Bundle Public Board Meeting 6 February 2025

Agenda
Final Agenda Public_Board_Meeting_6 February_2025

107 09:30 - Welcome, introductions and apologies

108 09:40 - Declarations of interest

109 Questions from members of the public

110 Minutes of previous meeting, action log and matters arising

110.a Minutes of the meetings held on 6 December 2024
Item 110a Public Board Minutes 6 December 2024

110.b Action log
Item 110b Public Board Action log 6 February 2024_

111 09:45 - Patient's story: Wetherby Young Offender Institution

112 10:05 - Chief Executive's report
Item 112 CEO report - 6 Feb 2025

113 10:15 - Waiting Times Update
Item 113 Reducing Waiting Campaign 6 February 2025

114 10:25 - Workforce Headlines and Strategy Update
Item 114 TRUST BOARD Workforce Headlines and Strategy Update January 2025 V2.0
Item 114i APPENDIX 2 Workforce Strategy Measures Dashboard - Jan 25
Item 114ii APPENDIX 3 Progress narrative on Workforce Strategy measures Jan 2025 Update

115 10:35 - Quality Committee Chair's Assurance Report: January 2025

116 10:40 - Internal Audit Reports
Item 116i LCH 042025 Health Equity Final Report
Item 116ii LCH 0625 Mortality Rates and Learning from Deaths FINAL IA Report (1)

117 10:50 - Mortality Report – Quarter 3
Item 117 Mortality Reports Cover v1rb
Item 117i Adult Mortality Report Q3 24-25 FINAL V
Item 117ii QAIG flash report CBU Child Death Q3 24 - 25 FINAL

118 11:00 - Patient Experience: Complaints and Concerns Report
Item 118 Trust Board Papers Patient Experience Six Month report July-Dec 2024

119 11:25 - Business Committee Chair's Assurance Reports: January 2025

120 11:30 - Audit Committee Chair's Assurance Report: December 2024
Item 120 Audit Committee Chair's Assurance Report December 2024

121 11:35 - Charitable Funds Chair's Assurance Report: December 2024
Item 121 Charitable Funds Committee Chair Assurance Report December 2024

122 11:40 - Performance Brief
Item 122i Board Cover paper - Performance Brief December 2024
Item 122ii Performance Brief - December 2024_Q3 v3
Item 122iii Performance Brief SPC Data Pack - December 24 Report
Item 122iv Appendix 2 - Development of HLIs

123 11:50 - Freedom to Speak Up Guardian – Six Monthly Report
Item 123 FTSUG Feb 2025.

124 12:00 - Safe Staffing Report
Item 124 Safe staffing report Jan 2025

125 12:10 - Significant Risks and Risk Assurance Report
Item 125 Significant Risks report Board 060225

126 12:20 - Register of Sealings
Item 126 Use of Seal April 2024 to February 2025

127 12:25 - Enhance Business Case
Item 127 - Enhance Future Funding - Board - 6.2.25 amended 30 01 25
Item 127i Appendix Enhance BUSINESS CASE FINAL

128 12:40 - Any other business. Questions on Blue Box Items and Close

129 Blue Box: Board workplan
Item 129 Public Board workplan 2024-26 v8 28 01 2025

Leeds Community Healthcare NHS Trust

Trust Board Meeting Held In Public
Meeting Rooms 1&2 First Floor Wetherby Health Centre
Hallfield Lane
Leeds LS22 6JS

Date 6 February 2025
Time 9.30am - 12.45pm
Chair Brodie Clark CBE, Trust Chair

AGENDA			Paper
2024-25 107	9.30	**Welcome, introductions and apologies** *(Trust Chair)*	**N**
STANDING ITEMS			
2024-25 108	9.40	**Declarations of interest** *(Trust Chair)*	**N**
2024-25 109		**Questions from members of the public**	**N**
2024-25 110		**Minutes of previous meeting, action log and matters arising** *(Trust Chair)* *For approval*	
110a		Minutes of the meeting held on: 6 December 2024	**Y**
110b		Action log: 6 February 2025	**Y**
2024-25 111	9.45	**Patient story:** Wetherby Young Offender Institution *(Lynsey Yeomans)*	**N**
STRATEGY AND PARTNERSHIPS			
2024-25 112	10.05	**Chief Executive's Report** *(Selina Douglas)*	**Y**
2024-25 113	10.15	**Waiting Times Update** *(Sam Prince)*	**Y**
2024-25 114	10.25	**Workforce Headlines and Strategy Update -**reviewed by Business Committee January 2025 *(Jenny Allen/Laura Smith)*	**Y**
QUALITY AND SAFETY			
2024-25 115	10.35	**Quality Committee Chair's Assurance Report:** January 2025 *(Helen Thomson)*	**N**
2024-25 116	10.40	**Internal Audit Reports -** reviewed by Quality Committee January 2025 • Health Equity • Mortality Rates/Learning from Deaths *(Dr Ruth Burnett)*	**Y**
2024-25 117	10.50	**Mortality Report – Quarter 3 –** reviewed by Quality Committee January 2025 *(Dr Ruth Burnett)*	**Y**
2024-25 118	11.00	**Patient Experience: Complaints and Concerns Report -** reviewed by Quality Committee January 2025 *(Lynsey Yeomans)*	**Y**
BREAK			

FINANCE, PERFORMANCE AND SUSTAINABILITY			
2024-25 119	11.25	**Business Committee Chair's Assurance Reports:** January 2025 *(Khalil Rehman)*	**N**
2024-25 120	11.30	**Audit Committee Chair's Assurance Report:** December 2024 *(Khalil Rehman)*	**Y**
2024-25 121	11.35	**Charitable Funds Chair's Assurance Report:** December 2024 *(Alison Lowe)*	**Y**
2024-25 122	11.40	**Performance Brief** *(Andrea Osborne)*	**Y**
WORKFORCE			
2024-25 123	11.50	**Freedom to Speak Up Guardian – Six Monthly Report** *(Selina Douglas presenting on behalf of John Walsh)*	**Y**
2024-25 124	12.00	**Safe Staffing Report –** reviewed by Quality Committee and Business Committee January 2025 (Lynsey Yeomans)	**Y**
GOVERNANCE AND WELL LED			
2024-25 125	12.10	**Significant Risks and Risk Assurance Report** *(Lynsey Yeomans)*	**Y**
2024-25 126	12.20	**Register of Sealings** *(Selina Douglas)*	**Y**
2024-25 127	12.25	**Enhance Business Case –** reviewed by Business Committee January 2025 - **for approval** *(Selina Douglas/Sam Prince)*	**Y**
CLOSING BUSINESS			
2024-25 128	12.40	**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 128.

***Blue Box**		
2024-25 129	**Workplan**	**Y**

Agenda item:	2024-25 (110a)

Title of report:	Minutes Trust Board Meeting Held in Public: 6 December 2024

Meeting:	Trust Board Meeting Held in Public
Date:	6 February 2025

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

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

Previously considered by:	N/A

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

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

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

List of Appendices:	None

Attendance

Present:	Brodie Clark CBE	Trust Chair
	Selina Douglas	Chief Executive
	Helen Thomson Deputy Lieutenant (DL) (HT)	Non-Executive Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Khalil Rehman (KR)	Non-Executive Director
	Alison Lowe (AL) OBE	Non-Executive Director
	Rachel Booth (RB)	Non-Executive Director
	Lynne Mellor	Associate Non-Executive Director
	Sam Prince	Executive Director of Operations
	Dr Ruth Burnett	Executive Medical Director
	Andrea Osborne	Executive Director of Finance and Resources
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
Apologies:	Lynsey Yeomans	Executive Director of Nursing and Allied Health Professionals (AHPs)
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
	Helen Robinson	Company Secretary
In attendance:	Catherine Duff	ICAN Clinical Lead for Nursing, Occupational Therapy and Physiotherapy, Leeds Community Healthcare NHS Trust
Minutes:	Liz Thornton (Not present minutes produced from a recording)	Board Administrator
Observers:		
	Sarah Dowbekin	Associate Director Continuous Improvement, MIAA
	Jonathan Hodgson	Internal Audit Manager, Audit Yorkshire
	Dr Elizabeth Pal	Community Paediatric Trainee, Leeds Community Healthcare NHS Trust
Members of the public:	None present	

Item 2024-25 (83)

Discussion points:

Welcome introduction, apologies, and preliminary business

The Trust Chair opened the Board meeting and welcomed members, attendees, and observers. Lynne Mellor was welcomed to her first Trust Board meeting as a new Associate Non-Executive Director.

Apologies

Apologies for absence were received from Lynsey Yeomans, Jenny Allen, and Helen Robinson.

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.

Item 2024-25 (84)

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 (85)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2024-25 (86)

Discussion points:

Minutes of the last meeting, matters arising and action log

a) Minutes of the meeting held on 4 October 2024

The minutes were reviewed for accuracy and approved as a correct record of the meeting.

b) Action log

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

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 February 2025. **Ongoing.**

2024-25(74): Medical Director's Annual Report: the Statement of Compliance for 2023/24 had been circulated via email on 4 October 2024. **Action closed.**

2024-25(78): Board Members Service Visit Reports - whether future Board Member service visit reports should include non-executive director's observations on Quality Walks: this action would be carried forward to the meeting on 6 February 2025. **Ongoing.**

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: this action would be carried forward to the meeting on 6 February 2025. **Ongoing**

2023-24 (123): Chief Executives Report: Tier 3 Weight Management service waiting times - update to Quality Committee and Board in Autumn 2024: an update was included in the Chief Executives report for this meeting - Item 2024-25 (88). **Action closed.**

Item 2024-25 (87)

Discussion points:

Patient story: Edan's story

The Board heard a patient story concerning access to paediatric occupational therapy services and welcomed Emma, Edan's mum and Catt Duff a member of staff from the Trust.

