensure there is continued care provision for our most vulnerable patients. Patient needs will be risk assessed and appropriate actions will be implemented. The Trust approach will be to prioritise the service provision that would be delivered every day including Xmas day/ Boxing day.

9.3 In the event of the ESS being implemented:

- Services will confirm essential car users who will need a Temporary Fuel Logo for the period of the fuel disruption (see application at Annex C).
- Temporary Fuel Logos will be issued by the ICT for teams\staff who may require fuel in order to fulfil their duties in the organisation.
- A Temporary Fuel Logo will be issued to the team\staff member to be used at a designated fuel station for the purpose of one visit.

- The Temporary Fuel Logo is to be returned after fuel has been obtained, along with a copy of the receipt from the filling station verifying the amount of fuel obtained.
- A log will be maintained each time a Temporary Fuel Logo is used and the circumstances as to why it was required (see Annex B).
- A copy of the filling station receipt is to be retained with the log.
- Fuel obtained with a Temporary Fuel Logo must be used for Trust business only.
- Staff will be expected to obtain fuel under MPS for their own personal use.

Note
Abuse of the ESS scheme is a criminal offence, which may lead to prosecution

10. CAR SHARING/ VOLUNTEER DRIVERS

10.1 During a major fuel disruption LCH will encourage staff to car share. Each service will be requested to supply details of staff that use a car to travel to work, the area travelled from and copies of the duty rotas (see template at Annex D).

10.2 A number of staff will have access to electric cars either through private ownership of through one of the Trust leasing schemes. These staff will be encouraged to become volunteer drivers for essential services.

10.3 Staff that have problems travelling to work are to contact their manager who will try to match them up with another member of staff living in the same area and working on the same day\shift. This driving member of staff could be from another team or service.

11. FLEXIBLE SHIFTS, AGILE & WORKING FROM HOME

11.1 During an elongated fuel crisis, flexibility with regards to working patterns may require consideration. Service managers will need to be sensitive to problems staff have regarding being at work at certain times due to transport arrangements.

Temporary changes to shift patterns may be required during the duration of the fuel disruption. Increasing the length of the working day and reducing the number of days worked is an effective way of reducing fuel consumption for staff. Flexibility on start and finish times will be considered and agreed where acceptable.

11.2 Some staff may be able to agile work or work from home during a severe fuel disruption. Wherever possible sufficient essential on-site cover must be maintained in clinical locations.

The ICT will oversee and manage changes to working patterns through management structures.

12. LCH EMERGENCY PLANNING DOCUMENTS

12.1 This plan is part of a suite of emergency documents. These plans, developed in consultation with partners, enhance contingency measures and planning across the Trust which provides an established framework by which the Trust will respond to events.

12.2 As part of the LCH Business Continuity Management System, the EPRR Policy, Business Continuity Policy, Trust-Wide Business Continuity Plan and service level Business Continuity Plans support the Incident Response Plan and a wider suite of incident specific emergency documents to enhance contingency measures and planning across the Trust.

12.3 Plans for specific emergencies will be activated as appropriate and in tandem with the Incident Response Plan if required. These specific plans include: Severe weather (eg heat wave, snow, ice and flooding), lockdown, evacuation and shelter, new and emerging pandemic, infectious disease.

12.4 Details of available plans can we found in the On-call folder on the H:Drive and on the On-call channel on MS Teams.

REFERENCE DOCUMENTATION

LCH documents:

- Incident Response Plan
- Trust-wide Business Continuity Plan
- Joint EPRR and Business Continuity Management System\Statement\Policy
- Service level Business Continuity Plans for individual LCH service areas
- HR Policies

Other Guidance:

- National Emergency Plan for Fuel (NEP-F) *{restricted document}*
- The Energy Act 1976
- The Civil Contingencies Act 2004
- The Health and Care Act 2022
- PAS 2015: Framework for Health Services Resilience
- PAS 200: Crisis Management guidance and good practice
- ISO 22301 & ISO 22313: Business Continuity Management Systems – Requirements
- NHS England EPRR Core Criteria
- NHS Guidance on Planning for Disruption to Road Fuel Supply
- HM Government (2007) Data Protection and Sharing – Guidance for Emergency planners and Responders

LIST OF ESSENTIAL FUEL USERS

Those using fuel to travel as a part of delivering an essential function:

The number of staff considered to be essential fuel users and able to access fuel from designated fuel stations will be considered by the Silver and Bronze command teams. The criteria will be determined by:

- The number of temporary fuel logos available to the Trust.
- The length of time the disruption creates risks for services/ patients
- The strategic decisions taken at a regional/ citywide level around prioritising services based on whole system risks.

As an absolute minimum, essential fuel users will be from services that operate 365 days a year – including Christmas day and Boxing day.

Staff will only receive a Temporary Fuel Logo if their manager is satisfied that they meet the requirements of Annex C to this plan and that all other possibilities have been exhausted, including use of public transport, cycling, walking, the Minimum Purchase Scheme (MPS), car sharing, home working and other flexible working practices.

Leeds Community Healthcare NHS Trust

TEMPORARY LOGO ISSUE LOG (to be completed by issuing manager)

Team: _____ Location: _____

Issuer: (Print name) _____ Role: _____ Signature: _____

Logo Serial No.	*Full Name of Holder*	*Reason for Issue (From Annex A to this plan)*	*Vehicle Registration Number*	*Fuel (P/D)*	*Date Logo Issued*	*Amount of fuel bought with Logo (Litres)*	*Logo Holder Signature*	*Date Logo Returned*
001	Mr Other Person	IHTT	C4R R3G	P	12 Feb 12	50	Example	14 Feb 12

Continuation sheet _____ of _____

Logo Serial No.	*Full Name of Holder*	*Reason for Issue (From Annex A to this plan)*	*Vehicle Registration Number*	*Fuel (P/D)*	*Date Logo Issued*	*Amount of fuel bought with Logo (Litres)*	*Logo Holder Signature*	*Date Logo Returned*

Continuation sheet _____ of _____

TEMPORARY LOGO GUIDANCE

Guidance issued with Temporary Logo Application

Any temporary logo issued is wholly to enable you to access the Temporary Logo Scheme (TLS) as a driver of a non-logoed vehicle, and to enable you to undertake the **essential health, social care and critical life-saving** services provided by you on behalf of Leeds Community Healthcare NHS Trust.

Only the person to whom this document has been issued is entitled to use it to obtain fuel at a Designated Filling Station (DFS) operating the Emergency Services Scheme. A list of the local DFS is available by contacting your Emergency Planning Manager.

Abuse of this Scheme is a criminal offence under section 18(2) of the Energy Act 1976 and offenders may be prosecuted.

In order to obtain fuel, authorised users must produce the Temporary Logo document along with their (photographic) Staff ID at the point-of-sale or kiosk at the DFS. They should also ensure that they have a valid means of payment, as the Temporary Logo does not entitle you to free fuel.

DFS operators will only allow access to fuel once they are content that a recognisable logo has been displayed (vehicle or temporary), ID and means of payment has been confirmed. Once the Fuel Retailer is content that they are a legitimate user they will then turn on the pumps.

Where there is doubt about a Temporary Logo or identification the DFS operator will contact the local Incident Co-ordination Team on the number provided to them for advice. Temporary Logo users may also use this number if the DFS operator has refused to allow them access to fuel.

Fuel purchased under the TLS should only be used by the named member of staff carrying out **critical functions** of the Trust. It should not be used for non-critical or domestic use ie a Temporary Logo user should not fill their tank, use ¼ of the fuel for a critical service and the remaining ¾ for private travel. Fuel for non-critical or domestic use should be purchased under the Maximum Purchase Scheme (MPS) at non-DFS retail filling stations.

There is no maximum purchase when refuelling under the TLS at a DFS. Users are also allowed, subject to certain conditions, to fill portable containers with fuel required for their work.

Any misuse of this document may not only give rise to a prosecution as detailed, but also internal disciplinary action by LCH.

The Department of Energy and Climate Change's legal advice is that "**Once issued with a logo, on the part of the user, the filling of a vehicle where its use is not necessarily incidental to the carrying out of the functions of the service provider is where the offence lies**".

TEMPORARY FUEL LOGO APPLICATION – ESSENTIAL / PRIORITY USER

(extracted from the requirements of NEP-F and NHS England guidance)

Part 1 – For completion by individual staff member

Name (Driver):	Contact Tel No:	Date:
Department (or Company carrying out contracted work)		
Role and brief description of service(s) provided, including any call out required:		
Vehicle Make/Model:	Registration No:	

Declaration: In applying for a temporary fuel logo I confirm that I understand:

- The purpose and scope of the scheme and the penalties for its misuse.
- The Trust may seek clarification and documentation to support this application.
- Any purchase made under this scheme will be monitored, cross referenced and audited.
- I am required to return the temporary logo to the issuing manager immediately after use, accompanied by a copy of the purchase receipt.
- I agree to abide by the conditions for use of the temporary logo, as stated in the LCH Fuel Disruption Plan.

Name: …… Signed: …… Date: ……

Part 2 – For completion by issuing manager

Name (Manager):	Contact Tel No:	Date:

Assessment of Role/Service	Yes	No	Reason
Has the above service been identified as a *Critical Service* in the LCH Incident Response Plan?			
Is the staff member conducting **essential health, social** or **lifesaving** services which must be maintained during an emergency period?			
Which of the following criteria are met by the individual applying for the temporary fuel logo?: • Reduce mortality or progression of disease • Alleviate human suffering (incl palliative care) • Meet legal obligations (eg Children Act, Mental Health Act or other) (give details) • Emergency, clinical or social service • Other function or service (give details)			
Would this scheme be used for the purpose of getting this member of staff to work?			
Could this role be fulfilled using other (spare) LCH\LYPFT logoed vehicles (including pool/lease cars?)			
Could the above service be delivered using public transport / taxi / bicycle?			
Could the above service be delivered through car sharing arrangements or home working?			
Could the above service be delivered by using the Maximum Purchase Scheme (MPS)? (*see guidance*)			

Temporary Logo Serial No		Date & Time issued:	
Application **approved / rejected** *(delete as appropriate)*	Reason:		
Name:	Date:	Signature:	

Note: This completed application is to be submitted to the LCH EPRR Manager.

CAR SHARING TEMPLATE *(for use by service managers)*

LEEDS COMMUNITY HEALTHCARE NHS TRUST Team: _____

Ser No	*Name*	*Home Address*	*Normal Work Location*	*Shift Start Time*	*Shift Finish Time*	*No of Travel Spaces Offered*	*Providing travel to work for (names)*

Fuel Crisis – Checklist of Actions (for consideration by Trust)

The following is extracted from NHS England guidance on fuel planning, which is used as a source of reference within EPRR Core Competency requirements.

Priority or Essential Users

The following guidance on defining a priority or essential user in priority order should be followed:

1. Activities to reduce mortality, morbidity, and significant progression of disease.
2. Activities that will alleviate human suffering, including palliative care.
3. Activities that meet any legal obligations.
4. All other emergency clinical and social services.
5. All other routine clinical and social services.
6. All other functions and services.

Considerations that may assist in workforce planning

Actions to Alleviate Fuel Pressures
▪ Car sharing
▪ Use of official vehicles, contracting the services of a local taxi company as a means of moving staff around particularly from home to work.
▪ Consider options for using staff private hybrid fuel or electric vehicles in support of critical activities.
▪ Cancel or reschedule non-essential meetings.
▪ Introduce/expand telephone conference facilities for meetings.
▪ Flexible working hours may need to be considered, particularly as fuel disruption may affect other services such as schools and childcare providers therefore some staff may have competing priorities for their time.
▪ Bring children to work/providing crèche facilities, for the same reasons as above.
▪ Staff unable to get to work but who are within easy reaches of a partner NHS organisation could be temporarily stationed there.
▪ Drivers' hours may need to be reviewed (ie those drivers routinely covered by commercial driving regulations).
▪ Introduction/expansion of a "Work from Home" Plan for those staff who do not necessarily need to go into the work environment.
▪ Reduced working week ie longer work days thus reducing the number of journeys to work.
▪ Offer temporary contracts to recently retired staff who can access a location more easily ie those who live in close proximity to the workplace or who may have fewer personal restrictions such as childcare requirements.
▪ Use new volunteers with similar circumstances to those above.
▪ During a prolonged period of fuel disruption GP appointments may be reduced to concentrate on urgent and emergency patient services. ▪ It may be appropriate to consider how that can be managed ie activate "out of hours" service during the day. ▪ NHS 111 services may need to be utilised differently to support the wider patient pathways
▪ Further advertise the use of the "Pharmacy Repeat Dispensing Service" whereby patients who are stable on long-term medication are issued with up to twelve prescriptions (up to a one-year supply) by their GP. These prescriptions can then be left with the pharmacy of their choice avoiding the need for patients to make a trip to the GP

for a prescription and then to the pharmacy to have the medicine dispensed. Increased uptake of this service can reduce the number of car journeys.

Guidance to Staff on Conserving Fuel Measures

- Do you really need to drive? Don't use the car unless you must. You can walk / cycle / use public transport / carpool / share vehicles with others.
- Combine your errands – don't make 2 car trips if you can do it in 1.
- Maintain your car properly – poorly tuned engines can more than double your fuel consumption.
- Check your tyre pressure: having the correct pressure can save you fuel.
- Plan your journey: avoid travelling at peak times if you can – sitting in traffic will waste your fuel.
- Know your route - you won't waste fuel getting lost or driving further than necessary.
- By keeping a constant speed you will consume less fuel – drive steadily. (As a rule of thumb a one-unit increase in speed requires a 3-unit increase in power consumption).
- Restrict your speed – the most efficient speed to drive at is 56 mph where permitted. This is also true for HGVs and large vehicles.
- Don't idle: one minute of idling consumes more fuel than starting your engine - turn off the ignition if you're waiting.
- Use fewer electrics: they make your car burn more fuel.
- Don't carry unnecessary weight in your car – only take what you need, the heavier your car the more fuel it will consume.
- Avoid panic buying.

Business Continuity Checklist - Fuel Supply Disruption

To assist in the development and review of plans the following checklist has been developed specifically in relation to fuel shortages.

The lists identify important and specific activities that the Trust can do to prepare for a fuel shortage and many of the activities will also contribute to the development of general business continuity plans.

Assess the impact of fuel shortage
Identify the critical functions that must be maintained for the service (see their Business Continuity Plan).
Identify the key functions and activities delivered by your service which would be affected by a fuel shortage.
Consider which critical activities and resources (including staff) support your key services (eg supplies, suppliers, sub-contractor services/products, security)
Consider how internal resources could be re-allocated to ensure the delivery of key products and services is maintained. Are staff able to cover other roles safely to ensure that your critical services can be delivered? Will additional training be required?
Discuss with your suppliers/sub-contractors whether they have robust Business Continuity Plans in place – your resilience is only as good as that of those you depend on. Ask your suppliers how they plan to respond to a crisis and what support they will give to your organisation. Consider whether future contracts should reflect concerns.
Decide how a reduction in service could be achieved while still delivering critical services. How non-critical work would be stopped safely, smoothly and restarted again when possible to do so.
How will the support functions of your organisation be affected by a fuel shortage, eg building maintenance, cleaning, food provisions for staff
Identify how you would learn of a fuel shortage and what criteria would need to be met for your service to implement business continuity measures. What actions would need to be taken and at which points?
Assess the feasibility of increasing flexible working for staff (eg working from home).

Travelling to and from place of work
Document how staff normally travel to work and whether alternative forms of transport would be available if required.
Consider whether it is possible for staff to work from home and support\encourage this where feasible.
Consider the use of satellite sites. Staff may live closer to these premises and be able to access those locations to work.
Is car-sharing possible for some staff?
Encourage staff to use alternative means of transport instead of private vehicles, this may take longer but may enable staff to get to the organisation’s premises. This could take the form of offering flexibility in their working time or providing relevant facilities eg bike racks, showers etc.
Is it possible to organise communal travel for some staff, for example by taxi or minibus?

Communication
It is crucial to have clear and concise messages ready to share with your staff, patients, service users, carers, health partners and suppliers in the event of disruption.
Have clear and concise messages ready, and a means of communicating to all interested parties\stakeholders, that you are implementing some business continuity measures and how this will affect them.

Consider the messages you might need to give patients, the wider health system, stakeholders, and the process for doing so. In some circumstances it may be useful to discuss possible impacts in advance. This dialogue will help inform planning on both sides and will be particularly important if your services are likely to be impacted or delayed.
Ensure that all services have a named contact and the emergency contact details for all staff. (Access to these details should be included in service BCPs).
Consider how your suppliers are going to be affected by a fuel shortage and discuss with them. Ensure there are clear lines of communications between you both, and a process of keeping suppliers and the organisation informed of progress.
Have clear and concise messages ready, and a means of communicating them to your staff and all interested parties, to let them know that business is returning to normal and that business continuity measures are no longer in effect.

Other considerations
During a fuel shortage there may be other demands on staff (eg children may not be able to attend school, staff sickness). Consideration should be given to the impact of this.
Consider reducing the number of meetings that involve travel, and instead consider tele-conferencing or re-scheduling.
Can mutual aid – could sharing expertise or resources physically or at a distance with other organisations\stakeholders help in delivering your critical services?
Do weather or seasonal work patterns affect your plans, for example in terms of travel options or demand for your services?
How will patients and other service users be affected by the fuel shortage? This could lead to reduced/increased demand for your services - both will have BCP implications.
Consider keeping a supply of critical supplies to ensure you can continue to deliver some, if not all, services in case your supplier is unable to complete their deliveries.
Keep details of alternative suppliers should your primary supplier fail.

Recovery

The following may need to be considered during the recovery stage:

- An increase in patients whose illnesses may have been exacerbated if they have not been able to receive appropriate treatment.
- Backlog of scheduled work.
- Breakdown of community support mechanisms.
- Disruption to daily life (public transport systems, schools, etc).
- Disruption to utilities and essential services.
- Disruption to communication services (including postal deliveries).
- Disruption to supplies (including suppliers, partners, contractors, etc).
- Financial issues.
- Performance targets affected.
- HR and disciplinary issues.
- Reputation damage.

LCH DIRECTORS

On receipt of a warning notification that potential fuel disruption is anticipated Directors and General Managers will:

- Activate the Trust-wide Business Continuity Plan
- Oversee the effective activation and implementation of this Fuel Disruption Plan and service level BCPs as appropriate within their areas of responsibility.
- Ensure that any activation of service level BCPs is notified to the Incident Co-ordination Team (ICT).
- Support all services within their Business Unit\service area to manage staffing and activity during a fuel shortage in line with BCPs.
- Cascade communications messages effectively to staff, as required.
- Agree mutual aid plans with other organisations, including access to bunkered fuel.

Ensure the process for procurement of fuel is effectively implemented throughout the fuel disruption.

An Incident Log must be maintained:

- Records should be kept regarding instructions received, actions taken and any further incidents.
- Logs should be made in black ink. All entries must be timed, dated and signed.

At the end of the incident all notes, logs and records (originals) should be forwarded to the EPRR Manager.

GENERAL MANAGER

Heads of Service will be alerted to a potential fuel disruption by the Accountable Emergency Officer and Emergency Planning Manager.

Necessary actions may include, but will not be limited to:

- Monitoring the situation and updating the General Managers of any significant changes.
- Ensuring care for vulnerable patients is being maintained.
- Ensuring staff well-being is being considered.
- Providing support to the Incident Co-ordination Team (ICT), if\as requested.
- Ensuring sufficient staff and resources are available to maintain LCH critical services as outlined in service level Business Continuity Plans.
- Ensuring situation reports are completed and forwarded in line with deadlines as requested.
- Cascading communications messages effectively to staff, as required.

An Incident Log must be maintained:

- Records should be kept regarding instructions received, actions taken and any further incidents.
- Logs should be made in black ink. All entries must be timed, dated and signed.

At the end of the incident all notes, logs and records (originals) should be forwarded to the EPRR Manager.

HEAD OF SERVICE /SERVICE MANAGER / TEAM LEADER

Service Managers should be alerted to a potential fuel disruption by their Line Manager.

Necessary actions may include, but will not be limited to:

- Ensuring staff are aware of their service level Business Continuity Plan (BCP) and individual responsibilities. See checklists at Annex F to this plan and action as appropriate.
- Responding to actions disseminated and cascaded from the ICT or senior managers.
- Activating and managing BCPs to maintain continuity of services which may include redeployment, flexibility within shift patterns, home working etc.
- Maintaining a list of essential car users that may be entitled to Temporary Fuel Logos.
- Facilitating and managing the use of Temporary Fuel Logos, if authorised to issue.
- Promoting fuel saving measures within services to staff, as appropriate.
- Ensuring staff are regularly briefed on the situation and updated on developments, including the Trust's actions.
- Cascading communications messages effectively to staff as required.

An Incident Log must be maintained:

- Records should be kept regarding instructions received, actions taken and any further incidents.
- Logs should be made in black ink. All entries must be timed, dated and signed.

At the end of the incident all notes, logs and records (originals) should be forwarded to the EPRR Manager.

EPRR

- Ensure relevant emergency plans are fit for purpose and complaint with current legislation and guidance.
- Hold a secure copy of the National Emergency Plan for Fuel (NEP-F), for use during incidents, if required.
- Review the scenario Risk Assessment, ensuring it is updated and fit for purpose.
- Work closely with and assist the Incident Co-ordination Team (ICT).
- Advise ICT on the correct procedures for implementation of the Temporary Logo Scheme and Emergency Services Scheme in the event that the NEP-F is activated
- Collaborate with senior management to confirm the list of essential car users that may be required for the fuel disruption.
- Provide up to date communications from external partners and stakeholders to the ICT for wider dissemination as appropriate.
- When requested by ICT, issue Temporary Fuel Logos to essential service teams.
- Facilitating Sitrep requirements.

The EPRR Team will commence and maintain an Incident Log:

An Incident Log must be maintained:

- Records should be kept regarding instructions received, actions taken and any further incidents.
- Logs should be made in black ink. All entries must be timed, dated and signed.

At the end of the incident, all notes, logs and records (originals) will be forwarded to the Accountable Emergency Officer.

Appendix 9

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

FINAL

Chemical, Biological, Radiological and Nuclear (CBRN) Plan

1. This document is part of a suite of Emergency Preparedness, Resilience and Response (EPRR) plans which have been developed to provide the framework by which Leeds Community Healthcare NHS Trust will respond to specific incidents\events.
2. This document must be read and applied in conjunction with the LCH Incident Response Plan, incident specific plans and service level Business Continuity Plans as appropriate.
3. An electronic copy of the latest version of this document is available in the On-call channel on MS Teams and the Trust H:Drive.
4. All On-call managers are asked to familiarise themselves with the contents of the LCH emergency documentation.
5. In the event of an emergency, to contact the On-Call Manager please ring:

0845 2657599

Please note: All approved and ratified policies and procedures remain in place until there is notification of an amended policy or procedure by the EPRR Team.

Document details:	Leeds Community Healthcare NHS Trust CBRN Plan
Version:	Final Version
Persons / committees consulted:	External: ICS colleagues ICB Internal: LCH Communications Team LCH Workforce LCH EPRR Testing & Learning Group Trust Leadership Team LCH Business Committee
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Date	Version	Author	Changes/ Reason	Documents Replaced (if any)
July 2024	1.0	Rebecca Todd EPRR Manager	New document	CBRN Plan aligned to the latest JESIP IOR Brochure 1.1 (June 2024)

Contents

Annexes

Action Cards:

1	Emergency Planning Manager	Action Card 1
2	On Call Manager/Incident Control Manager	Action Card 2
3	Communications Lead	Action Card 3
4	Heads of Service/Operations	Action Card 4

Introduction

It is recognised that people involved in a CBRN incident could self-evacuate leading to them presenting at hospital or other health facilities for treatment. In the event of an incident taking place Yorkshire Ambulance Service (YAS) will issue an alert to all NHS partner organisations advising them of an incident and the potential for self- presenters.

All NHS-badged facilities are required to have an understanding and the capability to undertake the initial management of self-presenters from incidents involving hazardous materials. This capability incorporates the newly revised JESIP IOR Brochure (June 2024).

Leeds Community Healthcare has a responsibility to ensure that anyone self-presenting at a Trust-owned building who has been impacted by a Chemical, Biological, Radiological or Nuclear (CBRN) incident can receive immediate assistance prior to the arrival of the emergency services. This requires Trust staff to be aware of, and appropriately trained to enact the Initial Operational Response (IOR) in order to manage the patient, access the relevant equipment and monitor the situation until the emergency services are able to attend.

The NHS England Emergency Preparedness, Resilience and Response (EPRR) Guidance states that Community Trusts must maintain up to date plans and training to ensure the Trust is able to provide an initial response at any time.

Scope

This document aims to outline the details as to how Leeds Community Healthcare will ensure the requirements of the NHS England EPRR Core Standards are met by demonstrating an understanding of the Trust's CBRN\Hazmat capacity and an awareness of agreed principles, common terminology and an understanding of the roles and responsibilities applicable to Leeds Community Healthcare.

As stated in the NHS England EPRR Core standards, Leeds Community Healthcare is required to:

- maintain up to date specific Hazmat\CBRN plans and response arrangements aligned to the risk assessment extending beyond the Initial Operational Response (IOR) arrangements
- maintain a programme of regular training and exercising within the organisation and in conjunction with external stakeholders
- signpost key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents
- undertake Hazmat/CBRN risk assessments appropriate to the nature of the organisation
- identify responsible roles/people for the following elements of Hazmat/CBRN:
  - Accountability – via the Accountable Emergency Officer (AEO)
  - Planning
  - Training
  - Audit and maintain the Hazmat\CBRN grab bags (accessible at Reception for all LCH sites)
- hold appropriate equipment to ensure safe decontamination of patients and the protection of staff. Equipment provided should be proportionate with the Trust's risk

assessment and in line with the ‘planning for the management of self-presenting patients in healthcare settings’ guidance
- ensure an accurate inventory is maintained regarding the equipment required for the decontamination of patients
- clearly define waste management processes within the Hazmat/CBRN plan
- have in place an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments
- undertake training for all staff who are most likely to encounter potentially contaminated patients and patients requiring decontamination
- ensure staff who may be in contact with potentially contaminated patients are sufficiently trained in Initial Operational Response (IOR) principles and isolation as appropriate
- ensure staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented
- ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated into the organisation’s EPRR exercising and testing programme.

Strategy

The key elements of the LCH Strategy will be to:

- Preserve, protect and save life
- Minimise the risk to the patient, staff and members of the public
- Mitigate and minimise the impact of an incident
- Maintain accurate logs\records of the incident
- Provide communications in conjunction with the emergency services, ICB and wider partners
- Maintain public confidence and protect the reputation of the Trust
- Work with and support partner agencies during subsequent incident investigations
- Ensure the earliest return to business as usual

Aims and Objectives

The overriding objective is to ensure that all casualties receive initial treatment at the earliest opportunity.

- Early identification of a CBRN\Hazmat incident and activation of this plan
- Identification of the immediate actions required by staff in specific roles
- Jointly undertake risk assessments in line with Joint Emergency Services Interoperability Programme (JESIP) principles
- Determine the decontamination requirements of any self-presenting patients
- Ensure staff responding to the incident are working in a safe environment
- Co-ordinate the removal of any affected patients to a safe location
- Gather information regarding any threats present at the incident and share appropriately with partner agencies
- Make relevant partners in the wider health sector aware of the nature and scale of the incident if possible.

Governance

- This document will be presented to the LCH Trust Leadership Team, LCH Business Committee and Trust Board for Approval
- The document has been developed in partnership with the Special Operations Manager/ National Inter-agency Liaison Officer (NILO) for the Yorkshire Ambulance Service NHS Trust.
- The document will be stored on the LCH H:drive and on the MS Teams channel for access by EPRR and On-call Managers.

Roles and Responsibilities

EPRR responsibilities and accountabilities which apply to the Trust Board, Accountable Emergency Officer (AEO) and executive and non-executive directors are set out in the LCH EPRR Framework. These are generic responsibilities and accountabilities which include command and control arrangements.

Training and Exercising

The Trust has a responsibility to ensure that all staff who may be required to support a CBRN/ Hazmat incident have the training, equipment and skills to respond in a safe and effective manner.

All reception staff are required to view the Initial Operational Response (2023) - NARU training resource once every six months.

The outcome of testing and exercising will identify and record any lessons learned that will be shared with the LCH Business Committee and Trust Board and incorporated into the revised plan.

Resources

There are CBRN\Hazmat bags on Reception at each Trust location including the Trust Headquarters at White Rose Park. Each bag contains:

- 1x gown\robe (each LCH bag contains a large Tyvek suit)
- 2x pairs of gloves
- 2x IIR disposable face masks with nose clip
- 2x aprons
- Pack of paper towels
- Orange bags for clothing\waste
- Guidance for LCH premises (including contact details)
- Hazmat Manager's Guidance

Definition of CBRN and Hazmat

CBRN – the actual or threatened dispersal of CBRN (Chemical, Biological, Radiological or Nuclear) material (either on their own or in combination with each other, or with explosives), with deliberate criminal, malicious or murderous intent.

Hazmat – an accidental release of a substance, agent or material which results in illness or injury to the public or the denial of an area or interruption of the food chain.

Both CBRN and Hazmat incidents are very similar in terms of response, however the Police may take the lead at a CBRN incident due to the potential terrorism aspect, whereas the Fire Service would take the lead at a Hazmat incident.

Advice to patients in the open air:
- Avoid eating, drinking, smoking or touching their face and eyes
- Remove outer clothing but avoid pulling clothes over their head unless absolutely necessary
- If possible, use absorbent material such as tissue or paper towels to first blot and then rub any exposed skin
- Wash with water if there are any signs of exposure to caustic substances eg itching or pain
- Wait for the emergency services to arrive and act upon their instructions

Advice to patients, staff and the public within a building:
- Where appropriate evacuate the area. In most cases the fire alarm will not be used as people will need to evacuate away from the contaminated area, therefore evacuation will be done through verbal instructions to alternative exit points.
- Consider shutting down air-conditioning, fans and re-circulation air systems, but only where this action will not delay the evacuation process
- Once outside follow the 'open air' guidance above.

Patient focused actions:
- Exit the building
- Disrobe
- Decontaminate

Whilst disrobing will remove the majority of contaminant, exposed areas will require decontamination to remove agents\substances from hair and skin.

Decontamination
The immediate removal of contamination from hair, skin, eyes, mouth and nostrils by any means available. This can be divided into either dry or wet decontamination.

- **Dry decontamination** is the default option and should be performed with any absorbent material such as paper towels etc

- **Wet decontamination** should only be used when the contaminant is caustic (i.e. provokes a skin irritation) or is particulate in nature eg radiological or biological and should be performed using any immediately available source of water.

Chemical Advice
Specialist advice regarding the nature of a contaminant is available to Yorkshire Ambulance Service (YAS) from a number of sources to support commanders and staff with the management of an incident. These include:

- The National CBRN Centre (NCBRNC) – 24\7 scientific advice
- Defence Science and Technology Laboratories (DSTL) for chemical and biological incidents
- Atomic Weapons Establishment (AWE) for radiological and nuclear events

- UK Health Security Agency (UKHSA) for health-related issues and other wider health matters

These agencies collectively form the Emergency Co-ordination of Scientifics Advice (ECOSA) and relevant information will be shared with all affected partners until a specific Scientific Tactical Advice Cell (STAC) has been established for the incident.

Initial Cordon
The initial cordon is temporarily established by the first responders on scene prior to any more detailed scene assessment or scientific\analysis being conducted. This provides a means of facilitating the Initial Operational Response (IOR) whilst maintaining staff safety.

PPE
In the event of a CBRN\Hazmat incident the Trust must ensure the safety and welfare of staff on scene through access to appropriate PPE (mask, gloves and apron).

The Trust's PPE requirements have been discussed and agreed in line with the requirements of the Initial Operational Response (IOR) and the Yorkshire Ambulance Service Special Operations Manager.

Patient care
The following considerations also need to be given for patients who may have additional needs for example:
- Physical – difficult for the patient to decontaminate
- Communication – casualties who have difficulty hearing, seeing or understanding instructions
- Social\Cultural needs – religious or cultural needs which will make decontamination more difficult.

CBRN Countermeasures
Countermeasures are a group of medicines designed for use in specific scenarios which are held in central stockpiles to enable the protection and treatment of the public should CBRN materials be released in a terrorist act or during an industrial incident.

NHS England have produced guidance for the requesting and receipt of countermeasures. These are held for rapid deployment, within two to five hours, following an incident depending on stocks and locations.

Countermeasures will usually be sent to an Emergency Department. Organisations should make their requests via the NHS England regional first on call.

Whilst the Ambulance Service does not have a formal role in this process it is understood that there may be a requirement to support or assist with the administering of CRBN countermeasures, particularly if there is a mass casualty incident.

Staff Welfare
The Health & Safety at Work Act 1974 places a legal duty on all employers “to ensure, as far as is reasonably practicable the health, safety and welfare” of all their employees and adequate training of staff to ensure health and safety.

The Management of Health and Safety at Work Regulations 1999, places responsibilities on the employer to make arrangements for the management of staff health and safety, and where necessary monitor and record information to be used for health surveillance requirements.

Waste Management
All waste material arising from disrobing and decontamination should be double bagged in clinical waste bags (orange bags provided in the grab bag), tied for disposal and stored in a separate area for disposal at a later stage. Any hazardous waste considered to be a risk will be assessed in conjunction with the Dangerous Goods Safety Advisor (DGSA), the Trust Clinical Waste Contractor or Infection Prevention and Control (IPC). All clinical waste is removed by a registered contractor. In May 2024 the Trust renewed its four-year contract with Mighty\Cliniwaste.

References
- JESIP - Initial Operational Response to Incidents suspected to involve hazardous substances or CBRN materials – June 2024
- NHS England Guidance - NHS England » Hazardous Materials (HAZMAT) and Chemical, Biological, Radiological and Nuclear (CBRN)

Supporting Documentation
Guidance for Primary and Community Care Facilities: Managing incidents involving hazardous materials, including:
- Building Closure notice
- Instructions to the Contaminated Patient\s

Appendices
- Remove, Remove, Remove
- LCH Short Guide for the Initial Management of Self-presenters from Incidents Involving Hazardous Materials, including
    - LCH First Contact Action Card (P17\18)
    - On-call Manager Action Card (P19\20)
- LCH CBRN grab bag monthly audit return template

Appendix 1


If you think someone has been exposed to a HAZARDOUS SUBSTANCE
Use caution and keep a safe distance to avoid exposure yourself.
TELL THOSE AFFECTED TO:
REMOVE THEMSELVES...
...from the immediate area to avoid further exposure to the substance. Fresh air is important.
If the skin is itchy or painful, find a water source.
REPORT... to the emergency services.
REMOVE OUTER CLOTHING...
...if affected by the substance.
Try to avoid pulling clothing over the head if possible.
Do not smoke, eat or drink.
Do not pull off clothing stuck to skin.
REMOVE THE SUBSTANCE...
...from skin using a dry absorbent material to either soak it up or brush it off.
RINSE continually with water if the skin is itchy or painful.

Appendix 2

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

Short guide for the initial management of self-presenters from incidents involving hazardous materials

1) This document is part of a suite of Emergency Preparedness, Resilience and Response (EPRR) plans which have been developed to provide the framework by which Leeds Community Healthcare NHS Trust will respond to specific incidents\events.
2) This document must be read and applied in conjunction with the LCH Incident Response Plan, incident specific plans and service level Business Continuity Plans as appropriate.
3) An electronic copy of the latest version of this document is available in the On-call channel on MS Teams and the Trust H:Drive.
4) All On-call managers are asked to familiarise themselves with the contents of the LCH emergency documentation.
5) In the event of an emergency, to contact the On-Call Manager please ring:

0845 2657599

Response

A contaminated person may present at any healthcare setting or NHS branded building. It is likely the first contact with a staff member will not be a clinician but a member of reception, counter or security staff. The guidance in this section can be followed by staff with little or no training and could have a significant positive impact on a patient's outcome.