Emma spoke about the barriers she had encountered in trying to access Occupational Therapy support and expressed her concern that therapy was not available to Edan because he was under

5 years old and his level of disability did not meet the NHS threshold. Emma said that the NHS was not supporting Edan effectively enough to build and develop his skills at an early age. She said that this would impact on the amount of long-term support Edan needed and increase the overall cost of his care to the NHS.

The Executive Director of Operations said that she was sorry to hear about Edan's experience. She explained that the Trust's Occupational Therapy Service was small, the criteria for accessing treatment were tight and currently the Trust was not commissioned to provide occupational therapy to children under 5 unless they had a Complex Developmental Assessment, which she understood Edan was not eligible for.

The Board agreed that this was a difficult but important story for the Trust to hear. Executive Board members felt there were other systems in the city which should be able to provide alternative funding for Elan and other children to enable them access therapy services. The Chief Executive agreed to raise this with Integrated Care Board commissioners.

Action: To speak to ICB commissioners about the service.
Responsible Officer: Chief Executive

The Chief Executive provided assurance that as part of the Trust's planning round there would be a focus on current capacity within the Trust's therapy services including the support on offer for children and families in all areas.

Non-Executive Director (IL) said it was clear that Emma had done a significant amount of work to support Edan's development on her own and she was a powerful advocate for him. He asked if she had been able to access any support groups in the city.

Emma said that opportunities were limited but groups could be accessed at Penny Field School and at the Mencap Centre in East Leeds.

Action: To connect the family to an advocacy service.
Responsible Officer: Chief Executive.

Non-Executive Director (AL) suggested that the Trust should consider producing self-help guides, videos to support therapy input and information leaflets about accessing resources for children who do not meet the current access thresholds for treatments.

The Trust Chair thanked Emma for presenting Edan's story so powerfully. He said that the Board would like to share the story more widely with other organisations in the city and take away and progress the actions suggested today. He said that the Trust would maintain contact with Emma to ensure that she received feedback on progress and asked that the Trust Board receive a further update at its next meeting on 6 February 2025.

Action: An update on progress made against the actions from the meeting to be reported to the Trust Board on 6 February 2025.

Responsible Officers: Chief Executive and Executive Director of Operations.

2024-25 Item (88)

Discussion points:
Chief Executive's report
The Chief Executive presented the report which focussed 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

She particularly highlighted:

- The Community Collaborative Time Out on 22 November 2024 which had provided a space to collectively think about the future of community health and social care in light of the Darzi report and the upcoming 10-year plan. A further workshop was planned for January 2025 to bring the relevant providers together and review the blueprint Neighbourhood paper and how this could be brought to life.
- The NHSE Regional Teams had held a consultation event on the 21 November 2024 on the Long-Term Plan and System Development covering the three big areas for discussion, outlined in the Darzi report:
  - Analogue to Digital
  - Sickness to Prevention
  - Hospital to Community.

  NHS England have requested feedback to inform the draft plan which will be published in Spring/Summer next year. The Trust would share the consultation details with staff to encourage them to take part in January 2025. The Trust would also be part of a submission from the Leeds system.

The Trust's responses would be shared with the Board when finalised.

The Executive Director of Operations provided a brief verbal update on system flow. The Trust was in silver command and daily check-ins were scheduled. Demand was primarily at 'front door.' Flu outbreaks were prevalent across the city.

Neighbourhood Teams were operating under pressure but there were no spikes in activity to report.

Non-Executive Director (IL) asked about the number of patients who were no longer meeting the criteria to reside in hospital.

The latest figure was reported as 230.

Non-Executive Director (HT) asked about measles outbreaks in Leeds. The Executive Director of Operations informed the Board that current outbreaks were in the east of the city and had not spread more widely. The expectation was that a vaccination programme would be managed by the Children's Nursing/Health Visitor Team in schools.

The Executive Director of Operations updated the Board on the outcome of three recent tender exercises:

- The Trust had retained the Custodial Healthcare Services at Wetherby Young Offenders Institute and Adel Beck Secure Children's Home. The new contract would start on 1 April 2025 and would include an additional service at Aldine House Secure Children's Home in Sheffield.
- The Liaison and Diversion bid had been unsuccessful. The Trust would work with the new provider who would deliver services across the Yorkshire and Humberside Region.
- The short-term bed tender had failed to find a compliant bid. A further update would be provided in the private session.

Outcome: the Board

- received and noted the report.

Item 2024-25 (89)

Discussion points:

Trust Priorities 2024-25 - Update

The report was presented by the Executive Director of Finance and Resources and provided a mid-year progress update against the Trust's 2024/25 priorities.

It was noted that the report had been considered by the Trust Leadership Team (TLT) and at the Quality and the Business Committees.

The priorities were aligned to a specific goal and had been developed with a cross-cutting intention to support achievement of the other goals.

Outcome: the Board

- noted the progress made against the Trust's priorities so far during the year and recognised the contribution that staff have made to that progress whilst striving every day to provide the best possible care to the communities the Trust serves.

Item 2024-25 (90)

Discussion points:

Digital, Data and Technology Strategy including sign off-off Year 1 Business Case

The Executive Director of Finance and Resources presented the Strategy which had been originally presented for approval to Business Committee and Trust Board in September 2024. A number of comments and suggestion were made by Non-Executive Director members that meant the Strategy required amending accordingly.

The Board noted that the Strategy has been strengthened in terms of the links to supporting the digital inclusion agenda; confirming that the work would reduce health inequalities and strengthen the clinical leadership requirements. Further detail has been added to reflect the approach taken to stakeholder engagement in the development of the Strategy and informing the strategic direction.

The current workplan for delivery of the strategy had been added as an appendix to the report.

Following further discussion at Quality Committee and Business Committee the wording had been adjusted to reflect the benefits of self-management processes on reducing costs, improving patient outcomes, and streamlining processes, as well as strengthening the use of data to reduce health inequalities.

Non-Executive Director (IL) stated that he felt that the clinical leadership requirements still required strengthening, and he would like to hear more about the Trust's ambition to contribute to the NHS Community Health Services (CHS) Data Plan 2024/25 to 2026/27.

The Executive Director of Finance and Resources said that as a minimum the workplan would be reviewed quarterly in line with reporting on progress towards delivery of the Strategy and these aspects would be considered as part of that process.

Associate Non-Executive Director (LM) asked who the target audience was for the Strategy when launched.

The Executive Director of Finance and Resources said the Trust's Communications Team was working on a simple visual way of publicising the salient points within the Strategy internally and also externally with a view to influencing the national agenda.

Associate Non-Executive Director (LM) was also interested in what the Trust was doing to understand and receive assurance around what partners in the supply chain were doing to manage cyber security issues and she offered her expertise in this area if required.

Outcome: the Board

- reviewed and approved the Digital, Data and Transformation Strategy.

Item 2024-25 (91)

Discussion points:

Patient Safety Strategy Implementation Final Update Report

The Executive Medical Director presented the report on behalf of the Executive Director of Nursing and AHPs.

The paper provided the Board with a six-monthly and proposed final update of progress against the implementation of the national Patient Safety Strategy into the Trust.

Non-Executive Director (RB) commented that to ensure successful implementation and embedding in the Trust there needed to be a mindset shift across the Trust's workforce.

The Executive Medical Director said that she was confident that the culture in the organisation was changing at a senior level and filtering down within teams. Themes and trends would be scrutinised and reviewed during quality walks.

Outcome: the Board:

- considered the paper, and received assurance that the Trust was following the methodology and culture set out in the Patient Safety Strategy
- agreed that the Patient Safety Strategy was now business as usual for the Trust and to conclude Board reporting.

Item 2024-25 (92)

Discussion points:

Quality Committee Assurance Report: November 2024

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

- AB Action Plan – the Committee noted that there would be a Trust-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 and Value Programme – progress against target and workstream updates were reported. The 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.

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 9: Failure to prevent harm and reduce inequalities experienced by our patients – this was due to the fact that a service spotlight item had not been presented, and equity data not being included in the mortality report. This made it difficult to determine a reasonable level of assurance for this strategic risk.

The Board discussed the assurance level for Risk 2: Failure to manage demand for services which tended to fluctuate between **reasonable** and **limited**.

Non-Executive Director (HT) observed that levels of assurance were solely based on papers presented for each meeting. She agreed that there should be a more consistent approach and she would welcome a discussion with the Company Secretary about how this could be achieved.

In relation to Risk 2 the Executive Director of Operations explained that a review of waiting lists was underway to:

- ensure no waits were longer than 40 weeks
- reduce 26-40 week waits
- cleanse each list to ensure consistency
- tighten up on did not attend rates
- ensure no groups are disadvantaged
- introduction 'one-stop' clinics for multiple wait lists.

A further update on progress would be provided to the Quality Committee.

Associate Non-Executive Director (LM) asked if there has been an internal audit of waiting lists. The Executive Director of Operations informed the Board that an internal audit had not been scheduled as part of this year's audit plan but would be welcomed at some point in the future, particularly to look at the effectiveness of waiting list management .

Outcome: the Board

- noted the update reports and the matters highlighted.