The information in this section is summarised on an action card which can be found on page 4 of this document. It is advisable to make this section and the action card visible and easily accessible to staff who are likely to be the first contact with a contaminated person.

Recognition

The following signs may indicate a person is contaminated:

- Signs of powder, liquid or other contaminant on skin or clothing
- Airway irritation and breathing difficulties or coughing
- Eye and skin irritation
- Nausea and vomiting
- Indicating they have been at an incident and may be contaminated

The above symptoms can be present in a range of other conditions, and as such staff may need to use intuition to recognise an incident has taken place.

Further information which could help with the recognition of a contaminated person is listed below:

- Media reports of an incident
- Signs of an incident occurring – loud noises, smoke plume
- Numerous persons presenting with similar symptoms
- Emergency Services activity in the area

The emergency services use a process called STEPS 1-2-3 plus. This process alerts responders to be cautious of multiple patients in an area all displaying similar unexplained symptoms.

Step 1	One incapacitated casualty with no obvious reason	approach as normal
Step 2	Two incapacitated casualties with no obvious reason	approach with caution
Step 3+	Three or more casualties incapacitated in close proximity for no obvious reason	instigate CBRN response actions

Initial Operational Response (IOR)

A contaminated patient could present at any building with an NHS logo requesting assistance. The first 15 minutes of a CBRN response are critical, with prompt and appropriate action reducing further harm and potentially saving lives.

Vigilance and early recognition are important as the Initial Operational Response (IOR) should be implemented at the first point of contact. The purpose of the IOR is to:

- Maximise the safety of the public and save lives
- Minimise the operational risks to responders
- Ensure an effective transition to the specialist operational response, ie the ambulance service

If a contaminated patient presents at your base you should:

- immediately call for assistance from a colleague or supervisor (if on site) to support with the response
- escalate the incident by asking the colleague to call 999 requesting assistance from the emergency services. Even if no support/ colleague is available, this action should still be the first taken.
- remain at a safe distance from the patient and locate your HAZMAT bag (behind Reception)
- Put on the apron, clinical gloves and a mask
- Even if equipment is available, ensure you do not approach or touch the patient.

Help those affected to follow the **Remove, Remove, Remove** process. This should happen within 15 minutes of the casualty arriving:

1) **Remove themselves**… from the immediate area to avoid exposing others. If possible, move uphill or upwind as fresh air is important.

- If skin is itchy or painful find a water source

2) **Remove outer clothing**… if affected by the substance advise the person to:

- Avoid pulling clothing over the head if possible
- Avoid drinking, eating or smoking
- Avoid pulling off any clothing stuck to skin

3) **Remove the substance**… from the skin using a dry absorbent material to either soak it up or brush it off – for example blue roll, paper towel or dry wipes.

- Only rinse with water if the skin is itchy or painful.

Consider locking down the area by closing doors or using barrier tape to deter anyone else from entering. The on-call manager will help with this decision.

Local Escalation

The Trust on-call manager should be made aware of the incident as soon as possible and the organisation's CBRN and Incident Response Plans should be activated. At this stage the incident will be managed by senior managers – see Action Card for on-call manager.

The incident should also be urgently escalated to the WY ICB through existing on-call routes. Business continuity plans will need to be activated to ensure services are maintained for patients.

Additional Resources

A training video showing the IOR process enacted at an acute trust is available through the following link:

Initial Operational Response (2023) - NARU

First Contact Action Card

Emergency actions when managing potentially contaminated patient(s) in any healthcare setting. Tell those affected to: **REMOVE THEMSELVES** ... from the immediate area to avoid further exposure to the substance or exposing others. If possible, move uphill or upwind. Fresh air is important. If the skin is itchy or painful, find a water source.
REMOVE OUTER CLOTHING ... if affected by the substance. Try to avoid pulling clothing over the head. Do not smoke, eat or drink. Do not pull off clothing stuck to skin.
REMOVE THE SUBSTANCE ... from skin using a dry absorbent material to either soak it up or brush it off. Rinse continually with water only if the skin is itchy or painful.

Additional guidance relating to REMOVE, REMOVE, REMOVE: REMOVE or ISOLATE	Reassure the patient(s), direct them outside the building. Limit their movement and do not make physical contact.
CONTAIN	Consider the need for lockdown, limiting access and egress, and\or switching the air conditioning off.
ALERT	Dial 999 for ambulance, provide details of the substance if known, symptoms and numbers of casualties, then follow internal alerting process.
DISROBE	Instruct patient to REMOVE outer clothing, not to eat, drink or smoke (to avoid pulling clothes over-head and not to pull off if stuck to the skin).
ASSESS	REMOVE the substance from the skin using either dry, absorbent material or water dependant on:

Where the substance IS NOT burning or irritating the skin
DO NOT touch the patient(s)

- Provide blue/white roll or other absorbent material
- Instruct patient(s) to blot and gently rub exposed skin surfaces beginning with hair (head back), hands and face working down and away from the body
- Instruct patient(s) to place all contaminated materials in the waste bag provided, and to remain in isolation until the emergency services arrive
- Attempt to maintain privacy and dignity and follow any other specialist advice (a disposable suit is provided for this purpose in the HAZMAT bag)
- Observe for signs or effects of substance on non-exposed personnel

Where the substance IS burning or irritating the skin
DO NOT touch the patient(s)

- Provide a clean water source
- Instruct patient(s) to begin rinsing affected areas starting with hair, (head back) hands and face working down and away from the body for minimum of 90 seconds
- Instruct the patient(s) to place all contaminated materials in the waste bag provided and remain in isolation until the emergency services arrive

- Attempt to maintain privacy and dignity and follow any other specialist advice (a disposable suit is provided for this purpose in the HAZMAT bag)
- Observe for signs of effects of substance on non-exposed personnel

The patient should be advised not to leave the area or go directly to hospital, as in doing so they will put themselves or others at further risk of exposure to the contaminant on clothing or skin.

On Call Manager Action Card

Emergency actions when informed of a potential CBRN incident:

ENSURE FIRST CONTACT ACTIONS ARE COMPLETE ... check that the affected person/ people have been removed to a safe place, that the ambulance has been called and that the grab bag has been deployed.

LOCKDOWN/ EVACUATION PROCESS ... based on information gleaned from the people on the ground make a decision on whether to implement a partial or full lockdown – see details below.

The 1st on-call manager/ 2nd on-call manager should consider whether to attend the site to take control of the incident. Alternatively, there may be a senior manager on site or in close proximity who can take on this role.

FURTHER ESCALATION\ACTIONS

- 1st on-call to inform the 2nd on-call as soon as possible and together decide whether to declare a major incident, call an Incident Co-ordination Team or visit the site.
- The ICB on-call should be contacted – details in the Incident Response Plan.
- If a major incident is declared there will be a requirement to inform the Chief Executive and Chair of the Trust.
- If an Incident Co-ordination Team is established, they will manage the situation up to the point where they can de-escalate. This could be due to the incident being taken over by the emergency services, at which point the Trust will become part of the wider incident response.

Lockdown/ Evacuation

There are two main considerations in deciding whether to lockdown the premises:

1. **Extent of possible contamination**. Under no circumstances should people be evacuated through contaminated areas. If the person presenting with CBRN symptoms has been through a known route that can be avoided in any evacuation procedures, then an evacuation can take place. This should be a “word of mouth” evacuation directing everybody to the exits that have not been contaminated. If the contaminated areas are unknown or widespread then instructions should be issued for everybody to stay where they are. This will mean implementing lockdown procedures – see Trust lockdown plan. If anybody leaves through a potentially contaminated area it is important that their details are collected for follow up actions/ treatment. The emergency services will take control of evacuation/ decontamination when they arrive.

2. **Ownership of the building**. For buildings that are owned by the Trust, the decision to lockdown/evacuate can be made by the On-call manager/. Where Trust staff are tenants in another organisation’s buildings the decision will need to be made jointly with the organisation that owns the building. The table below gives more details.

Building	Decision to lockdown/ evacuate
Bramley Burmantofts Chapeltown Halton Hannah House	The on-call manager can make the decision to lock down/ evacuate. The Trust may have tenants that will need to be communicated with and updated on the situation.

Building	Decision to lockdown/ evacuate
Holt Park Hunslet Kirkstall Meanwood Morley Pudsey Rothwell Seacroft Woodsley	
Armley Beeston East Leeds Middleton Parkside Woodhouse Wetherby Wortley Beck Yeadon	At all these sites, the Trust is a tenant alongside other tenants such as GP practices, Leeds city council etc. The building owners (CHP – 0161 868 9512) will take the decision around lockdown/ evaluation, and therefore the on-call manager can only take responsibility for decisions affecting LCH staff.
Kippax	This building is owned by NHS Estates (0191 3371593) and is shared with a GP practice. The On- call manager can only advise Trust staff.
St Georges Centre, Tribecca House, Killingbeck Court	These buildings are owned and managed by Leeds City Council. It is likely that the first contacts will be Leeds City Council staff. The on-call manager can only advise Trust staff. LCC contact Debbie Tate, Assistant Area Building Manager – 07891 278010 (Facilities) - deborah.tate@leeds.gov.uk
White Rose Office Park (Independent Landlord)	The on-call manager can only advise Trust staff. WRP Security Manager Tel: 0113 387 7777 (24 hours) WROP-Security@Gough-Kelly.co.uk WRP Landlord Jonathan Shires (General Manager) 0113 277 3661 \mobile: +44 (0) 7932 326795
Rutland lodge	The On-call manager can only advise Trust staff.

Appendix 3

NHS
Leeds Community Healthcare
NHS Trust

HAZMAT CBRN Audit Sheet

Site:

Month:

Completed By:

Please email to Rebecca.todd@nhs.net on the last working day of each month.

Each site should have a HAZMAT bag, to be used in the event of self-presenting people who believe they may have been contaminated.

Location of HAZMAT Bag	
Is Guidance for LCH Premises available in the fire folder	
Is HAZMAT Managers Guidance available in the fire folder	
Does the bag contain the following items	
A gown / robe	
Pack of paper Towels	
2 Orange Bags	
2 Pairs of gloves	
2 Masks	
2 Aprons	
Guidance for LCH Premises available	
HAZMAT Managers Guidance available	

Has all front of House at this site viewed the CBRN / HAZMAT power point presentation and watched the video in the past 6 months.	

If you have any queries or concerns please contact Rebecca Todd, Emergency Planning Manager.

Agenda item:	2024-2025 (104i)

Title of report:	2025-2028 Green Plan Refresh

Meeting:	Trust Board Meeting Held in Public
Date:	6 December 2024

Presented by:	Sam Prince - Executive Director of Operations/Deputy Chief Executive					
Prepared by:	Harriet Jones – Sustainability Manager					
Purpose: (Please tick ONE box only)	Assurance		Discussion	X	Approval	

Executive Summary:	The sustainability department are presenting to Board to evaluate the Trust's performance against the 2022-2025 Green Plan and outline the intended ambitions for the upcoming 2025-2028 Refresh. The presentation highlights how there have been little progression with regards to lowering carbon emissions throughout the Trust. However there has been progress with accuracy of carbon recording data. The presentation outlines the proposed tactics and plans required to stabilise and cut emissions to remain on course to achieve the Net Zero target. It highlights the resources needed to allow delivery of the plan. The presentation also states the need to bring forward the Trust's net zero target to 2040 to avoid becoming an outlier. It finally defines the need to introduce the start of a formal climate adaptation planning over the next 3 years.

Previously considered by:	Estate Strategy Implementation Board (ESIB) – 07/11/2024 Senior Leadership Team (SLT) – 13/11/2024 Business Committee – 27/11/20224

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	X
	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)	• Support ambitious nature of the Green Plan refresh • Discussion around how to facilitate and resource a green agenda that could achieving a 2040 net zero target comparative to 2045. • Discussion into how should the Trust resource this 3-year plan?

List of Appendices:	Appendix 1 – Proposed projects 2025-2028 in 4 main emitting areas.

Green Plan Refresh 2025-2028

- **Introduction**

In 2022 the first Green Plan was produced and highlighted the 4 main emitting areas of the organisation: procurement, estates, travel and waste. The main ambitions of that plan were to create a robust and accurate carbon data recording method and to firmly embed the sustainability agenda across the Trust. The plan lacked SMART goals and objectives as sustainability within the Trust was in its infancy and the foundation had not yet been established. Therefore, although the Trust has fared well against the objectives set in the 2022-2025 plan, the organisations emissions continue to remain stubbornly high and steadily rising to pre-pandemic levels. One of the ambitions in the 2022-2025 Green Plan was to take advantage of the emission reduction seen throughout 2020-2021 during the pandemic. Unfortunately, this has not been achieved as emissions continue to rise, and this issue must be addressed in the refresh.

The purpose of this presentation is to showcase the ambitions of the upcoming Green Plan 2025-2028 refresh. It seeks approval from the senior management team to be an ambitious plan, with SMART projects that will result in carbon emission reduction.

- **Current position/main body of the report**

There has been a variety of input from both internal and external sources in preparation for the Green Plan refresh. This includes engagement with key stakeholders and redirecting the overall tactics and plans required to deliver key sustainability objectives over the next 3 years.

Engagement work in preparation for Green Plan refresh

During 2024 engagement with key sustainability stakeholders has been a priority. This engagement work has helped form the main principles for the Green Plan refresh and its associated plans for the next 3 years.

Travel and Trasport: In October 2023 NHS England, through the Greener NHS, released the guidance document: Net Zero Travel and Transport Strategy 2023. This document outlined key tactics Trusts should recruit within travel and transport to transition to Net Zero. The contents of this document have been incorporated into the refresh including:

- A Trust wide Travel and Transport survey which took place throughout September 2023 to gather data regarding staff commuting.
- Collaboration with CPC Drive and Tusker to formulate new and innovative staff vehicle benefit schemes including the subsidised salary sacrifice and pre-loved schemes.

Estates: There has been robust evaluation of the 2023 Heat Decarbonisation Plans outlining the actions required to make meaningful decline in carbon emissions over the next 3 years. These findings were presented to the Estates Strategy Implementation Board (ESIB) for approval.

Procurement: The joint Leeds Community Healthcare and Leeds and York Partnership NHS Foundation Trust sustainability procurement has been revived.

This has focused and aligned collaborative working and goals over the next 3 years with LYPFT as the Trusts main partner for procurement.

Strategic priorities over the next 3 years

The presentation outlines the main priorities over the next 3 years and what is required for their delivery:

1. Stabilise and facilitate the decrease of emissions throughout the Trust. This will be through specific projects in the 4 main emitting areas demonstrated in the Green Plan 2025-2028 Roadmap slide and evaluated in Appendix 1.
2. Establish where responsibilities for delivery of projects lie. This will either be through embedding sustainability responsibility in already established roles within departments or creating new sustainability roles within the sustainability team.
3. Mobilise staff engagement through the carbon champion network group and embed sustainability in all aspects of decision making.
4. Start the groundwork for a robust climate adaptability plan, both specifically to the organisation and beyond throughout the Leeds / West Yorkshire region.

➢ **Impact**

The 2025-2028 Green Plan aims to have a significant impact on the Trusts carbon emissions. There is also opportunity to reap financial benefits and improve efficiencies within the organisation.

- **Quality**

As outlined in the governance slide of the presentation many of the sustainability ambitions are in alignment with the motivations of the Quality and Value Programme.

- **Resources**

There are several resource considerations needed for successful delivery of the 2025-2028 Green Plan:

- Finance allocation over the 3 years for specific building improvements / transition away from fossil fuels.
- Investment into the sustainability team either through new dedicated positions or protected time for individuals in established teams. For example, the department which takes on responsibility for the Trusts' travel and transport strategy.

- **Risk and assurance**

The main risk of the success for the 2025-2028 Green Plan is the current lack of governance framework and project ownership. The current absence of project ownership means impact from just the sustainability team is limited. To ensure the 2025-2028 Green Plan projects can be achieved and monitored correctly clear channels of governance must be established before work commences. The presentation provides solution by proposing a governance framework which will be important to establish before the final published version of the plan.

The presentation also states the Trust needs to be more ambitious with its current Net Zero target, aiming for 2040 rather than 2045. This is due to LCH being an outlier with its target comparative to other regional Trusts, WY ICB and the Council.

Next steps

- Presentation to be discussed at both Senior Leadership Tram and Business Committee during November 2024.
- Formal writing of the Green Plan Refresh 2025-2028 to be brought to SLT and Business Committee for approval February / March 2025.

- **Recommendations**

Board is recommended to:

- Support ambitious nature of the Green Plan refresh
- Discussion around how the Trust can lower its target of Net Zero to 2040 to align with other anchor institution.
- Discussion how should the Trust resource the 3 year plan? Expand its sustainability department or embed sustainability responsibility into already established departments through their business planning processes.

Harriet Jones
Sustainability Manager
November 2024

Appendix 1: Table of proposed projects in the 4 main emitting areas within the Green Plan Refresh

Area and Year	Travel and Transport	Estates	Procurement	Waste
2025 – 26	Sustainable travel strategy to be developed and incorporated into estate strategy and Trust's future Green Plan. Implement tactics to stabilise and start to decrease the number of business miles throughout the Trust. Review of the Trust's parking arrangements and align parking strategy with the sustainability agenda.	Evaluate which buildings will be utilised long term and prioritise decarbonisation. Have sustainability input within the Estate Strategy refresh. Review boiler replacements for each retained estate and establish which will be candidates for alternative heating systems (heat pumps). Investment and installation of cloud and sub monitoring systems.	Embed sustainability consideration into product selection, both clinical and non-clinical. Work and establish aligned goals with LYPFT as provide LCH store and supply operations. Material management established with control over products selected with sustainability consideration.	Continue with wider anchor institutional networks to tap into potential waste energy product systems. Trial options such as Biobins. Recycling specific policy written alongside overall waste policy.
2026 – 27	All vehicles offered through Trust staff benefit schemes to be electric. Start to consider patient transport needs in collaboration with the Trust's taxi policy review.	Budget for projects to move away from fossil fuel energy and invest in renewables. Take advantage of grant availability but with the caveat that if the Trust does not qualify for funding planning must still be in place to decarbonise.		Aim to become a paperless organisation.
2027 – 28	Reduce staff commuting emissions by 25% through shift to active travel, public transport and shared transport.	Conclude which retained estates will be continued in the long-term estate strategy and from that point budget for a decarbonisation transition into 2030.		

Green Plan 2025-2028

Summary and Overview

Harriet Jones

Sustainability and Environmental Manager
LCH

NHS
Leeds Community Healthcare
NHS Trust

Committed to Net Zero by 2045

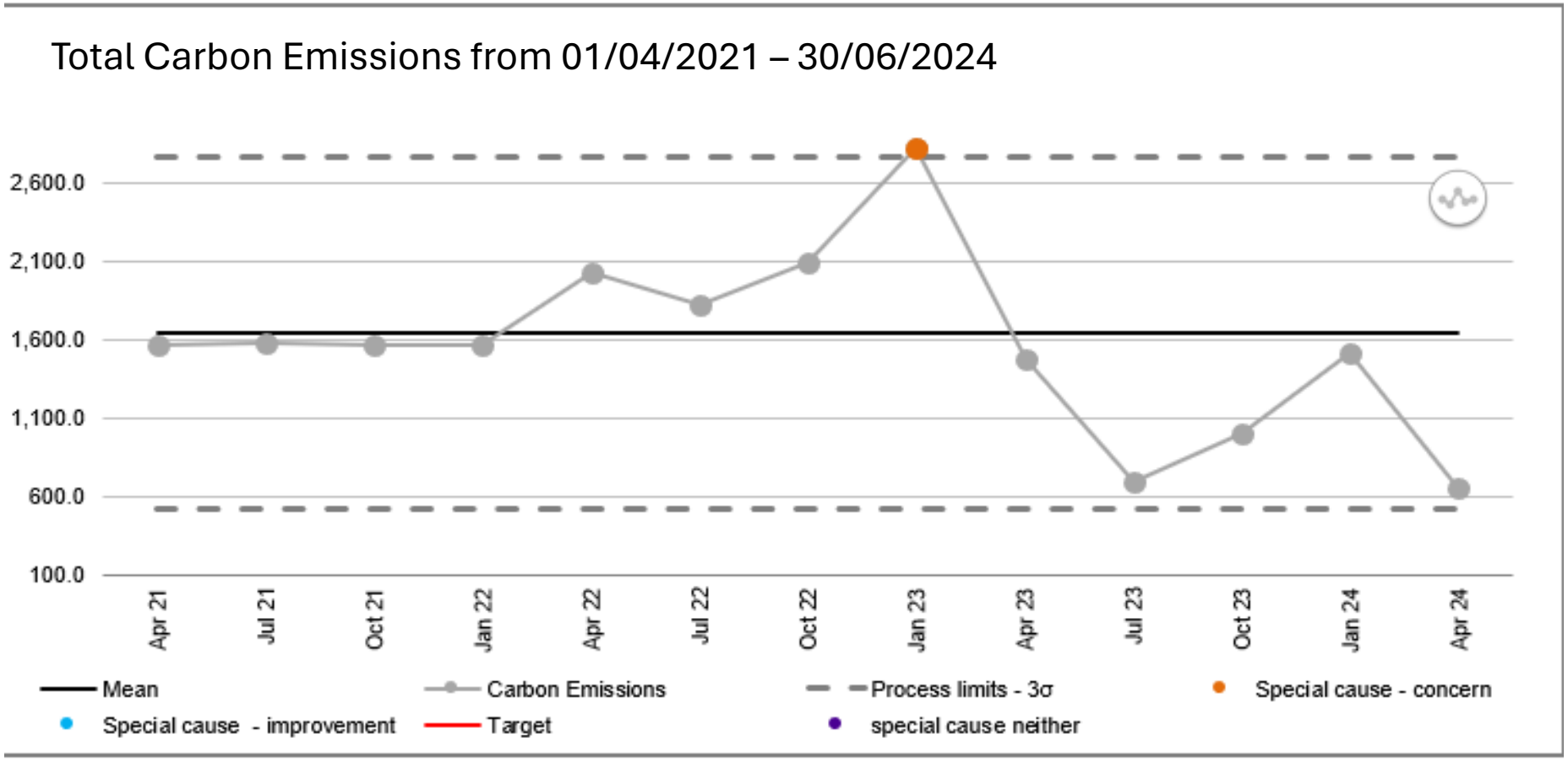
Travel

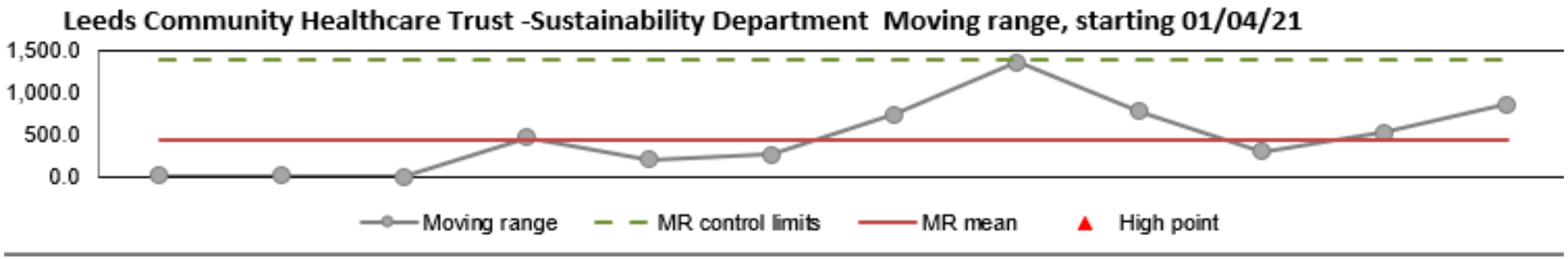
Buildings and Estates

Procurement

Waste

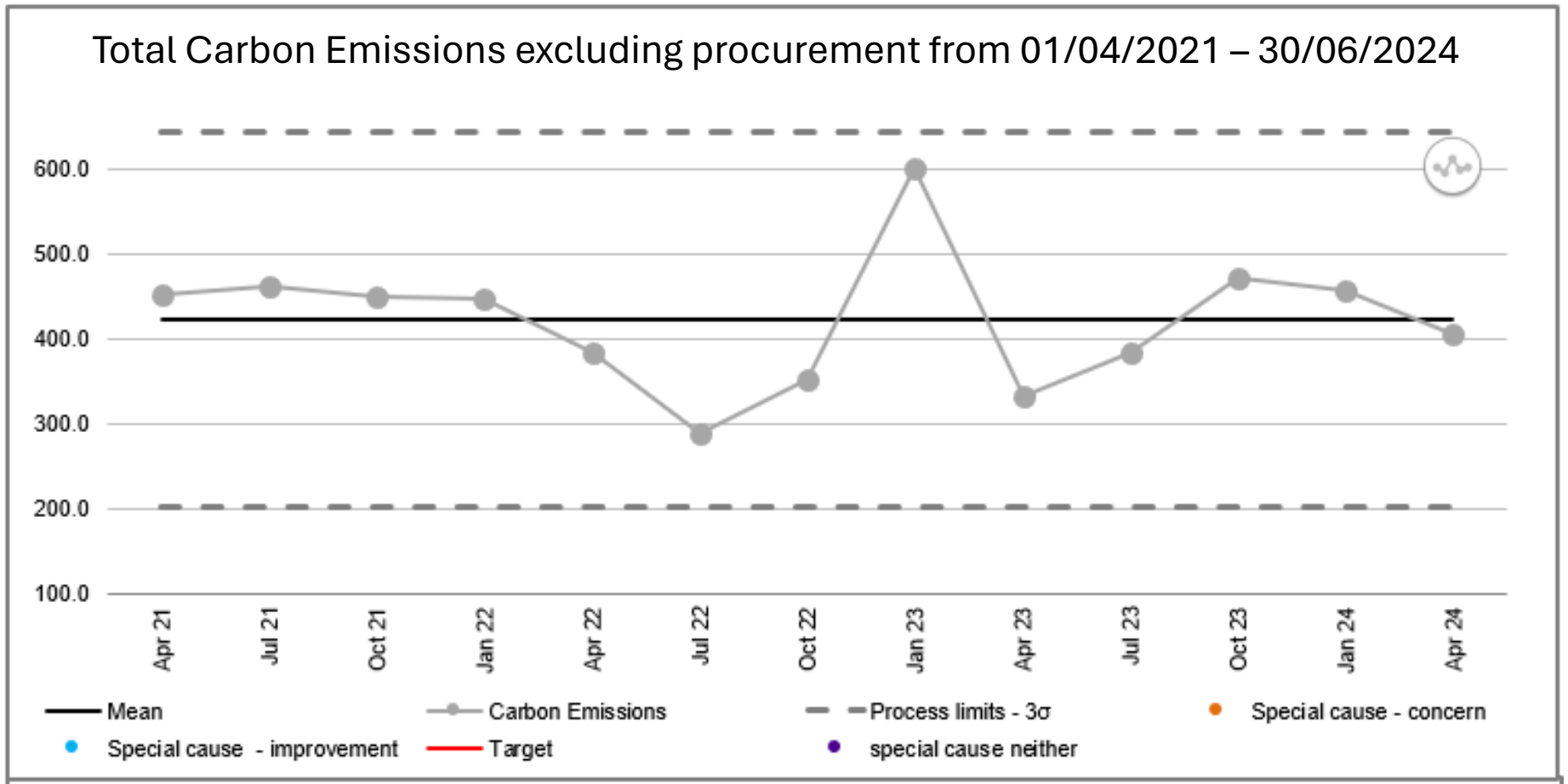
Summary

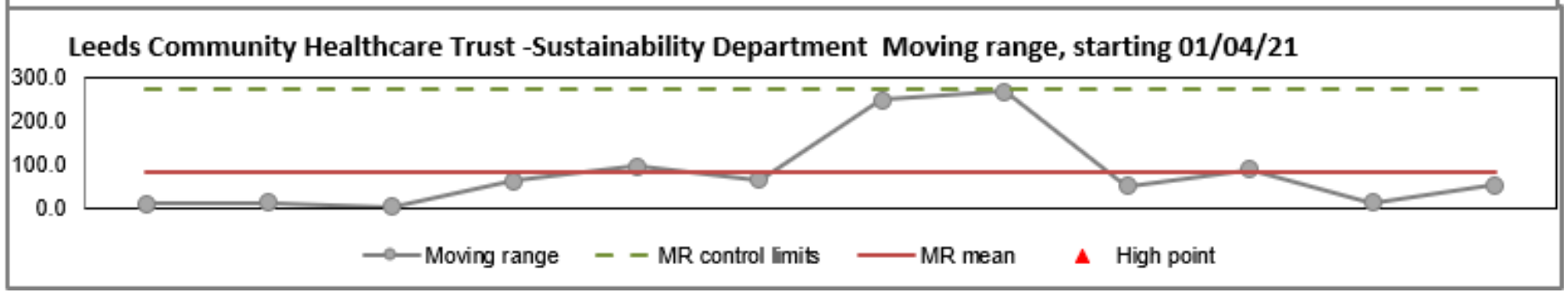




- First 4 quarters: no robust data collection methods. Had to divide the total by 4 for general overview
- Significant peak in Q4 2022/23 – believe to be recording error in estates data
- Drop shown in April 2023/24 due to change in procurement recording

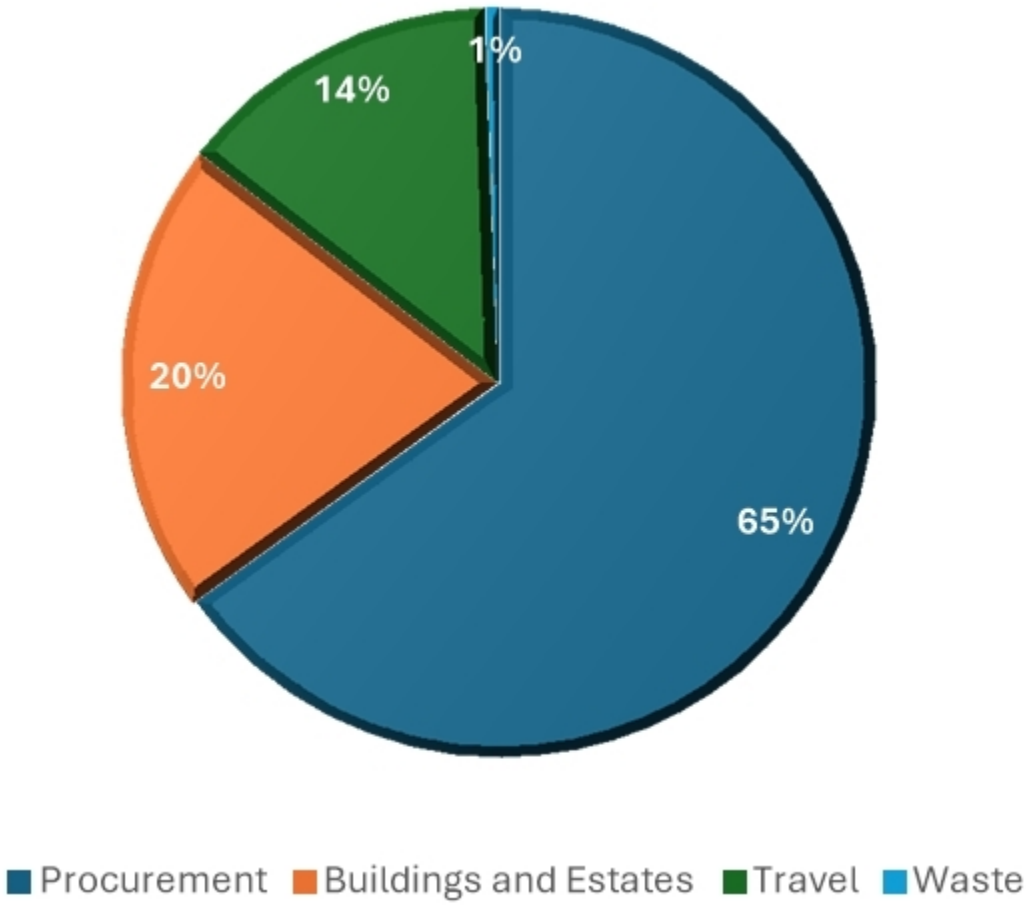
Summary Continued





- Drop in emissions following covid pandemic
- Emissions have continued to steadily rise and highlights efforts over the past 3 years have not had a direct impact on the Trusts carbon emission trend.

Carbon Emission Split and Priorities from Data



Green Plan 2025-2028

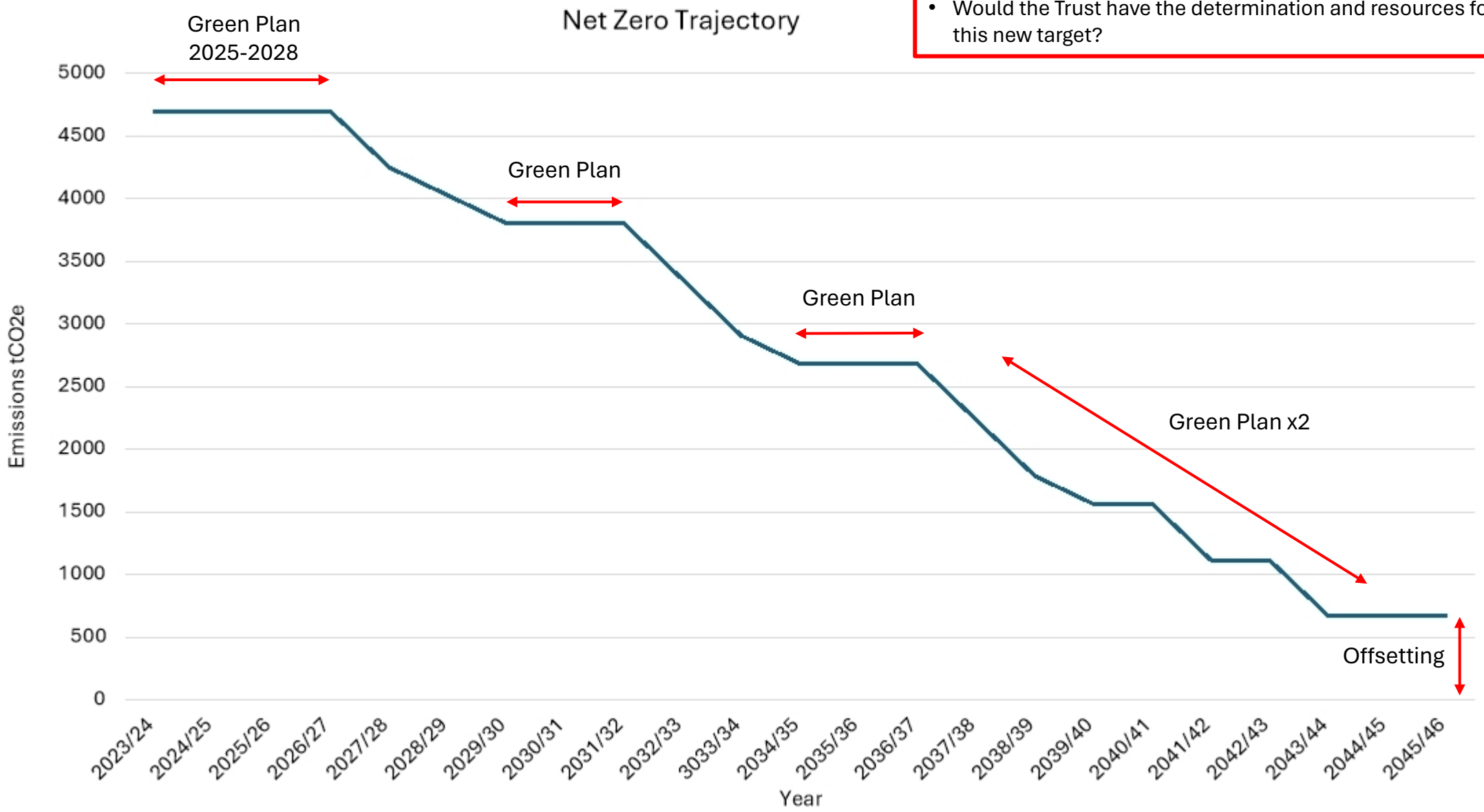
Stop the Rise of Emissions

Stabilise Emissions

Emission Decline

Net Zero Trajectory – High Ambition Green Plans

- Net Zero target should be more ambitious at 2040 comparative to 2045
- LCH is becoming an outlier with its target comparative to other regional Trusts, WY ICB and the Council.
- Would the Trust have the determination and resources for this new target?