Item 2024-25 (93)

Discussion points:

Business Committee Assurance Reports: October and November 2024

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

October

- Workforce culture workshop – the Committee heard about the progress in staff retention and reducing turnover; also, the impact that the communications strategy had had on engagement through the Quality and Value programme. There was some discussion about the impact that the recent riots had had on staff sentiment and morale and how this was managed. The Committee was assured that there was a good level of focus and attention from the Trust leadership on engagement, communication and driving a positive culture through action.
- Quality and Value update – Continued forecast of financial balance. 90% of the £15.8m target saving identified but 42% of that was non recurrent, adding pressure on the workstreams to deliver recurrent savings. 12 service redesigns were in progress using the Benefits Realisation toolkit. The Committee asked for more detail on EQIA output.
- The Committee received a corporate benchmarking report which identified that in a number of key areas, the Trust's costs were higher than other organisations due to economies of scale. Drivers for increase in costs were discussed and these included investment in digital and tech to address previous under-investment. Overall, there were opportunities to identify further efficiencies through the data provided by this exercise and the Committee was assured this is being considered as part of the Quality and Value Programme.

November

- Green Plan refresh – the 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. The refreshed detailed plans would be presented in February/March 2025.
- 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.

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 reports and the matters highlighted.

Item 2024-25 (94)

Discussion points:

Audit Committee Assurance Report: October 2024

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

- Two limited opinion Internal Audit Reports had been received and reviewed by the Committee – Enhance Programme, and eRostering and Critical Incentive Shifts. Further

discussion around the eRostering audit would take place at the October Business Committee meeting.
- 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.

The Board noted that the risk assigned to the Committee Risk 7: Failure to maintain business continuity (including response to cyber security) had been assigned a **reasonable** level of assurance.

Outcome: the Board
- noted the assurance report and the matters highlighted.

Item 2024-25 (95)

Discussion points:

Performance report

The Executive Director of Finance and Resources presented the highlight report. which provided the Board with:
- An update on progress relating to the development of the Performance Brief (as the Trust worked towards 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.

The Board noted that the development of a published version of the Performance Brief remained in progress and had made comments on the format of the reports presented at the Quality and Business Committee in November 2024. In the meantime, the report presented to the Board provided key updates and escalations.

Outcome: the Board
- received and noted the update.

Item 2024-25 (96)

Discussion points:

Emergency Preparedness, Resilience and Response Improvement Plan (EPRR)

The Executive Director of Operations presented the Improvement Plan which required approval in two parts.

Part 1 – EPRR annual compliance

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

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

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

Part 2 – Policies and Plans (Blue Box Item 103)

The Board was asked to approve a number of additional policies and plans for submission:

- 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

The Team responsible were commended for their work on the EPPR Improvement Plan.

Outcome: the Board
- approved of submission of the EPRR policies and plans.

Item 2024-25 (97)

Discussion points:

Guardian of Safe Working Hours (GoSWH): Quarter 2 update

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

The Guardian drew attention to the following issues:

CAMHS ST historic rota compliance and payment issues update

This issue had reached a conclusion that had been put forward to affected Junior doctors.
Since the last report to the Trust Board, the Guardian had worked with the BMA team and had been informed that some of the affected Junior doctors were considering further actions through a formal grievance case route, as offered by the Trust.

One junior doctor had raised a grievance case on 23 November 2024 via correspondence to the Trust's Director of Workforce.

Non-Executive Director (KR) queried the timeline for dealing with the grievance. The Director of Workforce, Organisational Development and System Development (LS) said that it was important that the process was a thorough one and it would take time to progress in line with the Trust's agreed grievance policy.

The Board discussed the possible financial implications for the Trust. The Guardian explained that this was hard to quantify and dependant on the outcome of the grievance process. There was no benchmarking information or guidance available but support and advice was available from NHS Employers.

The Executive Medical Director informed the Board that the doctor who had raised the grievance was no longer a resident doctor in training in the Trust.

Community paediatric training issue

Work continued to improve the community paediatric training for speciality doctors sub specialising in community paediatrics. Changes had been put in place to ensure doctors had more time in community paediatrics. Plans to change the current rota pattern to ensure doctors got around 70% of the time for training were being investigated for the next cohort of doctors starting in March 2025. This was a significant achievement that would improve the training in community paediatrics.

The Board thanked the Guardian for the significant amount of work done to investigate and conclude work related to the CAMHS historic rota and offered the Board's support if necessary to resolve the issues.

Outcome: the Board
- supported the GoSWH with the work in relation to community paediatric training opportunities

- noted that there was a risk for the Trust from the grievance case raised by Junior doctor affected by CAMHS historic rota issue.

Item 2024-25 (98)

Discussion points:

Significant Risks Risk Assurance Report

The Chief Executive introduced the report which provided information about the effectiveness of the risk management processes and the controls in place to manage the Trust's most significant risks.

It was noted that there were three risks on the Trust risk register that had a score of 15 or more (extreme). There were a total of 10 risks scoring 12 (very high).

The Board noted the changes that had taken place to risks scoring 15 (extreme) or above since the last risk register report and discussed assurance on the rationale underpinning the changes in ratings.

The Executive Medical Director observed that that a significant percentage of the high and extreme risks were impacted by national issues outside the immediate control of the Trust.

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 (99)

Discussion points:

Board Assurance Framework (BAF) Quarterly update

Following the agreement of the Trust's strategic objectives and priorities for 2024/25, it had been 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 November 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 (100)

Discussion points:

Chief Executive Officer/Chair Action: Approval of Auditor Panel Terms of Reference

The Trust Chair presented the paper which reported an action taken by the Chief Executive Officer (CEO) and Chair on behalf of the Board outside the Board's usual meeting schedule to approve the Terms of Reference for the Auditor Panel in order to commence the selection process for the Trust's external auditors.

The action had been approved by the CEO and Chair in November 2024, in consultation with two non-executive directors: Ian Lewis and Helen Thompson.

Outcome: the Board

- ratified the decision on the Auditor Panel's Terms of Reference.

Item 2024-25 (101)

Discussion points:

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

The Executive Director of Finance and Resources presented the contract award proposal to make a direct award, under the framework contract RM6261,dto the existing suppler (O2/Virgin Media) which included the following benefits:

- Provide value for money with a reduction in mobile data charges.

- Had 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 would retain their same mobile telephone number.

The proposal also included the extension of ad Mobile Device Management solution which enables security updates and device protection for a further twelve months.

The total value of the business case over the lifetime was £1,157,366 including VAT. The expected cost reduction was circa £2m over the life of the contract.

Outcome: the Board

- approved a direct contract award via Framework RM6261 with O2/Virgin Media for a three-year contract.

Item 2024-25(102)

Discussion points:
Any other business Blue Box Items and Close
There were no matters raised.

The Trust Chair closed the meeting at 11.50am

Date and time of next meeting
Thursday 6 February 2025 9.00am-12.00 noon

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

AGENDA ITEM 2024-25 (110b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) action log: 6 February 2025

Key		Key colour code
Total actions on action log		
Actions on log **completed** since last Board meeting on 6 December 2024 with a **proposal to close**	4	
Actions not due for completion before 6 February 2025: **progressing to timescale**	0	
Actions not due for completion before 6 February 2025: agreed timescales and/or requirements **are at risk or have been delayed**	0	
Actions outstanding at 6 February 2025**: not having met agreed timescales and/or requirements**	0	

Agenda Item Number	Action Agreed	Lead	Timescale/Deadline	Status
6 December 2024				
2024-25 (87)	**Patient Story – access to paediatric occupational therapy services:** to raise this with ICB commissioners.	Chief Executive	Post meeting	Tim Ryley is the Leeds Accountable Officer- recommended to the Family that they make direct contact. **Propose close**
2024-25 (87)	**Patient Story – access to paediatric occupational therapy services:** to connect the family to advocacy support.	Chief Executive	Post meeting	Contact made with Carers Leeds. They are keen to help details sent to the family. **Propose close**
4 October 2024				
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 Medical Director/ Executive Director of Nursing and AHPs	Trust Board meeting 6 February 2025	Verbal update to Trust Board meeting 6 February 2025 – **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.	Executive Director of Nursing and AHPs	Trust Board meeting 6 February 2025	Verbal update to Trust Board meeting 6 February 2025 – **Propose close**

Agenda item:	2024-25 (112)

Title of report:	Chief Executive's report

Meeting:	Trust Board Meeting Held in Public
Date:	6 February 2025

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: • West Yorkshire Community Health Services Provider Collaborative • International Nurses Celebration Event • Quality and Value Programme • Spotlight on…Children's Community Nursing Service – CIVAS

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 West Yorkshire Community Health Services Provider Collaborative

The WY Community Health Services Provider Collaborative held its Quarterly Meeting on January 20, 2025, and discussed the three key government policy areas for health and care: the "Getting Britain Working" white paper, the English Devolution white paper, and the emerging 10-year plan. The meeting summarised each policy, reviewed ongoing initiatives, assessed their implications for West Yorkshire, and identified potential opportunities and next steps. While national policy is evolving, our Partnership is actively addressing these objectives and has established priorities that align with them. There is considerable potential for these national policies to enhance and accelerate our current initiatives. We also reviewed our collective WY key highlights from 2024 and an ambition for 2025 to work collaboratively.

3 International Nurses Celebration Event

The Trust has 4 International nurses in our cohort 3, who joined LCH in October 2023 and completed their first year in December 2024. Like the other 2 cohorts, we celebrated their first year of completion to appreciate their hard work and let them feel valued within the organisation. The Executive Director of Nursing and AHPs thanked the cohort and presented them with their completion certificates.

4 Quality and Value Programme

The Trust remains confident of delivering the £15.8m savings targets for 2024/25. The year-to-date delivery is running almost £0.7m ahead of planned for December. Whilst this gives assurance on the delivery of the planned surplus for the year it should be noted that the proportion of non-recurrent savings being delivered in year is £7.2m against planned position of £2.6m, i.e. an additional £4.6m of non-recurrent savings are being delivered through the grip and control measures in place.

5 Spotlight on…Children's Community Nursing Service – CIVAS

The CIVAS service commenced IV antibiotic therapy (Ceftriaxone) in February 2024. To date 116 patients have received the service, an average of 2.3 patients per week.

The service meets regularly with Leeds Children's Hospital to evaluate and tweak processes for continuous improvement.

Feedback from patients and families has been very positive. Some early feedback focused on the wait for patients in the hospital before getting back to their home. Positive examples have included benefits for neurodiverse children, generally better recovery and less stressful for families. One of the service's patients shared their experience with the Board and this was felt to be very positive by the family.

What is next for CIVAS?
- Leeds Children's Hospital are scoping additional antibiotics to be delivered by the LCH Children's Community Nursing Team.
- Leeds Children's Hospital Oncology Team are scoping possibilities for their CCNS team to deliver chemotherapy in the home. Conversations to progress this are imminent.
- Consideration of upskilling staff to perform venepuncture and cannulation.

Longer term targets
- Further expansion of the Hospital at Home model by the Children's Community Nursing Service.
- Keen to be more formally represented in any discussions where the service can influence its involvement to be considered as providers of hospital into community care pathways. Leeds Children's Hospital are already developing various Hospital at Home pathways provided by their own workforce, and the service is keen to not lose opportunities when they are already based and set up in community.
- Progression to a Virtual Ward model with use of clinical equipment that is able to report observations directly to systems and/or better cohesion of patient record systems between LCH and LTHT.
- Keen to be represented where the service could have influence over proposed community hubs by the government and not wanting this provision to be solely delivered by Primary Care.

6. System Flow

Leeds Community Healthcare has continued to play an important role in system flow. Following a relatively quiet festive period, we experienced a very busy period driven by significant increase in respiratory presentations. This resulted in a need to ensure people were safely discharged from hospital in a timely way to ensure there was admission capacity. System silver calls were held each day to support collaboration across the partnership. These have now been stood down.

LCH staff at the Transfer of Care Hub, in addition to their usual duties, supported Adult Social Care with short term assessment which enabled more people to rapidly access reablement and homecare. There was an additional focus on short term beds and the system procured additional beds to ensure flow. It is worthwhile noting to the board that the plan outlined in the summer around short term beds by the ICB to reduce bed capacity across Leeds would have meant there would have been fewer beds in the city therefore reducing flow.

Teams in neighbourhoods, in our specialist services and in our community bed bases worked exceptionally hard to both keep people out of hospital but also to ensure they returned home as quickly and safely as possible.

6 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
January 2025

Leeds Community Healthcare NHS Trust

Agenda item:	2024-2025 (113)
Title of report:	Access LCH - Reducing Waiting Campaign

Meeting:	Trust Board Held in Public					
Date:	6 February 2025					
Presented by:	Executive Director of Operations					
Prepared by:	Executive Director of Operations					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	√

Executive Summary:	This paper details the waiting list initiative running in the Trust between January and March 2025. The three-month focus on reducing waiting lists aims to make LCH services safer and more responsive by ensuring no-one waits more than 40 weeks to enter our services as a standard. It is noted that 40 weeks is still too long to wait, and the maximum wait standard will be reduced further during 2025-26)
Previously considered by:	Wide group of stakeholders including Trust Leadership and Senior Leadership Teams, Business Managers, Health Equity Lead, Consultant in Public Health, Head of Administration, Head of BI, BI Manager, Named Nurse Learning Disability, Partnership Development Manager

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?	Approach to ensuring we do not inadvertently disadvantage any groups during the campaign
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	Trust Board is asked to acknowledge the approach to improving patient experience through reduction in waiting times

ACCESS LCH - REDUCING WAITING CAMPAIGN – JANUARY-MARCH 2025

1 INTRODUCTION

This paper details the waiting list initiative running in the Trust between January and March 2025. The three-month focus on reducing waiting lists aims to make LCH services safer and more responsive by ensuring no-one waits more than 40 weeks to enter our services as a standard. It is noted that 40 weeks is still too long to wait, and the target wait standard will be reduced further during 2025-26.

2 AMBITION

The law states that patients should wait no longer than 18 weeks from referral to treatment for non-urgent, consultant-led treatments. This standard does not generally cover the majority of work in the Trust because many of our interventions are nurse or therapy led. However, before the Covid pandemic, the Trust adopted the standard for all pathways and was successful in maintaining waits at under 18 weeks. Due to a number of factors including increased demand, increased acuity, and the complete cessation of some services during the pandemic, waiting times in the Trust have grown and there is now a need to ensure timely access for patients waiting 40+ weeks for their first appointment.

This campaign aims to reduce waiting lists with ambition to:

- Ensure no-one waits more than 40 weeks to enter our services as a standard (Maximum wait standard to be reduced further during 2025-26)
- Reduce the number of people having to wait 26-40 week for services
- Cleanse every waiting list so that we are confident the numbers are an accurate record
- Ensure every clinical slot in the core provision is booked (aim 100% utilisation in terms of booking)
- Halve DNA rates – Trust average is currently 5.13% - to 2.5% (NB – the target will be refined to be specific to each service in scope). There will be a focus on a reduction of DNAs on those groups with the highest DNA rates' (which is likely those in IMD 1). This approach should both improve outcomes as well as achieving our strategic goal of equity.
- Attempt to provide “one stop” clinics for people waiting on multiple waiting lists

3 SCOPE OF THE CHALLENGE

Whilst all services will be expected to participate in the initiative, special focus will be given to the services with waiters over 52 weeks including Podiatry, Adult Speech and Language Therapy, Community Gynaecology, Continence, Urology and Colorectal Services, Children’s Services (Child Development Centre, Children’s Occupational Therapy), Tier 3 Weight Management, Neighbourhood therapy and Communication Aids Services

There are three services which require a system response to resolve – CAMHS, Preschool autism and PND – these services will participate in the campaign, but it is unlikely that the “no 40 weeks wait” target will be met in the timeframe.

3 ACCESS LCH

Each service has considered the opportunity for both maximising weekday capacity and providing evening and weekend working. Three centres – Beeston Hill, Armley and Chapeltown - have been opened to enable weekend clinics. The first weekend clinics commenced on 1 February 2025.

Additional administrative and clerical capacity has been sought to cleanse the lists, check we have communication needs and reasonable adjustments recorded and book people into existing clinic slots. The central team will focus on waiting list validation, front of house reception and direct contact with patients for booking in (with a view to reducing DNAs/cancellations and was not brought)

The DNA policy will be rigorously followed and patients discharged after two non-attendances where we can demonstrate that we have offered appointments in a way that meets their communication needs and have met their reasonable adjustments, and that the person is not vulnerable/at risk.

Each service has considered what work could be completed virtually.

4 GOVERNANCE

A weekly steering group has been established to oversee the campaign. The group feeds into both the Patient Access Group and Trust Leadership Team. Progress will also be reported through Business Committee.

The Business Intelligence Team has been asked to develop a weekly report for each service so they can track progress. This will include target, progress, underlying issues, actions taken, risks and support required. A specific request has been made to include impact for IMD1 as well as general equity reporting.

Learning from the campaign is being collated through Quality Improvement colleagues and will be incorporated into business as usual.

5 RECOMMENDATIONS

Trust Board is asked to acknowledge the approach to improving patient experience through reduction in waiting times.

Sam Prince
Executive Director of Operations
29.1.25

Agenda item:	2024-2025 (114)

Title of report:	Workforce Headlines & Strategy Update

Meeting:	Trust Board Held in Public
Date:	6 February 2025

Presented by:	Director of Workforce					
Prepared by:	Director of Workforce Workforce Project Manager					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	

Executive Summary:	This paper provides the Business Committee and Trust Board with information about key headlines linked to the LCH Workforce portfolio. It is produced three times a year. It is reviewed and discussed at Business Committee prior to coming to Trust Board. The paper also provides an update on the progress made against LCH Workforce Strategy's outcome measures at the end of Q3 of 2024/25; and overall position against the Strategy's outcome measures to date.

Previously considered by:	N/A

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	√
	Use our resources wisely and efficiently	√
	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?	Paper is Workforce-focused. It includes EDI data and considerations

Recommendation(s)	It is recommended that the Business Committee and Trust Board: • Note the Workforce Headlines presented in this report • Note the progress achieved in pursuit of the target measures set out in the current LCH Workforce Strategy.

List of Appendices:	Appendix 1: New People Directorate Service Delivery Model Appendix 2: Workforce Strategy Progress Dashboard Appendix 3: Workforce Strategy narrative headlines

Workforce Strategy Update & Headlines

1. Introduction

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

It also provides an update on the progress made against LCH Workforce Strategy's outcome measures as at Q3 of 2024/25.

Key headlines in this month's report include:

- An update on the Workforce Directorate's transformation progress
- Celebrating the I Thrive cohort of the LCH Talent Development Programme
- Plans for the new People & Culture Committee
- Receipt of initial 2024 Staff Survey results

2. Workforce Headlines, January 2025

2.1 Workforce Directorate Transformation

The Workforce Directorate is progressing to its planned timescales with its Transformation programme of work, following approval of a Case for Change in late October 2024 and subsequent organisational change consultation.

The changes have commenced with a Workforce Directorate restructure which will be completed by 31 March 2025, forming a People Directorate for LCH.