Short-Term Vision: Green Plan 2025 – 2028

2025
- Evaluate which buildings will be utilised long term and then prioritise decarbonisation
- Review boiler replacements for each retained estate and establish which will be candidates for alternative heating systems (heat pumps)

2025
- Sustainable travel strategy to be developed and incorporated into estate strategy and Trust's future Green Plan

2025
Material management established with control over products selected with sustainability consideration.

2025-2026
- Installation of cloud and sub monitoring systems throughout long term estate
- Evaluate buildings to invest in renewables and begin preparatory actions e.g. surveys

2025-2026
- Invest in active travel facilities across our estate to encourage uptake
- Collaborate with public transport networks throughout the city to obtain offers for staff
- Stabilise mileage with a strategy to start to decrease – ie. new ways of working or route planner technology

2025
Recycling specific policy written alongside overall waste policy

2026
All vehicles offered through NHS vehicle salary sacrifice schemes will be electric

2027
Invest in renewable energy options; solar panels, LED upgrades and heat pumps

2027-2028
- All vehicles owned or leased by NHS to be zero emissions (pool cars)
- Reduce staff commuting emissions by 25% through shift to active travel, public transport and shared transport

2028

Costings and Opportunities : Green Plan 2025-2028

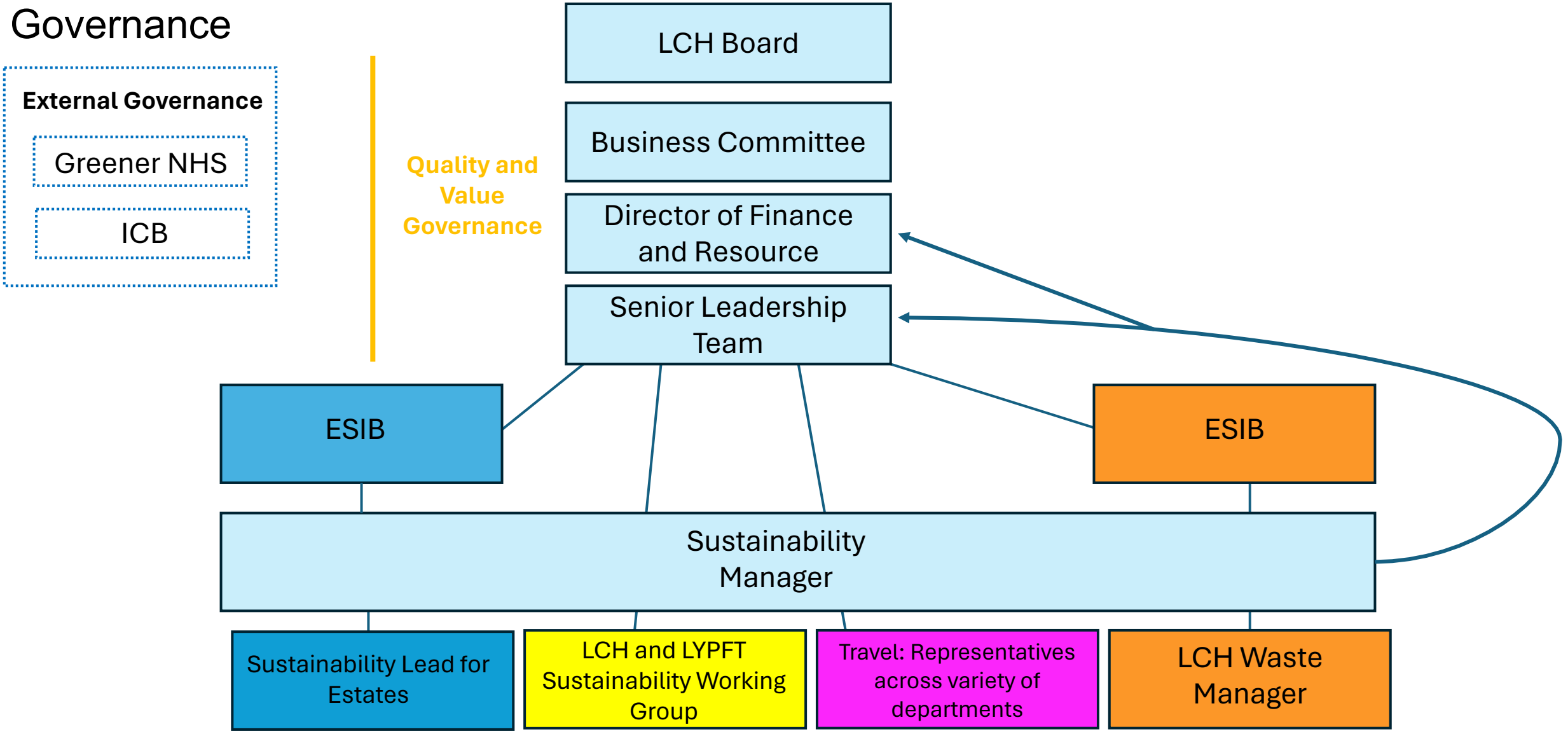
Area of Emissions	Action	Associated Costs	Estimated Carbon Reduction tCO2e
Buildings and Estates	Installation of cloud and sub monitoring systems	£398,000	79 tCO2e
	Surveys for existing boilers	£0 as followed by commissions work when boilers are upgrades	N/A
	LED upgrades	£200,750	26.31 tCO2e
	Solar panel installations	£768,000	76.93 tCO2e
	Heating renovation (ASHP/GSHP)	£2,671,923.75	170.63 tCO2e
Travel and Transport	Active travel facilities through entire estate	Need to be evaluated and calculated	TBC
	Public transport offers for staff	As standing	N/A
	Route journey planner software	Already covered through ABU	TBC
Procurement	Materials management contact with LYPFT	TBC	TBC
Waste	Recycling policy	N/A	TBC

3 Plan Commitment

Over the course of the next 3 years there are 3 key documents we are committed to writing:

- Green Plan Refresh 2025-2028
- Travel and Transport Plan
- Estates Strategy Refresh – sustainability to have greater role in rewrite

Governance


External Governance
Greener NHS
ICB
Quality and Value Governance
LCH Board
Business Committee
Director of Finance and Resource
Senior Leadership Team
ESIB
ESIB
Sustainability Manager
Sustainability Lead for Estates
LCH and LYPFT Sustainability Working Group
Travel: Representatives across variety of departments
LCH Waste Manager

Climate Adaptability (CA)

Departments Required for Robust CA Plan

Emergency preparedness, resilience and response

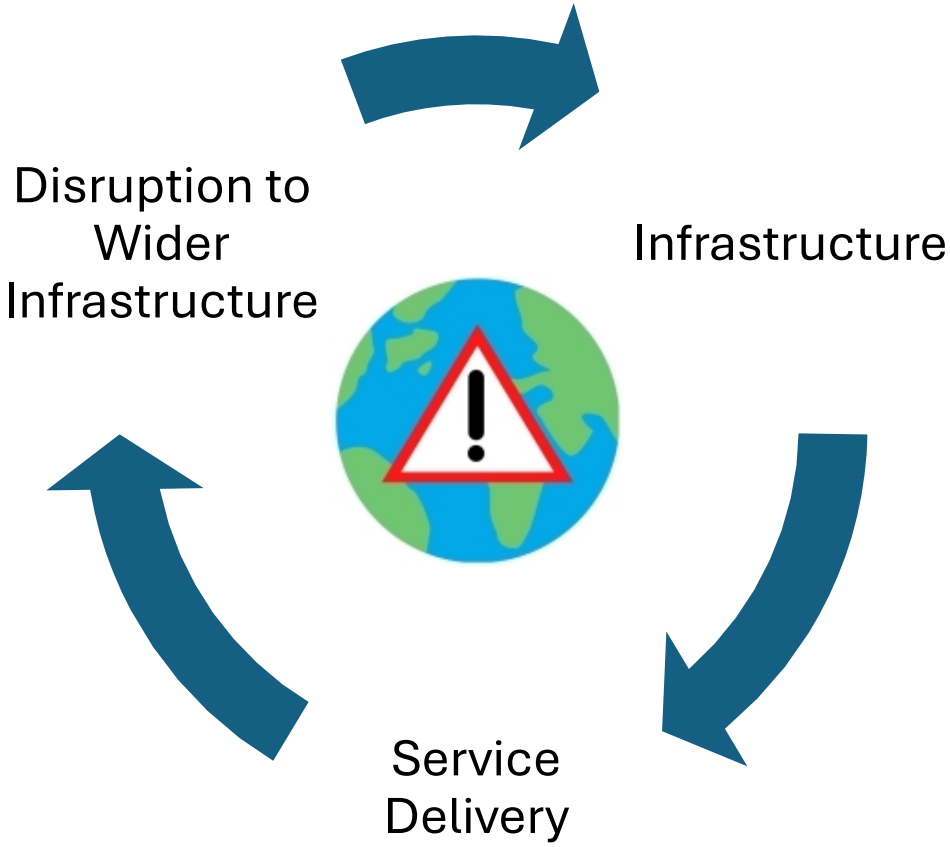
Business Continuity

Sustainability Team

Estates and Facilities

Clinical and Operational Leads

Senior Leadership Team



External Bodies Required for CA Plan

Anchor Institutions

Leeds City Council

WY ICB

Greener NHS

Information and guidance sourced from Adaptation Scotland: https://adaptation.scot/

Climate Adaptability 2025-2028 Green Plan

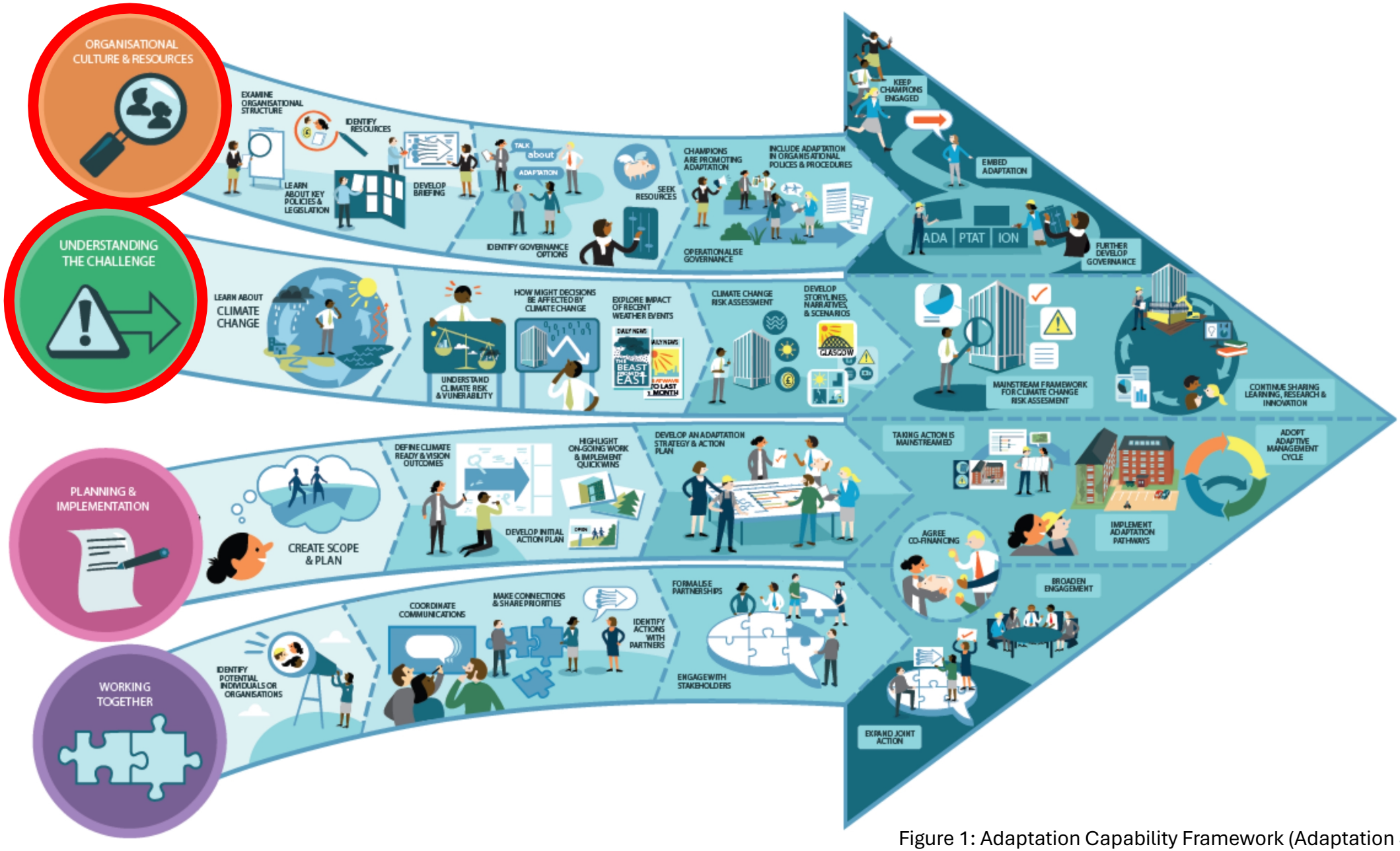


Figure 1: Adaptation Capability Framework (Adaptation Scotland 2024)

Summary

The Green Plan Refresh should:

- Have tangible/ smart objectives/ projects that will result in carbon reduction
- Be more ambitious and link in better with current plans (i.e. Quality and value programme)
- Have a specific focus on travel and estates, but be aware of all opportunities to become greener
- Recognise the medium-term planning required to adapt services/ sites in line with expected climate change

The Ask:

1. How will the Trust pool its resources and focus projects to adopt 2040 as the net zero target date from 2045?
2. How should the Trust ensure that sufficient resources are in place to deliver the new 3-year green plan? Should the Trust expand its sustainability function to manage the programme or is there scope to ensure that individual departments and services can implement the changes within their business planning processes.

Leeds Community Healthcare NHS Trust

Quality Committee Meeting: 22 July 2024

Agenda item number: 15d

Title: Mortality Report Quarter 1 2024-25

Category of paper:	**For assurance**
History:	**None**
Responsible director:	**Executive Medical Director**
Report author:	**Deputy Medical Director**

Executive summary

Purpose of this report:

To provide the Committee with assurance regarding the Mortality figures and processes within LCH NHS Trust in Quarter 1 24.25.

Main points to note:

- Quality Assurance & Improvement (QAIG) Group have met regularly and are quorate. The last business meeting was on Tuesday the 9 July 2024.
- Business Unit Learning from Deaths meetings have taken place regularly and have been quorate throughout the quarter.
- The number of adult deaths reported in this is reduced from the previous period and is tending towards the lower control limit. This is aligned with the National picture of mortality rates compared to previous years
- The use of ReSPECT appears to have plateaued at a rate of greater than 90%
- The number of patients with a recorded learning disability has increased by 50% (8), the reason for this is being investigated. However it was known that the recording of learning disability in mortality data has been inaccurate and work has been in place to address this.
- Following an unexpected deaths deep dive, the No Access Visit SOP has been changed to a policy.
- The ICB are leading an action to look at how Primary Care, acute trusts and ourselves communicate following an action point from a recent Coroners case.
- Timely review of Child Deaths remains a capacity issue, but immediate learning is noted, and child deaths are subject to comprehensive and robust oversight and review processes as part of CDOP.
- The number of child deaths is in line with historical trends; with a reduction in the high level noted in 2023. Learning from expected deaths and SUDIC in quarter and the pending assurance on review timescales were highlighted at QAIG
- Discussions are taking place with LTHT to ensure that we are maximising cross pathway learning

Recommendations:

- Quality Committee is recommended to receive this assurance regarding Trust mortality processes during Q1 of 24.25

1. Adults & Specialist

- The number of deaths reported by the Seacroft neighborhood team is higher than similar teams but is consistent with the referral numbers and complexity of patients.
- Holt Park neighbourhood team has a high rate of mortality reflective of the number of care homes in the area.
- 80% of patients died in their preferred place of death – this is consistent over the last 2 years.
- Work is ongoing within LMWS following a safety summit to look at multi-agency communication.
- Action plans are in place for LMWS and Police custody following coronial inquests

2. Equity

- While the vast majority of patients die in their preferred place of death, in over 80% of records the ethnicity is not recorded
- The palliative care network is producing a report that will explore preferred place of death and ethnicity in more detail.
- The largest number of deaths in the under 75s is recorded in the areas with greatest number of patients in decile 1&2 – Armley, Beeston and Chapeltown.
- It has been noted that the Adults flash report makes reference to White and Non-White deaths, which incorrectly clusters White patients from an ethnic minority and this will be appropriately reported moving forwards.