The restructure lays the foundations for our new People Directorate service model (**Appendix 1**). It has been designed to deliver improvements to customer experience and to the identification, design and delivery of new People initiatives; as well as realising workforce systems efficiencies.

Completion of the Directorate's Transformation programme, with the associated delivery of the improvements described above is scheduled to take place during 2025/26 and 2026/27.

The restructure element of the Transformation in 2024/25 is on target to deliver £300k recurrent savings to the LCH Quality& Value Programme. This represents a 15% reduction in the Workforce Directorate's contracted posts between 1 April 2024 and its new substantive structure.

2.2 LCH Talent Development Programme (focus on BME / Global Majority employees)

In December 2024, the Chair, Chief Executive and other LCH senior leaders joined the LCH I Thrive cohort *(pictured below, with the Chief Executive and LCH Course Lead)* to celebrate the cohort reaching the conclusion of their formal I Thrive programme.

The programme, delivered for LCH by ILN (Inclusive Leaders Network), has been well received by the participants who have offered positive feedback on the programme.

Most have highlighted an increase in confidence and greater motivation to search for and apply for development and promotion opportunities.

Following the programme the 18 participants continue to be supported in their development in the following ways:

1) Support to obtain and team up with a mentor.
2) A workshop in March 2025 to evaluate progress and update skills & knowledge
3) Continuation of Action Learning Sets.

The participants' managers were invited to a parallel "We Thrive" programme, assisting them to explore issues of fairness, inclusion, and equality. The programme was described as "personally and professionally challenging but enriching".

The LCH Course Lead and the course provider are in the process of gathering further evaluation material, to inform LCH's thinking and decision-making about the design and delivery of future similar development initiatives for 2025/26.

2.3 People & Culture Committee

Planning is underway for an LCH People & Culture Committee to be launched in 2025 / 26, as a new subcommittee of the Trust Board.

Covering a broad spectrum of People issues and associated data, the new Committee is being designed to ensure that Board members have even greater assurance regarding People matters at LCH; with additional dedicated time to discuss these in detail.

The introduction of the Committee is expected to enable deeper discussion on matters including Health & Wellbeing, Inclusion, Employee Relations & Engagement, Leadership and Staff Development, among others.

2.4 NHS Staff Survey

Initial results have been received by LCH this month for the 2024 NHS Staff Survey. Analysis is underway and services are receiving their results directly in order to commence work on their action plans.

Additional results including the benchmarking of LCH results with its cohort of comparator organisations are due to be received in the next 8 weeks.

Whilst results remain under embargo until late in March 2025 and therefore cannot be published yet, it is possible to report that with a strong response rate of 60%, LCH staff have chosen to engage with the survey in large numbers, which suggests ongoing high levels of staff engagement through this first year of the Quality & Value Programme.

The new People & Culture Committee and the Trust Board will receive a more detailed update on the Staff Survey in due course.

3. Workforce Strategy Delivery Progress – Quarter 3 2024/25

The dashboard at ***Appendix 2*** shows at-a-glance RAG-rated progress against the measures set out in the Workforce Strategy 2021-26.

Meanwhile, ***Appendix 3*** provides bullet points highlighting progress made since the last update, together with some brief narrative explaining the RAG status of each measure.

The RAG rating key is as follows:

	Will not achieve target by 31 March 2026
	Improvement or progress made, may be slower than originally planned
	Current trajectory indicates target will be achieved by 31 March 2026
	Target achieved or superseded

Still marked amber is the Inclusion target of 14.5% of the workforce being from a BME background by 31 March 2025. Measures introduced in the past year to support representation are correlating with an improved trajectory of improvement, however that trajectory of improvement is still too shallow to be certain of achieving the target within 2025/26.

Some targets have significantly overperformed on their original targets: for example bank fill rates have to date improved by 52% since 2021/22; a substantial overperformance on the 10% improvement target. Employee turnover has also outperformed both its original target of reducing to 13%, and its stretch target of reducing to 11%; and is currently maintaining in the region of 10%.

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

4. Conclusion

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

5. Recommendations:

It is recommended that the Business Committee and Trust Board:

- Note the Workforce Headlines presented in this report
- Note the progress achieved in pursuit of the target measures set out in the current LCH Workforce Strategy.

Laura Smith / Jenny Allen and Hannah Stankler
Director of Workforce and Workforce Project Manager
22 January 2025, updated for Trust Board 30 January 2025

Appendix 1: People Directorate Service Delivery Model

Introducing the People Directorate

This is our draft Service Delivery Model
It is based on 3 spheres, with a Business Partnering approach at its core
There is a draft proposed structure that underpins the model
Engagement with the Directorate and service leads is ongoing

The 3 spheres explained:

People Operations: day-to-day support for our customers who using our **existing** services

People Solutions: Designing and developing **new** products, programmes and solutions in response to organisational needs.

People Strategy, Performance & Governance: ensuring that the directorate does, and will continue to, deliver for the organisation

Appendix 2:

LCH Workforce Strategy Update: January 2025

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

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

LCH Workforce Strategy Update Jan 2025

Leeds Community Healthcare NHS Trust

RESOURCING

- ATS embedded and targeted training for managers in place.
- Reviewed the service structure and the recruitment teams roles and responsibilities to create a standard, fast and efficient way of working.
- Temporary Staff Bank have had increases in internal bank registration and external agency requests.

MEASURE 1

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

Bank fill rates **+52%**
Bank capacity **+ 87%**

ON TARGET

MEASURE 2

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

Turnover avg 24/25 **9.6%**

ON TARGET

MEASURE 3

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

ATS implemented

ON TARGET

MEASURE 4

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

ATS Implemented

ON TARGET

MEASURE 5

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

Review required in line with ATS implementation

IN PROGRESS

LCH Workforce Strategy Update Jan 2025

Leeds Community Healthcare NHS Trust

ORGANISATIONAL DESIGN

- Commenced an aligned operational and financial plan at the start of 2025.
- Continued interest in workforce planning methodology with the requirement for services reviews as part of our Quality and Value work.

MEASURE 1

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

Business unit have draft plans

IMPROVING

MEASURE 2

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

LCH Workforce Plan has been submitted

ON TRACK

MEASURE 3

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

eRostering fully implemented

COMPLETED

MEASURE 4

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

Principles embedded and supporting key LCH strategic work

ON TARGET

MEASURE 5

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

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

COMPLETED

LCH Workforce Strategy Update Jan 2025

LEADERSHIP

- In April we launched the LEAD program, a series of modules created in response to supporting managers through Q&V. n 2025, we will launch a new manager induction, the original objective before Q&V superseded this.
- In 2024 ‘I Thrive/We Thrive’ was successfully. Aimed at to improving workplace equity and career progression for employees from Black and Minority Ethnic (BME) groups. Eight sessions were delivered across March–December. Next Steps include Ongoing mentoring, Action Learning Sets, and follow-up support to sustain development, with participants championing inclusion as LCH Ambassadors.

MEASURE 1

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

Average increase in scores relating to leaders **+4.3% (2023)**

IMPROVEMENT

MEASURE 2

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

This course is no longer in place. We launched LEAD modules in April 2024 (see above)

SUPERSEDED

MEASURE 3

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

All senior leadership team completed a 360 assessment in 2021

COMPLETED

MEASURE 4

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

LCH Talent management programme in place for BME staff launched in 2024

COMPLETED

LCH Workforce Strategy Update Jan 2025

INCLUSION

- The Overall BME representation (ESR) remains at 14%, which could be due to reduction in recruitment activity, as a result of the Quality and Value Programme. There is variation across the various Business Units and People Business Partners will work with Business Units to improve representation in 2025/26.
- Executive Allies are aligned with each of the 3 x Staff Networks; REN, DNLTC and LGBTQIA+
- A celebration event was held, marking the end of the BME Talent Development Programme

MEASURE 1

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

WRES Overall **14%**

STATIC

MEASURE 2

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

LCH Talent management programme in place for BME staff

COMPLETED

MEASURE 3

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

Reduced gap from 5.45% to 1.11%

AWAITING 2024 STAFF SURVEY RESULTS

MEASURE 4

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

All new starters complete inclusion e-learning course

COMPLETED

LCH Workforce Strategy Update Jan 2025

Leeds Community Healthcare NHS Trust

WELLBEING

- HR team are actively working with Managers to address sickness absence "hot spots" and promote wellbeing support.
- A programme of HWB support is available for staff/services as part of Quality and Value Programme

MEASURE 1

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

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

AWAITING 2024 STAFF SURVEY RESULTS

MEASURE 2

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

Stress, anxiety, depression, and MSK issues remain the primary reasons for absence. Overall Sickness remains above 6.5%

SEASONAL VARIATIONS

MEASURE 3

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

Rates are trending as an improvement but remains above 3.5%

IMPROVEMENT

MEASURE 4

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

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

AWAITING 2024 STAFF SURVEY RESULTS

MEASURE 5

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

Appraisal paperwork revamped to include these conversations

Completed

LCH Workforce Strategy Update Jan 2025

SYSTEM PARTNER

- Collaborative work underway in new Health & Wellbeing initiative for Leeds
- Final Draft of Pay & Reward Framework due to be ratified by GP Confederation
- Partnership principles underpin collaboration in recruitment for exec and system roles

MEASURE 1

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

Collaborative recruitment. Stakeholder engagement in exec appointments

ON TRACK

MEASURE 2

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

T&Cs governance and suite of policies in place

ON TRACK

MEASURE 3

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

Multiple examples across LCH suite of services

COMPLETED

MEASURE 4

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

Examples include ICB fellowship and leadership programmes

COMPLETED

LCH Workforce Strategy Update Jan 2025

FOUNDATIONS

- Workforce Transformation project will look to refresh the service model for the directorate as well as fully document our service offer
- Service specific KPIs developed for some of our services, this will be an important focus for us in the new year with the introduction of our new People Services model.

MEASURE 1

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

Review taking place as per the Workforce Transformation project

IN PROGRESS

MEASURE 2

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

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

IN PROGRESS

MEASURE 3

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

Learning and Development strategy has been approved

Completed

LCH 04/2025 Health Equity

Leeds Community Healthcare NHS Trust

Final Report

03 December 2024

Internal Audit Contacts

Helen Higgs, Managing Director and Head of Internal Audit
helen.higgs2@nhs.net
07931 224784

Jonathan Hodgson, Assistant Director
jonathan.hodgson@nhs.net

Ellie Broughton-Taylor, Senior Auditor
ellie.broughton@nhs.net

William Ellis, Trainee Senior Auditor
william.ellis9@nhs.net

Contents

Final Report Distribution

Executive sign-off	Ruth Burnett, Executive Medical Director
Distribution	Dr Anna Ray, Consultant in Public Health
	Em Campbell, Health Equity Lead
	Andrea Osborne Executive Director of Finance and Resources
	Helen Robinson, Company Secretary
	Victoria Douglas-McTurk, Head of Business Intelligence and Performance
	Ann Henderson, Clinical Effectiveness and Compliance Manager
	Khalil Rehman, Audit Committee Chair
	Ian Lewis, Audit Committee Member
	Rachel Booth, Audit Committee Member
Committee	Audit Committee

Executive Summary

Objective	To gain assurance that the Trust is effectively addressing the health equity agenda.
Scope	Leeds Community Healthcare NHS Trust Board approved their three-year Health Equity Strategy in May 2021, this has since been extended until March 2025 where a unified Trust Strategy will be introduced and encompass the heath equity agenda. The purpose of the strategy is to address how the Trust will address unfair and avoidable differences in the health of different groups and communities. The overall aim of the Health Equity Strategy is stated: 'There are currently unfair and avoidable differences in the health of different groups and communities. These have an impact at many points in people's lives and as they move between stages – through birth and childhood, as adults and older people and at the end of life. As a provider of community health services working with communities at all these stages of life, we have both the ability and responsibility to make changes that will improve the health of diverse and marginalised groups and communities. This Health Equity Strategy is our response to this, in how we create equitable care and pathways.' The Strategy is complemented by the Strategic Goal within the LCH's Board Assurance Framework 'To embed equity in all that we do,' and 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. Under the Health and Care Act 2022 the focus for Trust Boards should be on contributing to the objectives of the Integrated Care System, under which West Yorkshire Integrated Care Board has a statutory duty to have regard to the need to reduce inequalities between patients in terms of access to and outcomes from health services.
Opinion	

Limited Assurance

Recommendations	
Major	0
Moderate	6
Minor	2

Overall, Limited Assurance can be provided that the Trust is effectively addressing the health equity agenda.

While the Trust has a Health Equity Strategy 2021-2024 in place which has Executive ownership along with an action plan to support delivery the strategy does not have quantifiable metrics to monitor progress towards achieving health equity, nor do the actions in the supporting plan have target dates for completion. Furthermore, delivery of the supporting action plan is not formally monitored nor is it shared for enaction with Business Units across the Trust. This view was reinforced by interviews held with Senior Leaders from the Adult, Children and Specialist Business Units, where discrepancies were found in the way the health equity agenda was being progressed, and there is limited use of available health equity data on the Performance Improvement Portal. To address this issue a Working Group should be established with representative from all Business Units which will ensure that ownership of progressing the health equity agenda is a shared responsibility across the Trust.

Additionally, the Board Assurance Framework outlines the Trust priority 'to ensure that the Quality and Value Programme has the least negative impact on those with the most need,.' A review of two of the four Equity and Quality Impact Assessments (EQIA)

	carried out for schemes within the Quality and Value Programme identified one instance where the EQIA was not documented but was still approved at the EQIA Panel. Minor areas of weakness have also been identified covering access to the West Yorkshire Integrated Care Board health equity data and updating the Quality Committee's Terms of Reference to specify oversight of health equity.
Key Findings	
	• The Trust's Health Equity Strategy 2021-2024 does not have quantifiable metrics to monitor progress towards achieving health equity which is a key characteristic to achieving a comprehensive and adaptive approach to reducing health inequalities as identified within the NHS Providers 'United Against Health Inequalities: Moving in the Right Direction' May 2024. • Interviews were conducted with senior management from three Business Units of the Trust established discrepancies in how health equity agenda is built into day-to-day work across the organisation. Furthermore, it was reported that health equity is seen as a responsibility for all staff and no one leads this area in particular within the Business Units. • Business Units access health equity data, to support decision making, through the health equity's data dashboards within the Performance Improvement Portal which are produced by the Trust's Business Intelligence Team. A report provided by the Business Intelligence Team found that in a three-month period between August and October 2024, the dashboards have been accessed by 28 members of staff, suggesting that the data is not being used often. • Testing of two of four schemes in the Quality and Value Programme which have approved Equity and Quality Impact Assessments (EQIA) identified one where the EQIA had not adequately documented the assessment of impact on health equity but was still approved by the EQIA Panel. • The action plan produced for 2024/2025 to support embedding of the Health Equity Strategy 2021-2024 was found not to have target dates against the actions recorded.
	• Currently the Trust does not have access to the West Yorkshire Integrated Care Board health equity data. • The Quality Committee's Terms of Reference do not include a requirement to gain assurance on health equity despite their having oversight of the Board's strategic risks that relate to this area.
	• The Trust have a Health Equity Strategy 2021-2024 in place which was approved by the Trust Board in May 2021 to initially cover a three-year period. In March 2024 at the LCH Board Workshop: Equity Strategy Refresh an extension of the strategy period was granted until March 2025, after which equity plans are to be aligned to the development of the organisational strategy. • The Health Equity Strategy 2021-2024 includes six of the seven key characteristics identified by NHS Providers in their 'United Against Health Inequalities: Moving in the Right Direction' report from May 2024 which should help achieve a comprehensive and adaptive approach to reducing health inequalities. • An action plan has been produced every year since approval of the Health Equity Strategy 2021-2024 to support embedding across the Trust. Review of the 2024/2025 action plan found there to be clear actions to support achievement of the Strategy's objectives, which have been RAG rated. • The 2024/25 action plan has 25 actions recorded with progress documented against each. One of the 25 action was marked as completed, this was tested and verified as part of this review. • Executive oversight of the health equity agenda was found to be adequate with LCH having a strategic objective to 'embed equity in all that we do' within their Board Assurance Framework, which is monitored and reviewed every quarter at the Trust Public Board. This

	is supported by the Trust's Executive Medical Director's objectives for 2024/25 is to deliver the next iteration of the Health Equity Strategy in 2024/25. • The Medical Directorate organogram demonstrates that a health equity team is in place which is headed by the Consultant in Public Health (0.25), who direct reports to the Executive Medical Director, and is supported by the Health Equity Lead. • The Trust is currently developing an Operational Competency Framework and tracker which is to support the development of all band 8a and 8b managers, plus aspiring staff, across the Trust. A review of the draft framework established that senior management will be required to have knowledge of equalities legislation and involvement with the completion of EQIA. • The health equity agenda and Health Equity Strategy 2021-2024 has been communicated across the Trust by having a dedicated page on LCH's staff intranet which includes signposts to key contact and resources, and a virtual Health Equity Community on MS Teams which is open to all staff and has been promoted in the Trust wide briefings emails. • The process for schemes that fall under the Quality and Value Programme to be assessed for impact on equity revolves around EQIAs being received by the EQIA Panel, which is attended by the Health Equity Lead, for scrutiny prior to approval. The Equity Impact Assessment within the standardised template used for EQIAs was found to ensure that impact on equity is assessed against all people who have protected characteristics as defined in the Equality Act (2010). • The timeframe for continuously monitoring impact on equity following approval of schemes was determined at the panel for both of the two schemes reviewed within the sample testing. • The Trust Board were presented with the Health Equity Strategy report in September 2024, the report discussed progress made towards implementation of the strategy and considered the associated risks. Further updates are planned for December 2024 and March 2025 for the 2024/25 year. • Both the Quality Committee and Business Committee have oversight of the three strategic risks that relate to the health equity. Review of May, June, and July 2024 Business Committee and May, and July 2024 Quality Committee Papers confirmed that the subcommittees are presented with updates on progress to achievement of the Health Equity Strategy 2021-2024 and the health equity agenda across the Trust. • The Quality Assurance and Improvement Group (QAIG) reports directly into the Quality Committee and has delegated ownership of monitoring of health equity. Review of April and July 2024 QAIG papers confirmed that regular updates are presented with escalations path available to Quality Committee around risk to delivery of the health equity agenda. • The Consultant in Public Health and Health Equity Lead are members of various external groups across both Leeds and the wider West Yorkshire region including West Yorkshire Health and Care Partnership's Health Inequalities Oversight Group. Evidence was seen of learnings from attending these networks being shared within the Trust.