3. Children

- 7 deaths were seen in Quarter 1, of which 4 were SUDIC, which is the average for the previous 24 months.
- Work is commencing around equity data, comparing this with national data

4. People with a Learning Disability

- Introduction of a dashboard on Datix – provides data for children with registered disability and autism.
- The underlying reason for the increase in mortality for those with a recorded learning disability is being explored with the lead nurse for Learning disability

5. Recommendations:

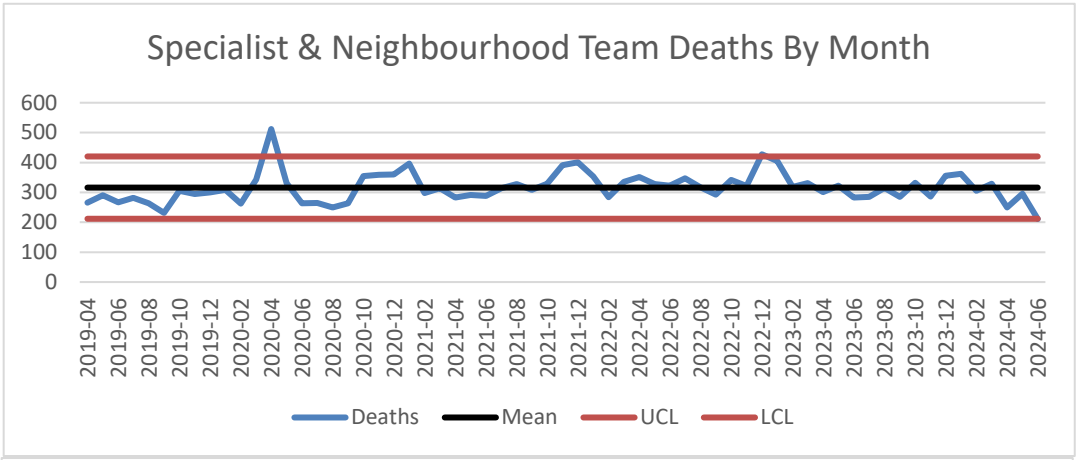
- Quality Committee is recommended to receive this assurance regarding Trust mortality processes during Q1 of 24.25

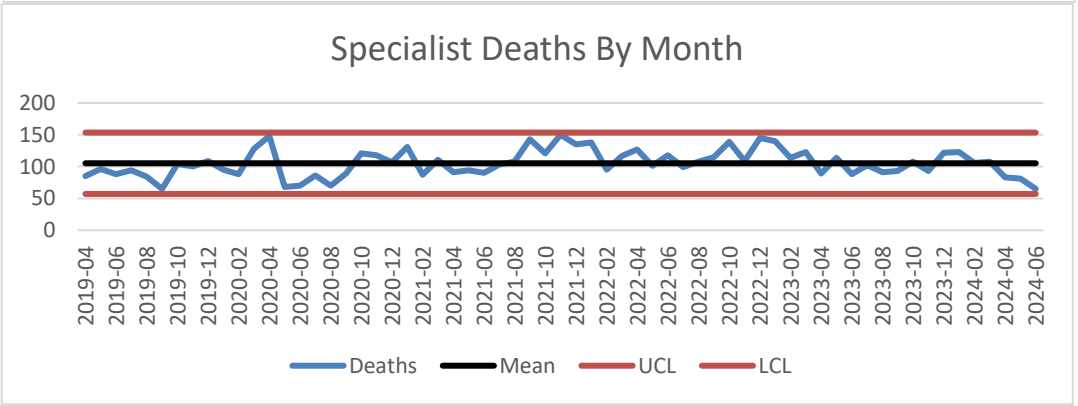
Adult Mortality report: QAIG. Q4 2023/24 (Apr – June 2024)

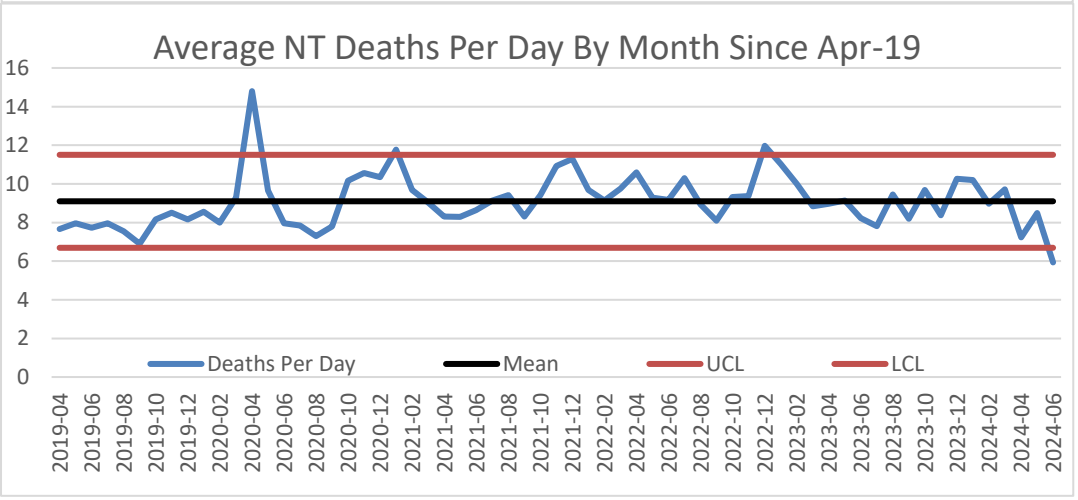
NB: BI data was captured earlier than usual on 27.06.2024. It is usually captured around 3rd of month but brought forward to ensure QAIG deadline can be met.

Leeds Community Healthcare NHS Trust

Quantitative data:

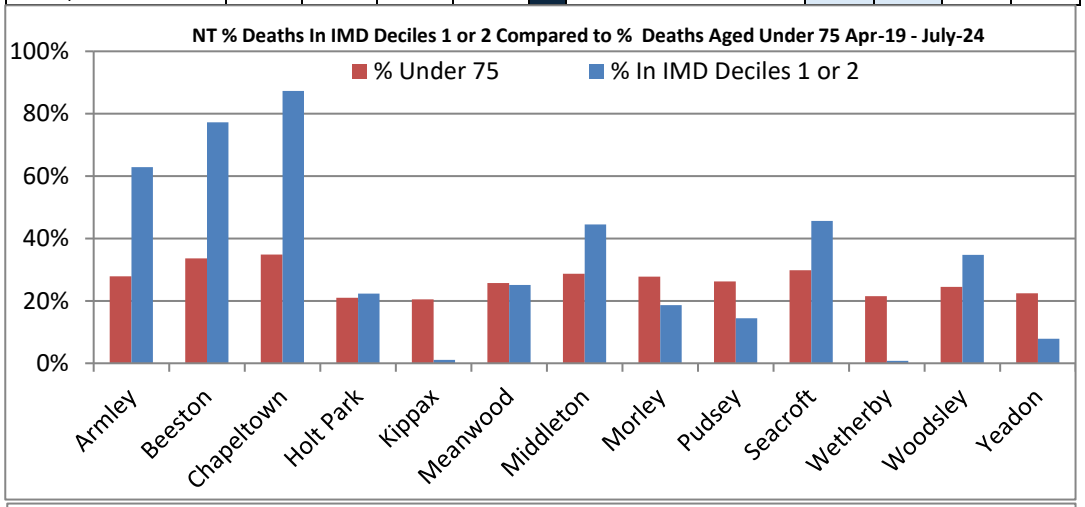


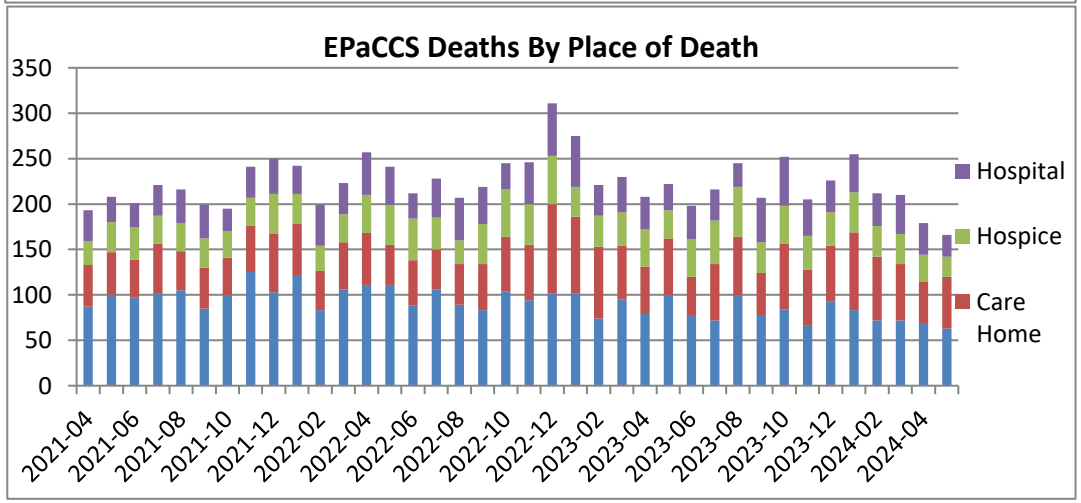




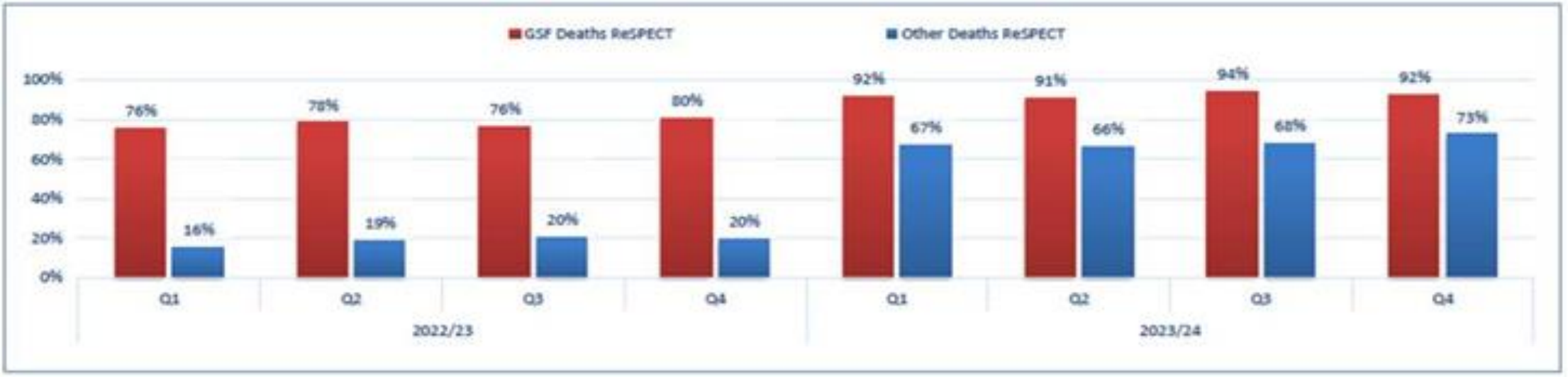
Jan - Mar 24 Mortality Figures for NTs & Selected Specialist Services				
Total	351	288	186	825
NT	303	244	158	705
Specialist	121	100	68	289
Specialist not in NT	48	44	28	120
In NT & Specialist	73	56	40	169
Specialist Deaths in Multiple Units	11	18	6	35

Adult data 2023/24	Q1	Q4	Q3	Q2
Level 2	193	217	256	229
Unexpected deaths	65	23	47	64
Expected deaths	295	141	282	289
Alliance CCB deaths	2	?	5	4
Virtual Ward deaths	1	?	2	3
LeDR	8	4	2	4





ReSPECT and EPaccs data



Analysis:

- Total adult deaths in Q1 2024/25 = 757 which shows an 8% reduction in quarter (Q4 Jan – March 2023/24 = 825). When compared to Q1 2023/24 – 832, this shows a 9% reducing trend in the year.
- ABU deaths Q1 2024/5 =653 (Q4 2023/24 = 705) 7% Reduction in quarter.
- SBU deaths Q1 2024/25 = 104 (Q4 2023/24 = 120) 13% Reduction this quarter.
- All ABU and SBU mortality data for this quarter sits within control parameters; the trend has moved towards the lower control level this quarter.
- The number of deaths reported for Seacroft NT were noted to be 25% higher than similar teams of size and demographic. This appears to be a consistent and continued trend in terms of the overall referral numbers and complexity of patients this team cares for at the end of life. Holt Park NT conversely shows that their reported death numbers match that of the largest teams across the city perhaps reflecting the large number of new care homes in this area that have contributed to an increase in referrals and patients of complexity being cared for by this traditionally smaller team.
- 27% of all deaths were under 75years and it was noted that in NTs Beeston (34%), Chapeltown (35%) Seacroft (30%)
- 100% of deaths for HITT and 83% LMWS were under 75 years.
- ABU 49% and SBU 37% of Level 1 assessments were completed when expected. ABU are 4% down in year and SBU are 1% lower.
- ABU 54% and SBU 52% for Level 2 assessments completed when expected. Both Business units are showing an 11% reduction in the quarter.
- Preferred place of death % remain the same or similar even though the numbers have changed.
- 93% of patients on EPaCCS who died had a ReSPECT plan in place. This is for patients across Leeds who are on Epaccs who died and combines hospital, systemone and Emis data.
- The increase in patients not included on EPaCCs who had a ReSPECT plan is particularly striking (blue column on the Bar graph above)
- 84% of people who died were included on EPaCCS and/or had a ReSPECT plan.
- There has been a 50% increase in the number of patients who died with a recorded learning disability. This could be due to raised awareness amongst the staff in terms of the requirement to report, however, Quality Leads will discuss with Lisa Smith, LCH Learning disability Lead Nurse and continue to monitor to report in Q2.
- 80% people died in their preferred pale of death (PPD) in NTs in 2023/24 compared to 78% in 2022/23. It was 80% in 2021.
- 25 unexpected deaths and 10 expected deaths reported via datix in month for ABU no Serious incident investigations were instigated.
- **Mortality overall from SBU in Q1: 17** deaths were reported in **Q1** (13 in Q4 23/24). 4 expected and 13 unexpected. Out of these LMWS (5) Respiratory (2) Cardiac (3) SLT (1) Long Covid (1) Police Custody (1) Diabetes (1) Adult Dietetics (1).
- LMWS, Police Custody and Long Covid deaths will follow the Rapid review process. Other services follow the mortality process and there were nil concerns.

Serious incidents as a result of patient deaths

- **SBU SI's due to death: 1**
- 95203: LMWS PSII. De-logged 02/05/24.
- 99238: LMWS SI led by LYPFT. Joint City-wide mental health services investigation re communication.

Themes/Trends

- There has been exponential growth of both residential care and Nursing care homes within the Yeadon and Holt Park area which will also be affecting the number of deaths being reported. Which would then benchmark their mortality reporting to that similar to our larger teams for e.g. Seacroft NT.
- The clinician's appreciation of the varied presentation of deterioration in frail older adults was a theme.
- Inappropriate use of tasks to GPs when patients present with a significant clinical change presentation
- Staff are still not following the no access visit guideline fully. Helpfully we have actions underway for this issue.
- Communication between the Hospital 2 'care team and community / patients when the patient is deteriorating and may still be being actively treated by secondary care.

Equity

- 80% of White and 84% Other Ethnic Groups have achieved their PPD since April 2019. Ethnicity was not stated in 81% of cases.
- 79% of White and 80% Other Ethnic Groups achieved their PPD in 2023/24. Asian or Asian British are more likely to achieve PPD (85%), followed by Other Ethnic Groups: 84%
- Non-White on EPaCCs with PPD and ADP recorded is 7.5%.
- Chapeltown, Beeston and Armley show that they have the highest number of deaths in decile 1&2 and the highest numbers of patients who die under the age of 75years.
- The palliative care network and the citywide planning ahead group are producing a report which will be available Q2 looking at preferred place of death and ethnicity.

Learning from ABU Mortality Review meetings

- There has been exponential growth of both residential care and Nursing care homes within the Yeadon and Holt Park area which will also be affecting the number of deaths being reported. Which would then benchmark their mortality reporting to that similar to our larger teams for e.g. Seacroft NT.
- The clinician's appreciation of the varied presentation of deterioration in frail older adults was a theme.
- Inappropriate use of tasks to GPs when patients present with a significant clinical change presentation
- Staff are still not following the no access visit guideline fully. Helpfully we have actions underway for this issue.
- Communication between the Hospital 2 'care team and community / patients when the patient is deteriorating and may still be being actively treated by secondary care.

Learning from SBU Mortality Review meetings

- **LMWS:**
  - Ongoing city-wide serious investigation regarding communication between differing services. LCH learning from rapid review includes looking at joint triage/discussions between PCMH and CMHT, missed opportunities to discharge the patient and documentation of substance misuse. Serious investigation led by LYPFT with LCH input.
  - Non-contributory learning: Initial contact outside of 15 days- known to TLT and on service risk register.
  - Please see embedded document. LMWS patient safety summit presentation looking at multi-agency communication learning: Ben's story: Safety summit presentation.pptx
  - LMWS: Inquest learning: Action plan to be developed regarding recommendations from coroner.

Action Plan Blank-Inquest DF.docx

- **Respiratory:**
  - Non-contributory learning: Respect form not uploaded to PPM.
  - Non-contributory learning identified in relation to the potential for an earlier conversation with the patient regarding advanced planning (Respect).
- **Police Custody**: Inquest learning: Action plan to be developed following recommendations from coroner.

Action plan PCS 7901 MT.docx

CSRT REFERRAL SOP.docx

- **Stroke**: 96569: Referral SOP produced from learning from incident.

Notes:

- The Mortality pilot has been audited and shared with Clinical Effectiveness Team. A meeting to review findings was held on 05 March 2024. Time is saved with the new approach when reviewing mortality cases, which will be helpful with the increase in volume of community deaths. Thematically nothing new is emerging via the pilot other than we have greater complexity in some of the cases.

Highlights:

- ABU deaths Decreased by 7% quarter.
- SBU deaths decreased by 13% this quarter.
- All ABU and SBU mortality data for this quarter sit within control parameters, tracking the lower control limit.
- A review of the rise in unexpected deaths in some NTs has been undertaken on 30/4/ themes and learning attached.
- There has been a 50% increase (8) for patients who died and had a registered Learning disability.
- The Safeguarding Committee have agreed to trial service level mortality 1 and 2 assessments between April 24 – March 25 for all deaths involving people with LD admitted to hospital, regardless of duration.
- The Mortality Pilot has concluded; learning shared with Clinical Effectiveness Team.
- Time is saved using this approach, which is valued given the increasing number of community deaths.
  93% of adult patients who died in Leeds had a Respect template in place and 84% had both GSF EpACCS AND Respect IN PLACE.

Opportunities / Successes (Making Stuff better / Celebrations)	Risks / Issues
1. Business units and QPD have been working together to develop an improved mortality review process and have piloted the process as one integrated team. Within ABU the palliative 2.To support the new statutory medical examiner systems are being rolled out across England and Wales to provide independent scrutiny of all deaths not referred to His Majesty's Coroner. The Department of Health and Social Care (DHSC) death certification reform changes will become mandatory from April 2024. This guidance outlines the Leeds agreed response and step-by-step process for Leeds practices. (please see appendix 1) 3.The No Access Standard Operating procedure will be transferred to a policy (Must Do) Due to be ratified June 2024. 4.Citywide working group led by Penny McSorley to address the repeated theme from recent serious incident/coroner review around delays in treatment and risks associated with system wide care and communication pathways . 5.The development of the deteriorating patient and sepsis Trust improvement group is reviewing the introduction of a soft signs for sepsis assessment tool, there is planned additional training for all staff groups to support earlier recognition of deterioration with a specific focus on recognizing both chronic and acute signs for deterioration with associated proactive management guidance training. 6.To review guidance for completing level 1&2 mortality forms to improve baseline data content.	Difficulty in obtaining data to meet reporting submission timescales continues to be a challenge. Data is usually pulled on the first working day of the month after the quarter, to correlate with QAIG. This means that completing analysis of data is difficult. Consideration to move the reporting date to 20th -19th as per BU reports so they align. **Mitigation:** Reporting this month was undertaken on 27 March 2024 to ensure timely submission to QAIG. This means the data is incomplete by 6 days (2 working days re BH)

BAF RISK 1	BAF 2	BAF 3	BAF 4
During review of the mortality questionnaire to inform a pilot it was noted that the wording for 'serious mental illness' was only linked to cause of death. This has been updated to a serious mental illness at time of death, as opposed to being a causative factor. This should ensure data is accurate in future. Work is underway to capture data accordingly. Inclusion of the LD lead within the mortality quarterly review process continues to develop. The LD hub in My LCH is now active for staff support and learning from LD deaths. We are now reviewing LD deaths in more detail from a qualitative perspective.			

BAF RISK 1	BAF 2	BAF 3	BAF 4

BAF RISK 1	BAF 2	BAF 3 (Query)	BAF 4

S1 Systems, processes, and practices to keep people safe	S4 Medicines management	S5 Track record on safety	S6 Lessons learned and improvements made	E1 Standards, legislation, and evidence-based practice	E2 Outcomes of care and treatment	E3 Staff skills, knowledge, and experience	R4 Listening and responding to concerns and complaints

Medical Examiner Service (Leeds)

General Practice Referral Process

GP Practice notified of a patient's death

Medical examiners can advise, and if agreed locally can assist with, notification to the coroner

Notifiable Deaths

Notification to Coroner's Office

If the coroner decides not to investigate the death, they authorise completion of MCCD by a doctor

Non-reportable Deaths

Nominated GP practice staff prepare summary record with final entry from qualified attending practitioner

Either local arrangements facilitate medical examiner/ office access to the patient record, or nominated GP practice staff allow access/send clinical record to medical examiner office. The medical record summary should include:

- Previous Medical History
- Medicines History
- Clinical Records (last 3 months)
- Hospital correspondence for the last 3 months
- Other as deemed necessary by the GP practice
- Send community death referral form and Summary Care Record to Leeds ME Office: leedsth-tr.communitymedicalexaminer@nhs.net

- Medical Examiner Officer acknowledges receipt and informs practice of next steps
- Medical Examiner reviews patient record
- Interaction between the GP completing the MCCD and the medical examiner/or medical examiner officer regarding proposed causes of death can be completed by correspondence (eg email). **A verbal discussion is not always required.**

Medical examiner office gives the bereaved an opportunity to ask questions or raise concerns (clinical governance).

ME Sends Notification to Registrar & GP Practice

GP completes MCCD (and cremation form 4 where required)

GP practice electronically sends MCCD to Leeds Registry office

Death Registered

Clinical Governance - Any concerns raised which are care / practice related will be shared with you. We may at times request a further review of the case through your local Governance teams. We will also share any positive feedback directly with you.

Deep Dive Unexpected deaths Q3 2023/ Q4 2024

Background

Whilst overall numbers of deaths in Leeds continue to decrease (Although remain slightly higher than pre pandemic levels) and the Total numbers of unexpected deaths remains static between Q3 2023 and Q4 2024 we did note the findings below through our mortality surveillance process.

1.Unexpected deaths for **Yeadon Neighbourhood Team** showed a 64% increase for 2023 with 4 reported deaths via datix in 2022 and 11 in 2023

2.Seacroft Neighbourhood Team reported 10 unexpected deaths in 2022 and 21 in 2023 (52%increase)

3.Holt Park Neighbourhood Team reported 1 unexpected death in 2022 and 10 in 2023**.** (90-% increase)

4.Kippax Neighbourhood Team reported 3 unexpected deaths in 2022 and 13 were reported in 2023. (77% increase)

Aims

To Review a minimum of 50% of all reported unexpected deaths across all Neighbourhood Teams between Quarter 3 and Quarter 4 2023/24 , (1st October 2023 to March 31st 2024.)

There will be a focus to review 100% of reported unexpected deaths for Holt Park , Yeadon and Seacroft Neighbourhood Teams which have reported significant increase of over 50% in reported unexpected deaths when comparing 2022/23 figures to 2023/24 .

Questions to be considered during record reviews.

1. Was this an appropriate datix incident report for unexpected death and whether this was an expected death but not at the time it happened.
2. Were there any concerns relating to the death itself or care delivered at the time of or leading up to the patients death. Are these themes known or new.
3. Patient complexity status – was this a factor in the patients death
4. Any Delays with treatment , Ambulance delays etc
5. Was Respect completed if appropriate? And if discussions had taken place could this have prevented the unexpected death process.
6. Any previously unidentified themes.

Methodology.

There were 91 unexpected Deaths reported between Q3 2023 &Q4 2024 . We reviewed 55 records (40%) with 100% of recorded unexpected deaths for Seacroft Holt Park and Yeadon with comparison cases from all other neighbourhood teams .

Themes

1.The age of the deaths in Seacroft NT were an average of a younger age – health equity issue

2. The numbers of referrals and level of complexity of referrals into Yeadon Neighbourhood team is likely to be affecting the number of unexpected deaths .

3. There has been exponential growth of both residential care and Nursing care homes within the Yeadon and Holt Park area which will also be affecting the number of deaths being reported. Which would then benchmark their mortality reporting to that similar to our larger teams for eg Seacroft NT.

4.Level 1&2 completion – level of details submitted on the mortality review form – inadequate for a clear understanding of contributor factors

3. Some examples of very comprehensive care provided – staff to be thanked

4. Staff are still not following the no access visit guideline fully. Helpfully we have actions underway for this issue.

5.Clinician's appreciation of the varied presentation of deterioration in frail older adults was a theme .

6.Inappropriate use of tasks to GPs when patients present with a significant clinical change presentation

7.Communication between the Hospital 2 ' care team and community / patients when the patient is deteriorating and may still be being actively treated by secondary care.

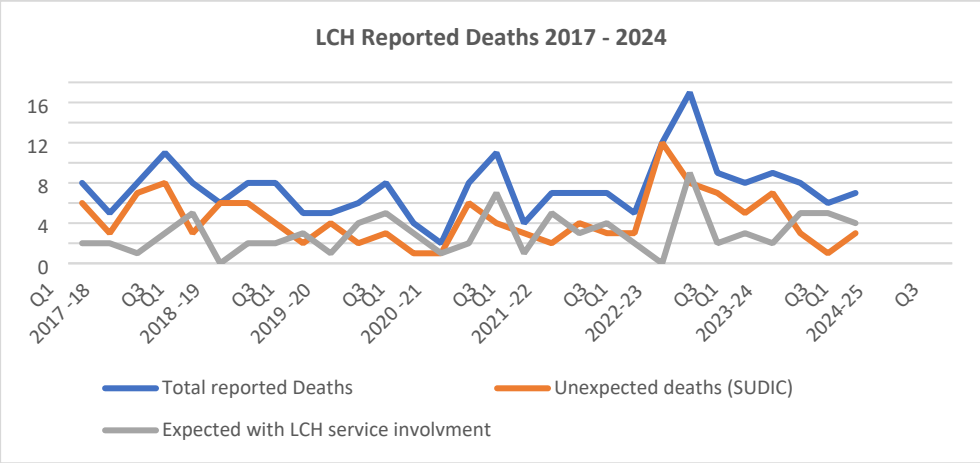
Actions

1. Steph Lawrence Executive Director of Nursing and AHP's will take a recent Patient Safety Incident investigation to ICB Citywide meeting to highlight the repeated theme around delays in treatment and risks associated with system wide care and communication pathways in the hope of establishing a working group to address and create improvement.
2. The No Access Standard Operating procedure will be transferred to a policy (Must Do) Due to be ratified June 2024. There has been an interim amendment to shift the responsibility re escalation and management of No access visit to Registered Clinician only with same day escalation to Leadership team.
3. To review guidance for completing level 1&2 mortality forms to improve baseline data content.
4. To include expected content when datix reporting an unexpected death into trust Datix investigator training .
5. The staffing skill mix is under review at Yeadon NT with structured engagement and assigned Senior clinicians to individual care homes to support complex care needs
6. The development of the deteriorating patient and sepsis Trust improvement group is reviewing the introduction of a soft signs for sepsis assessment tool , there is planned additional training for all staff groups to support earlier recognition of deterioration with a specific focus on recognising both chronic and acute signs for deterioration with associated proactive management guidance training.

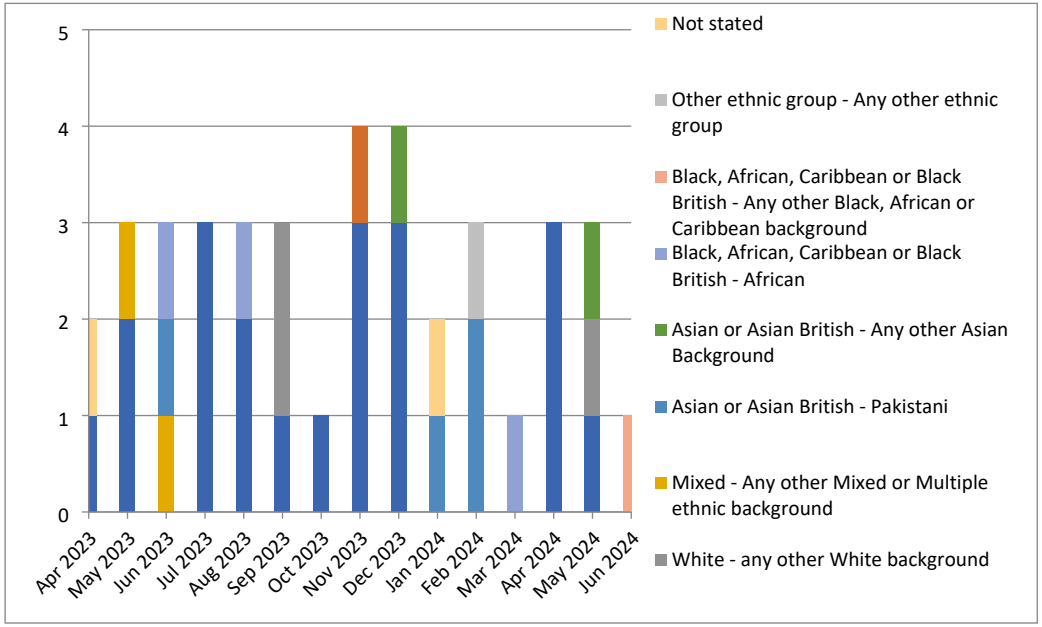
Key Opportunities Risks and Successes - Child Death, Q1 2024/2025 (Apr - Jun 2024)

Quantitative data

All LCH reported deaths – Q1 2017 – Q1 2025



Ethnicity



Analysis/Narrative

There were seven deaths in quarter one, the average for the previous 24-months is seven.

NB: following confirmation of a further expected death at the end of last quarter, the graph opposites now reflect this change.

Expected deaths.

Age	Cause of Death	LCH Learning from 24-hour rapid review
13y0m	Acute Respiratory Distress Syndrome. Relapse leukaemia	Awaiting rapid review
13y8m	Multi-organ failure. 1a Sepsis. 1b Septic shock. 1c C Diff	Awaiting rapid reviews
7y5m	1a Chest Infection 2 Juvenile Sandoff Disease	To review induction and supervision for Locum dieticians (NB this did not impact on the outcome)
16y6m	Multifocal Metastatic High-Grade Glioma	Awaiting rapid reviews
SUDIC		
11y1m	Awaiting cause of death	No identified learning for LCH
5y4m	Awaiting cause of death	Better use of Significant Events (NB this did not impact on the outcome)
18 days	Cardiac arrest	Better use of safeguarding node on both records where required.

Good Practice evident for 24 hour rapid reviews

- Evidence of the Care of Next Infant (CONI) programme offered to the family for the twin.
- Evidence of the new process for reviewing the child's sleeping area complete prior to the child's death.
- Good communication and multi-disciplinary working with families.

HIGHLIGHT & RAG RATE THE PRIMARY CQC DOMAIN BEING MET	*SAFE*	*EFFECTIVE*	*CARING*	*RESPONSIVE*	*WELL LED*

Key Opportunities Risks and Successes - Child Death, Q1 2024/2025 (Apr - Jun 2024)

Opportunities/Successes (Making Stuff Better/Celebrations)

Opportunity/Success
See Good Practice from the 24-hour rapid reviews

*BAF RISK 1 √	BAF 2	BAF 3	BAF 4

Opportunity/Success
There is now a dashboard (on Datix) to provide data for both children with and registered learning disability and autism. Quality Lead to verify this data.

BAF 1 √	BAF 2	BAF 3	BAF 4

Opportunity/Success
NHS England have provided training on 'Making Data' count. To consider whether it would be beneficial to add in a chart to demonstrate 'day's in between deaths'

BAF 1 √	BAF 2	BAF 3	BAF 4

A new SystmOne status marker for children who have Advance Care Plans is in place. This will make the Advance Care Plan more visible & accessible in the record. This will also be visible of the Home page.

BAF 1 √	BAF 2	BAF 3	BAF 4

Risks/issues

RISK
There are currently thirty-five child deaths to review, has increased slightly since last quarter.

Quarter and year	Number of deaths to review
Q3 22/23	35 (total number to review, not number of deaths per quarter)
Q4 22/23	39
Q1 23/24	28
Q2 23/24	24
Q3 23/24	35
Q4 23/24	32
Q1 24/25	35

Mitigation
Continue to review between 6 and 8 cases every 2 months.

*BAF 1 √	BAF 2	BAF 3	BAF 4

RISK
Risk remains of limited number of Paediatricians covering the Service, the service has Paediatricians who can cover notifications. This is on the risk register ID 1121.

Mitigation
The service has Paediatricians who can cover notifications.
There have been no reported incidents in relation to this.

BAF 1 √	BAF 2	BAF 3	BAF 4

Additional or supporting information (optional)

HIGHLIGHT & RAG RATE THE PRIMARY CQC DOMAIN BEING MET	*SAFE*	*EFFECTIVE*	*CARING*	*RESPONSIVE*	*WELL LED*

AGENDA ITEM 2024/25 (xx)

Q2 Mortality Report: Executive Summary

Key Updates

- Mortality Reporting: The mortality reporting processes have been updated to align with changes in the Medical Examiner process. QAIG reports have also been refreshed according to the NHS "Making Data Count" strategy, emphasising the use of Statistical Process Control (SPC) charts for better assurance.
- Adult Deaths: September 2024 saw deaths below the lower control limit, specifically in the ABU, triggering further investigations. Initial findings will be presented at the Q3 QAIG Business meeting.
- Mortality Reviews: Completion rates for both ABU and SBU Level 1 assessments are below the target of 75%. Changes to the review process were implemented in September 2024, supported by additional training, and progress will be reviewed in six months.

Equity Considerations

- Learning Disabilities: Further investigation into whether patients with learning disabilities disproportionately achieve their PPD. A communications plan has been developed to raise awareness among staff.
- Children's Deaths: Ethnicity recording for deceased children remains an issue, with 25% of ethnicity data missing. An action plan is being developed to with a focus on improvements in data entry, and local to national data alignment.

Recommendations for Committee

- Approve this report.
- Equity in Mortality Data: Support the implementation of updated demographic templates and audit process to improve ethnicity recording, particularly within the Children's Business Unit.
- Mortality Reviews: Ratify the target completion rate of 75% for mortality reviews at the QAIG. Monitor improvements following the introduction of the new process and provide additional training support.
- "Making data count" Integration: Continue to support teams working with BI to integrate SPC charts into mortality reporting for clearer trend analysis.

Key Mortality Data

Adults

Total Adult Deaths: The total number of adult deaths in LCH during September 2024 fell below the lower control limit for the first time since January 2023, specifically in the Adult Business Unit (ABU). This has triggered an investigation to understand potential causes, with initial findings to be presented at the Q3 QAIG Business meeting.

Mortality Reviews: Completion rates for mortality reviews (Level 1 assessments) have dropped to below 47% for both ABU and Specialist Business Unit (SBU). Notably, the SBU has recorded rates below control limits three times in the past two quarters. While Level 2 assessments remain within control limits, neither unit has met the target of 75% completion.

Action: The newly implemented mortality review process aligns with the Medical Examiner process, and additional training will support the achievement of the 75% target. Progress will be reviewed in six months, with a formal update at the next QAIG meeting.

People with Learning Disabilities

Death Numbers: The mortality rate for people with learning disabilities has overall remained stable at approximately two deaths per month since 2019, with some seasonal variation. There has been an increase in Learning Disability deaths in the last quarter, but this is expected due to the increased use of LD and reasonable adjustment flags. There has not been an increase in deaths of people with LD but an increase in the identification of people with LD. This is being monitored at through both the LCH mortality reviews and LeDeR process and highlights the necessity for precise, structured mortality reviews, particularly for adults with learning disabilities.

Preferred Place of Death (PPD): It is hypothesised that patients with learning disabilities may not achieve their PPD as frequently as the general population. Local reviews have highlighted gaps in awareness among staff regarding protocols for managing deaths of patients with learning disabilities.

Action: A communications plan has been developed to raise awareness and ensure training materials are readily available. A review of these deaths will evaluate if the preferred place of death is being met and assess the completeness of respect forms. Findings will be reviewed again in six months, following the initial communications push.