Findings and Recommendations

Finding 1: Health Equity Strategy- Quantifiable Metrics
The May 2024 NHS Providers 'United Against Health Inequalities: Moving in the Right Direction' report identified seven key characteristics to achieve a comprehensive and adaptive approach to reducing health inequalities. Review of the Trust's Health Equity Strategy 2021-2024 established that the strategy does not meet the characteristic 'Prioritised with clear measurable outcomes identified'. NHS Providers found that 'the most developed strategies have used precise metrics that focus on specific population groups or services. This allows for more targeted and effective interventions. Accompanied by an implementation plan, there are detailed metrics and a clear roadmap for achieving its objectives.' The Health Equity Strategy 2021-2024 does identify specific communities of interest which the Trust will target with the initial focus on Black, Asian and minority ethnic communities, people living in areas of high deprivation, and inclusion health groups being the most vulnerable and marginalised communities and where their actions can have the most significant impact. However, the strategy does not outline how the Trust will measure the impact the strategy is having on these specific communities of interest. Furthermore, the Business Intelligence health equity dashboards have not been developed alongside the Strategy to ensure impact is captured within the available data. By not having measurable outcomes defined from the outset, the strategy is not able to be assessed as to what a successful quantifiable progress or achievement of its objectives would look like, or assess where mitigating actions may be required.

Risk
The Trust does not have a clear strategy which to address the Health Equity agenda and make improvements to population health and healthcare.

Unique ID	Recommendations	Priority
3743	The Trust should ensure that when they develop the future health equity strategy quantifiable metrics are introduced from the outset to the monitor progress towards achieving health equity.	**Moderate**

Unique ID	Management Response	Responsible Officer	Target Date
3743	Agree with this recommendation. To strengthen the monitoring of the current strategy a measurement framework has been developed and, with support from the BI team, prioritised measures will be reported on to measure progress. Examples of good practice for metrics are well noted and will be used to develop quantifiable metrics within a future health equity strategy (standalone or equity elements integrated into the broader trust strategy).	Anna Ray, Consultant in Public Health Victoria Douglas-McTurk, Head of Business Intelligence and Performance	01 January 2026

Finding 2: Embedding the heath equity agenda in the Business Units

As part of audit testing interviews were held with Senior Leaders from the Adult, Children's, and Specialist Business Units to establish how the health equity agenda is being embedded across the Trust.

Firstly, it was established that whilst the Business Units all reported that they can demonstrate considering health equity in decision making and improvements to service through the EQIA process, and the Quality Challenge reviews undertaken, who was responsible for this and how equity was reported on was different across all Business Units. Health equity was reported as a responsibility of all staff across the Business Units, however by not having defined roles, there is a lack of oversight to progress this agenda within the Business Units. Furthermore, no one in the Business Units is responsible for reporting to the Consultant in Public Health or Health Equity Lead about progress made against the objectives set within the Health Equity Strategy 2021-2024 within their Business Unit.

Secondly, all staff across the Trust have access to the health equity data dashboards within the Performance Improvement Portal (PIP). This is the key way Business Units access data to inform their decision making and assess impact on those with protected characteristics and communities of interest. A report supplied by the Business Intelligence Team found that in a three-month period (August-October 2024) the data had only been accessed by 28 out of 3500 members of staff. The data provided found there were 35 unique ID's that had accessed the data (staff members can have more than one unique ID registered in the database and in this case 35 unique IDs related to 28 individuals).

The access report provided found that the 35 unique IDs came from;

- Three from Adult Business Unit
- Four from Children's Business Unit
- 17 from Specialist Business Unit
- Nine from Corporate Business Unit (including two Business Intelligence Team members performing maintenance)
- One unique ID from Operations Business Unit

During the interviews it was disclosed that additional training is wanted by the Business Units to actually understand what the data in these reports means and how it could be used or improved.

Each year to support the delivery of the Health Equity Plan 2021-2024 a supporting action plan is produced, as part of the audit testing the 2024/2025 action plan was reviewed. The action plan was found to not have buy in across the Trust, nor target dates for completions against the 25 actions recorded, therefore we could not determine if the action plan was progressing as planned.

Risk

The Trust does not have adequate workforce resource to enact upon the ambition of the organisations Health Equity agenda.

Unique ID	Recommendations	Priority
3744	A Health Equity Working Group should be established which has Senior Leader representation from all Business Units, Business Intelligence and is led by the Health Equity Team. This should be a formalised forum to report progress against the Health Equity Strategy and share best working practise, and report into the Governance Structure of the Trust The action plan to support the Health Equity Strategy should be presented at the Group on a regular basis and owned by the membership of the Health Equity Working Group.	**Moderate**
3745	Training on how to use the Health Equity dashboards should be delivered to representatives of the Business Units who attend the established Health Equity Working Group.	**Moderate**
3746	Resourcing of the action plan should be considered, with realistic target dates for completion recorded against all actions within the action plan, the dates should be determined by the RAG rating, with updates recorded monthly against the likelihood of achieving the action within the timeframe.	**Moderate**

Unique ID	Management Response	Responsible Officer	Target Date
3744	Strongly support this recommendation. A working group will be established that reports into the Governance Structure of the Trust and a joint action plan on health equity will be developed with its members.	Anna Ray, Consultant in Public Health	28 February 2025
3745	Training on how to use the Health Equity dashboards will be developed and delivered jointly by Business Intelligence and Health Equity, taking into account ongoing developments in reporting on the measurement framework (recommendation 1). As an interim action, the Health Equity lead will continue to deliver ad hoc/as requested support to teams and Business Units to understand and use the existing reports.	Anna Ray, Consultant in Public Health Victoria Douglas-McTurk Head of Business Intelligence and Performance	30 September 2025
3746	This recommendation will inform the development of the action plan developed by the proposed Health Equity working group. Review of the action plan (including timelines and process) will be a standing agenda item at the Health Equity Working Group.	Anna Ray, Consultant in Public Health	30 April 2025

Finding 3: Equity and Quality Impact Assessment
The Quality and Value Programme is the Trust's efficiency programme which in 2024/2025 equates to £15.8m. Any service redesign or schemes to make savings should be supported with an Equity and Quality Impact Assessment (EQIA). From a health equity perspective, the assessments will ensure that changes not only do not inadvertently create additional barriers to health equity but also address existing inequalities in the Trust's service provision. Within the Board Assurance Framework, the Trust's priority has been defined as 'to ensure that the Quality and Value Programme has the least negative impact on those with the most need and positively impacts where possible.' At the time of the review, four schemes from the Quality and Value Programme had conducted an EQIA and been approved by the EQIA Panel. Sample testing of two of these schemes, established that one EQIA had not been fully completed with impact on equity not documented. Additionally, the post EQIA Panel comments documented within the spreadsheet did not accurately capture the attendance of the Health Equity Lead or the scrutiny on the completion of the equity assessment, which has been provided separately via personal meeting notes. Therefore, the comments of the EQIA Panel were found not to be a transparent record of the decisions made to support the scheme in light of the impact on those with protected characteristics and could be inferred as equity was not assessed prior to approval. As we have only assessed schemes that fall within the Quality and Value Programme within the remit of this audit, we cannot make comment on wider compliance of the EQIA process that are used outside of this programme, therefore we are recommending that an investigation into the approval of EQIA without consideration for equity is explored further.

Risk
Financial decisions relating to shorter-term financial and operational pressures reduce the focus on health inequalities.

Unique ID	Recommendations	Priority
3747	The EQIA Panel should ensure that no Equity and Quality Impact Assessments are approved that have not been fully completed. Any that are not completed at point of panel date should not be signed off and rereviewed at a further meeting, an accurate record of the attendance and discussion should be captured within the post panel comment section.	**Moderate**
3748	All equity assessment conducted across the Trust should be reviewed to ensure that impact on equity has been fully considered and documented.	**Moderate**

Unique ID	Management Response	Responsible Officer	Target Date
3747	The recommendation as above is accepted and to achieve this the EQIA process will be applied to all EQIA's. To assure that the process is followed the following check points are in place: 1. EQIA Clinical Governance Officer will review all EQIAs for completeness and return to authors if any information is missing.	Ann Henderson, Clinical Effectiveness and Compliance Manager.	31 March 2025

Unique ID	Recommendations		Priority
	2. Quality Leads will complete a second review to ensure all information is included. If there are any questions arising from this review, the EQIA is sent back to the author for updates and responses. 3. Following these two processes the EQIA can then progress to panel. Prior to panel, all EQIAs are sent to panel members for review. If any omissions are identified at this stage, the EQIA would not progress to panel unless these omissions could be actioned prior to attendance at panel. An accurate record of the attendance and discussion is captured within the post panel comment section and entered onto Datix alongside the EQIA documents and any actions arising. Training on completion of EQIAs is in place to ensure documents are completed fully. Development of the EQIA document to incorporate the QIA and EIA into one document is in progress to prevent EIA section not being fully completed and considered alongside other potential consequences or impacts of the change. A process map of the EQIA process is being completed in conjunction with Business Change and Development Team to support adherence to the process. The EQIA Clinical Governance Officer post is in place until July 2025. If this post is not continued a further plan to ensure checkpoints are in place will need to be completed.		
3748	As this will have to be completed manually, a small sample of randomly selected EQIA's will be reviewed to see if the EIA section has been completed and the impact on equity considered and documented. As the EQIA document is developed, reporting on completion of all sections of the document should be able to be reviewed and reported on.	Ann Henderson, Clinical Effectiveness and Compliance Manager	31 March 2025

Finding 4: West Yorkshire Integrated Care Board Health Equity Data
West Yorkshire Integrated Care Board (WYICB) has a statutory duty to have regard to the need to reduce inequalities between patients in terms of access to and outcomes from health services. Leeds Community Healthcare NHS Trust as a Provider organisation should contribute to the objectives of the Integrated Care System. A way to do this is by accessing the population health data produced by WYICB to inform the decision making of the Trust. Currently the Trust does not have access to the West Yorkshire Integrated Care Board health equity data due to IT issues.