Children

Mortality Rates: Both expected and unexpected child deaths have remained within control limits, showing normal variation. Rapid reviews have been completed, and the findings were shared with the involved teams. No identified learning was considered to have directly affected the outcome of any child's death. Due to the potentially traumatic nature of child deaths additional support has been provided for staff undertaking child death reviews.

Data Reporting Improvements: Work is ongoing to align children's mortality reporting with NHS "Making Data Count" principles. This includes the introduction of SPC charts and improved narrative for assurance.

Action: The Children's Business Unit (CBU) is collaborating with BI to automatically pull key metrics from Datix, where mortality data is stored. An update on these improvements is expected by Q4, to be presented at the QAIG meeting.

Equity

Preferred Place of Death (PPD): A slow decline in achieving PPD has been observed since 2019, affecting all demographic groups, particularly non-white patients and those in the lowest socio-economic deciles (IMD 1 & 2). Currently, approximately 80% of patients achieve their PPD, but further trend analysis using SPC charts is needed to understand whether this decline is within normal variation.

Action: The BI team will assist in refining data presentation to identify trends more clearly, with results to be shared at the next QAIG.

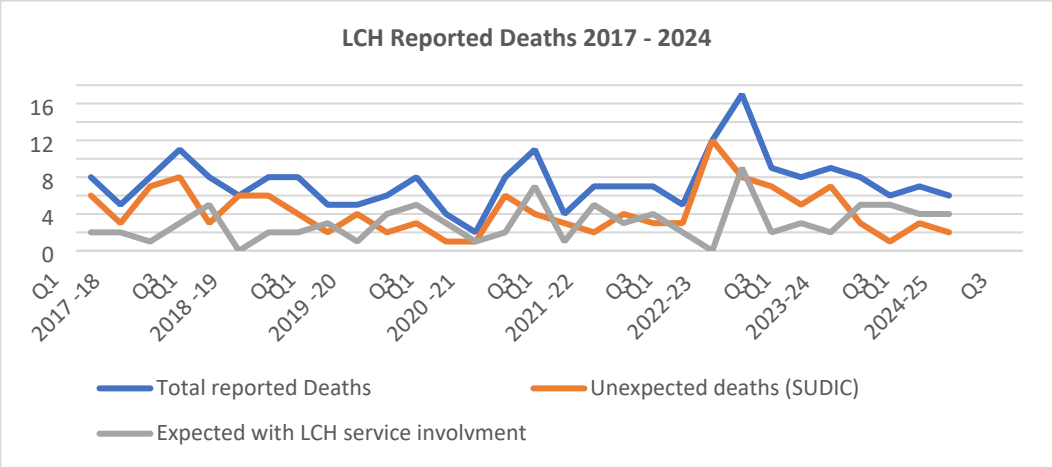
Ethnicity Recording: Ethnicity data remains incomplete for adult, there is a slight discrepancy between PPD (2.5% unknown) and Trust level reporting (6% unknown). 25% of child deaths do not have an ethnicity recorded. This lack of data presents challenges in addressing health equity across the Trust.

Action: The importance of accurate ethnicity recording has been stressed, with new demographic templates and an internal audit planned to ensure equity focused care.

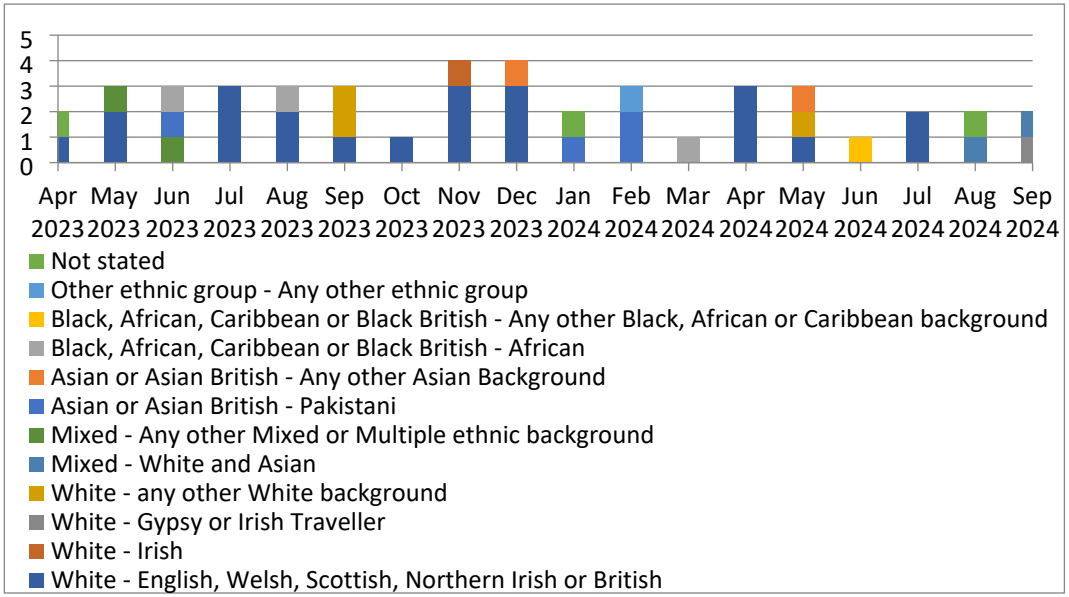
Key Opportunities Risks and Successes - Child Death, Q2 2024/2025 (Jul - Sep 2024)

Quantitative data

All LCH reported deaths – Q1 2017 – Q4 2025



Ethnicity



Analysis/Narrative

There were six deaths in quarter two, the average for the previous 24-months is seven.

Expected deaths.

Age	Cause of Death	LCH Learning from 24-hour rapid review	Esc to PSII
48wks	Refractory Acute Myeloid Leukaemia	Significant events node not updated with child's diagnosis Unclear from the SystmOne record what follow up care the family received.	No
4y10M	1b) Left Ventricular Hypertrophy and dysfunction secondary to hypertension 1c) Bilateral dysplastic Kidneys 2) Developmental Delay	Delay in completion of a support plan	No
12y6m	1a) Right hemi hydranencephaly with septo-optic deformity and ipsilateral hypoplastic middle cerebral artery.	Awaiting rapid review, reported 30/09/2024	No
46wks	Died post-surgery, awaiting further information	Awaiting rapid review, reported 30/09/2024	No

NB: Although learning was identified, this is not thought to have impacted on the child's death. This is early learning identified from rapid review, the information is scrutinised at the LCH Child Death meeting and Citywide, Child Death Overview Panel.

SUDIC

5y1m	Awaiting post-mortem	SLT waiting time for new referral longer than usual due service pressures 9–12-month development review completed via telephone as per service offer during covid pandemic, noted development delay at 27 months Awaiting Autism assessment (Oct 2022)	No
7wks	Awaiting post-mortem	Antenatal triage incorrect (although unlikely to have been completed – born at 33wks	No

HIGHLIGHT & RAG RATE THE PRIMARY CQC DOMAIN BEING MET	*SAFE*	*EFFECTIVE*	*CARING*	*RESPONSIVE*	*WELL LED*

Key Opportunities Risks and Successes - Child Death, Q2 2024/2025 (Jul - Sep 2024)

Opportunities/Successes (Making Stuff Better/Celebrations)

Opportunity/Success
To present data using SPC charts to determine any deviation

*BAF RISK 1	BAF 2	BAF 3 √	BAF 4

Opportunity/Success
Linked in with the co-chair for CDOP, she advised ethnicity is reviewed at a citywide level.

BAF 1 √	BAF 2	BAF 3	BAF 4

Opportunity/Success
The Quality Lead is working with CrISSP (Critical Incident Staff Support Pathway) Team to determine whether a post child death meeting debrief would be feasible.

BAF 1 √	BAF 2	BAF 3	BAF 4

The Internal Audit on deaths within LCH is underway.

BAF 1 √	BAF 2	BAF 3	BAF 4

Risks/issues

RISK
There is currently limited access to SPC charts due to an issue with enabled macros on LCH accounts
The child death date is not currently in Power BI.

Mitigation
Able to produce some data from Datix

*BAF 1	BAF 2	BAF 3 √	BAF 4

RISK
There are currently twenty-seven child deaths to review, this has decreased from last quarter (35).

Mitigation
Continue to review between 6 and 8 cases every 2 months.

*BAF 1 √	BAF 2	BAF 3	BAF 4

RISK
Risk remains of limited number of Paediatricians covering the Service, the service has Paediatricians who can cover notifications. This is on the risk register ID 1121. (improving situation to remain until closed on the risk register.

Mitigation
The service has Paediatricians who can cover notifications.
There have been no reported incidents in relation to this.

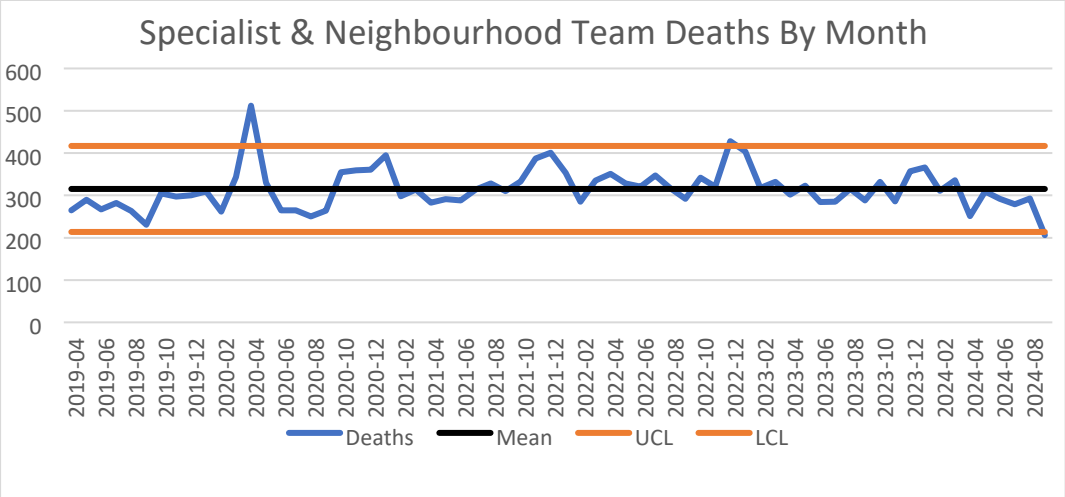
BAF 1 √	BAF 2	BAF 3	BAF 4

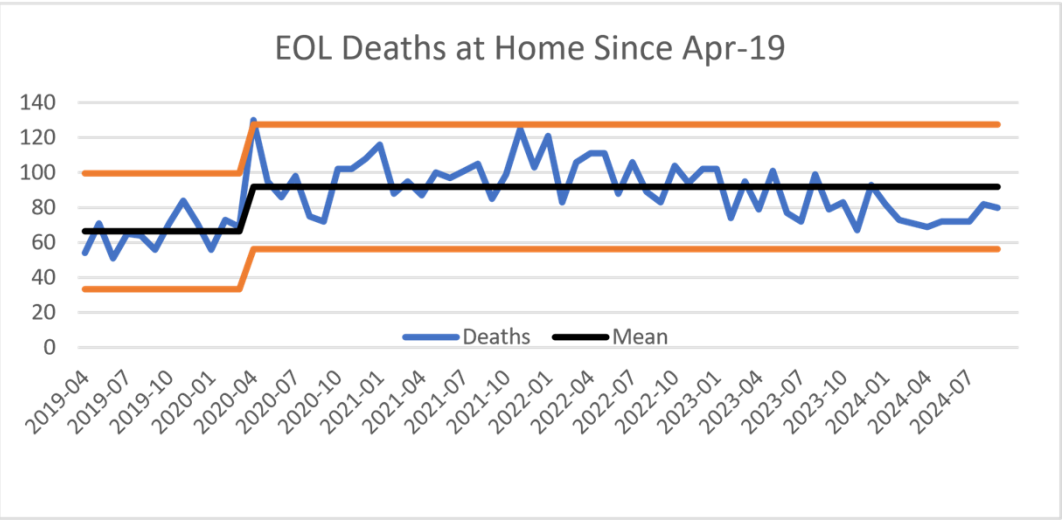
Additional or supporting information (optional)

HIGHLIGHT & RAG RATE THE PRIMARY CQC DOMAIN BEING MET	*SAFE*	*EFFECTIVE*	*CARING*	*RESPONSIVE*	*WELL LED*

Key Opportunities Risks and Successes Adult Mortality flash report, Q2 2024

Quantitative data





Plan to include for Q3

SPC charts for unexpected/Expected SBU/ABU
SPC for LD deaths
SPC for PPD

Analysis/Narrative

There were a Total of 778 Adult Deaths in Quarter 2 2024/25. Adult deaths are tracking within normal variation levels for reporting, Individual reporting for Team/services for SBU and ABU shows all teams are within usual variation with no outliers.

Learning Disability

10 people with a learning disability (LD) died in Q2. This is high for LCH reporting however, Lisa Smith has gained assurance that this is within usual parameters for Leeds citywide. Of these 10, 4 (40%) have had the required level 1 &2 Mortality reviews undertaken. One case had not been referred to Leder as per current LCH policy.

Clinical Leads in SBU and ABU will provide communication to teams to raise awareness of this requirement, and we will report progress in Q3 &4 reports to assess 6 months progress.

Preferred place of Death The numbers of patients dying at home are moving towards pre pandemic levels .

There were no new ethnicity trends identified for preferred place of death

Expected/Unexpected deaths

SBU = 76 Expected and 9 unexpected deaths.

ABU = 225 Expected and 41 Unexpected deaths .

It is noted that the numbers of reported deaths that were not recorded as either expected or unexpected is very high for adults which is a risk for both inaccurate reporting and missed opportunity for learning. (ABU = 61% and SBU 69%) Further exploration to take place to understand the data quality which will inform next steps and any action to be taken for improvement. We will report further in Q3.

Clinical Leads will re circulate the National definitions for Expected/Unexpected death to all Teams and services to promote accurate recording .

LMWS: Assurance report completed into deaths in service between Sept 22-Sept 24 from Datix. Results indicate that there are no concerns regarding increase/decrease in deaths reported. This will be monitored. **ASLT** In August a deep dive was completed for all Datix reported between 01/08/2023:31/08/2024 (12 months of data), to ensure that there were no deaths linked to breached waiting times. Results assured that there is a robust triage process to urgently respond where its required.

HIGHLIGHT & RAG RATE THE PRIMARY CQC DOMAIN BEING MET	*SAFE*	*EFFECTIVE*	*CARING*	*RESPONSIVE*	*WELL LED*

Key Opportunities Risks and Successes Adult Mortality flash report, Q2 2024

Opportunities/Successes (Making Stuff Better/Celebrations)	Risks/issues
1.It is now possible to track and monitor the Leder process and learning is now uploaded to the Learning disability web page on the intranet for Staff to view .	1.We are aware that there are delays with General practitioners recording deaths on S1 which can affect the accuracy of LCH reporting levels. 2.Within the last two years completion rates for level 1 &2 mortality reviews have consistently been 50% or below for both SBU and ABU. This creates a risk for inaccurate reporting for adult deaths in LCH . Quality Leads to meet with Business intelligence colleagues to be assured of the data accuracy. Actions and improvement will be reported in Q3 report
2.LD reviews and Leder feedback in Q2 show a requirement for earlier advanced care planning and has highlighted that the majority of LD patients are dying in hospital. Further work will be undertaken to cleanse and improve existing data capture and to explore the practice for completion of Respect/DNACPR trends and conversations relating to Preferred place of death to help inform future improvements.	3.Within the known backlog of patient safety incidents for ABU there are 28 deaths which have received an initial review, however , remain outstanding for formal review which is a potential risk for delayed identification for learning.
3. 80-85% of adults, over the last two years, achieve their Preferred place of death. Sarah McDermott and Em Campbell to explore challenges to the to achieving 100% Will provide an update on findings in Q3 report.	
4.Revised ABU mortality process is being fully embedded across ABU throughout Q3 following a successful pilot in the South 2 Neighbourhood Teams.	
5. Formal Communication has been shared across all adult services to highlight the new Medical Examiner role/ process (A leaflet has been developed) The Verification of death, policy ,training and competency has been reviewed and amended and is out for comment with circulation expected in the 3rd or 4th week of October.	
6 Clinical and Quality Leads met with external auditors to discuss Mortality processes within LCH . Feedback was generally positive. We have taken an action to consider the use of clinical audit to evidence the sustainability and impact from actions derived from Mortality surveillance meetings.	

Additional or supporting information (optional)

HIGHLIGHT & RAG RATE THE PRIMARY CQC DOMAIN BEING MET	*SAFE*	*EFFECTIVE*	*CARING*	*RESPONSIVE*	*WELL LED*

Leeds Community Healthcare NHS Trust

Agenda item 2024-25 (106)

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, Data and Technology Strategy	2x year To be confirmed	EDFR	SR 3,6	Deferred to Oct 2024			X	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						
Patient Safety Strategy Implementation Update	Final report to Board Dec 24	EDN&AHPS	SR 1,2,4				X Deferred to December 2024	X Final update report								
Health Equity Strategy	Annual (Sept)	EMD	SR1,9			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 Headlines 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 reports	4x year (June plus annual report, September, December and February)	EMD	SR 1,4	X				X -Blue box	X -Blue box		X -Blue box		X -Blue box		X -Blue box	X -Blue box
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
Audit Committee Chair's Assurance Report	as required	CS	SR7	X		X		X	X	X	X		X		X	X
Charitable Funds Committee Update Report	2x year (April and Oct)	EDN&AHPS	N/A							X				X		
Emergency Preparedness, Resilience & Response Statement of Compliance	Annual	EDO	SR2,7					X							X	
Emergency Preparedness, Resilience & Response Policies	Annual	EDO	SR2,7					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				
Green Plan	2x year (June and Dec)	EDO	SR 4,6	X				X -Blue box			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					Deferrred to be reviewed by Audit Committee March 2025		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 None for this meeting		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 -quarterly update report	Feb, June,Sept and Dec	CS	All	X			X	X	X		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