Risk
Failure to connect and build relationships with all system partners presenting the risk of not delivering Trust's strategic intent to improve population health and reduce health inequalities.

Unique ID	Recommendations	Priority
3749	The Trust should gain access to the West Yorkshire Integrated Care Board population health management data including the health equity elements.	**Minor**

Unique ID	Management Response	Responsible Officer	Target Date
3749	We will obtain access to the West Yorkshire Integrated Care Board population health management data and make available to appropriate LCH staff.	Victoria Douglas-McTurk, Head of Business Intelligence and Performance	30 June 2026

Finding 5: Quality Committee Terms of Reference
The Trust's Board have assigned the Quality Committee to have oversight of the strategic risks that relate to health equity, however the requirement to gain assurance on health equity is not documented within the Quality Committee's Terms of Reference.

Risk
Governance arrangements do not provide suitable oversight approach to delivering the Trust ambition to improve outcomes in population health and healthcare.

Unique ID	Recommendations	Priority
3750	The Quality Committee Terms of Reference should be updated to include responsibility of oversight of health equity.	**Minor**

Unique ID	Management Response	Responsible Officer	Target Date
3750	Agree with this recommendation. It had already been noted for the next review of the Quality Committee's Terms of Reference, which will take place in March 2025.	Helen Robinson, Company Secretary	31 March 2025

Additional Information- Health Equity Metrics

The Trusts Health Equity Strategy 2021-2024 was compared against the May 2024 NHS Providers 'United Against Health Inequalities: Moving in the Right Direction' report which identifies seven key characteristics that included; "*most developed strategies have used precise metrics that focus on specific population groups or services. This allows for more targeted and effective interventions."* As part of the Audit, it was requested that the review include research of publicly available metrics used by six other NHS Trusts to track health equity with the findings documented below;

Organisation	Documents reviewed	Details of Equity related metrics
NHS England	Health Inequalities Improvement Dashboard	The dashboard measures, monitors, and informs actionable insight to make improvements to narrow health inequalities. It covers the five priority areas for narrowing healthcare inequalities in the 2021-22 planning guidance. It also covers data relating to the five clinical areas in our Core20PLUS5 approach.
South West Yorkshire Partnership NHS Foundation Trust	Trust Board Integrated Performance Report: Strategic Overview (September 2024)	The Trust include several measures around % of equality data recorded for service users by ethnicity, disability, sexual orientation and deprivation, timely completion of EIAs and completion of mandatory equality training. Metrics have targets and are tracked month on month.
Sheffield Health and Social Care NHS Foundation Trust	Public Board of Directors Integrated Performance and Quality Report (July 2024)	The Performance and Quality report is presented at the Board of Directors meetings with a section on race equity incident reporting. This includes reporting on: - Physical Restraints by Person Ethnic Group - Seclusion by Person Ethnic Group - Rapid Tranquilisation by Person Ethnic Group - Mechanic Restraints by Person Ethnic Group - Patient Safety Incidents by Person Ethnic Group - Deaths (bed-based services) by Person Ethnic Group
Manchester University NHS Foundation Trust	Public Sector Equality Duty (PSED) Annual Equality Information Report January - December 2023	The Trust tracks the use of Interpretation & Translation Services each year. Metrics are focused on requests for interpretation services, use of face to face and video translation services, and written translation services. The Trust track which languages are most commonly requested for translation services.
Humber Teaching Hospital NHS Foundation Trust	Trust Strategy 2022 – 2027	The Trust's strategy includes an aim for staff to have a strong understanding and awareness of the principles of health inequalities and states that health inequalities data will be incorporated in performance reporting to enable the organisation to deliver services in a way that maximise the Trusts ability to address health inequalities.

Organisation	Documents reviewed	Details of Equity related metrics
Great Western Hospitals NHS Foundation Trust	Trust Board Perinatal Services 6 month summary (November 2024)	November 2024 Trust Board papers included the Perinatal Services 6 month summary which detailed the review of ethnicity representation in reported incidents within Maternity and Neonatal services at Great Western Hospitals NHS Foundation Trust.
Bradford District Care NHS Foundation Trust	Council of Governors November 2024	The Trust have a strategic priority to "consistently deliver good quality, safe and effective mental health and physical health services, making every contact count and meeting the needs of our communities, with a focus on reducing health inequalities.." The Trust also state that they will know when they have been successful when they "have a coherent set of metrics to track performance and safety, highlight inequalities experienced by protected equality groups."

Appendix A: Internal Audit Brief

<table>
<tr><td>Audit Objective</td><td colspan="3">To gain assurance that the Trust is effectively addressing the health equity agenda.</td></tr>
<tr><td>Audit Background and Scope</td><td colspan="3">Leeds Community Healthcare NHS Trust Board approved their three-year Health Equity Strategy in May 2021, this has since been extended until March 2025 where a unified Trust Strategy will be introduced and encompass the heath equity agenda. The purpose of the strategy is to address how the Trust will address unfair and avoidable differences in the health of different groups and communities. The overall aim of the Health Equity Strategy is stated:

‘There are currently unfair and avoidable differences in the health of different groups and communities. These have an impact at many points in people’s lives and as they move between stages – through birth and childhood, as adults and older people and at the end of life. As a provider of community health services working with communities at all these stages of life, we have both the ability and responsibility to make changes that will improve the health of diverse and marginalised groups and communities. This Health Equity Strategy is our response to this, in how we create equitable care and pathways.’

The Strategy is complemented by the Strategic Goal within the LCH’s Board Assurance Framework ‘To embed equity in all that we do,’ and 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.

Under the Health and Care Act 2022 the focus for Trust Boards should be on contributing to the objectives of the Integrated Care System, under which West Yorkshire Integrated Care Board has a statutory duty to have regard to the need to reduce inequalities between patients in terms of access to and outcomes from health services.</td></tr>
<tr><td>Key Risks</td><td>• The Trust does not have a clear strategy which to address the Health Equity agenda and make improvements to population health and healthcare.
• The Trust does not have adequate workforce resource to enact upon the ambition of the organisations Health Equity agenda.
• Financial decisions relating to shorter-term financial and operational pressures reduce the focus on health inequalities.
• Governance arrangements do not provide suitable oversight approach to delivering the Trust ambition to improve outcomes in population health and healthcare.</td><td>Methodology</td><td>• Discussions with key staff to confirm the actual controls in place.
• Fieldwork to ensure controls are operating as expected, including review of:
○ Review of the Health Equity Strategy and supportive Action Plan.
○ Interview with Senior Staff across Business Units.
○ The Trust’s workforce resourcing to support the implementation of the Health Equity Strategy.
○ Review of schemes within the Quality and Value Programme to assess Equity Impact Assessments and any negative impact on achievement of health equity agenda.</td></tr>
</table>

	• Failure to connect and build relationships with all system partners presenting the risk of not delivering Trust's strategic intent to improve population health and reduce health inequalities.		○ Use of Population Health data across the Trust. ○ Trust Health Equity governance arrangements including relevant Committee papers and minutes. ○ Reports to the Trust Board. ○ Review of the Trust's wider engagement within the Integrated Care System. In addition: The review to include research of information of publicly available health equity metrics used by other NHS Trusts.
Client Contacts	Dr Anna Ray, Consultant in Public Health Em Campbell, Health Equity Lead	**Internal Audit Contacts**	Helen Higgs, Managing Director, and Head of Internal Audit Helen.Higgs2@nhs.net Jonathan Hodgson, Audit Manager jonathan.hodgson@nhs.net Ellie Broughton, Senior Auditor ellie.broughton@nhs.net William Ellis, Trainee Senior Auditor william.ellis9@nhs.net
Executive Sign off	Ruth Burnett, Executive Medical Director	**Committee Reporting**	Audit Committee, December 2024

Appendix B: Basis of our Classifications

Opinion

 **High Assurance**	There is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met. The controls in the system are clear and if followed would work effectively in practice. Note this does not mean 100% compliance, there could be some minor issues relating to either systems design or operation which need to be addressed.
 **Significant Assurance**	The system is generally well designed but there may be weaknesses in the design of the system that need to be addressed. Whilst any weaknesses may be significant, they are not thought likely to have a serious impact on the likelihood that the system's overall objectives will be delivered.
 **Limited Assurance**	There are weaknesses in either design or operation of the system that may mean that core system objectives are not achieved. Multiple weaknesses across a range of core areas would suggest a limited assurance opinion level is applicable. However, it also true that one weakness can suggest a limited assurance opinion if it is fundamental enough to mean that core system objectives will not be achieved.
 **Low Assurance**	There is a weak system of internal control and significant improvement is required in its design and/or operation to effectively meet the system's objectives. It should be borne in mind that Low Assurance is not 'No Assurance.' The key point here is that there is a good chance that the system may not be capable of delivering what it has been set up to deliver – either through poor systems design or multiple control weaknesses.

Key Findings

	Action required, the issues present risk of significant damage or loss to the organisation, or problems with the safe or effective operation of the system under review.
	Review the benefits of taking action, these may be minor completeness or improvement issues which do not mitigate significant organisational risks.
	Key positive assurance highlights on the design, operation, and effectiveness of the system of internal control in place.

Prioritisation of Recommendations

Grading	Definition
Major	Recommendations which address fundamental weakness in system design that presents a significant risk to achievement of objectives, or widespread major non-compliance with the internal control framework.
Moderate	Recommendations which address significant weakness in system design that presents a risk to achievement of some objectives, or limited areas of non-compliance with the internal control framework.
Minor	Recommendations relating to good practice, improvement, or completeness with low impact on overall system of internal control.

Appendix C: Limitations and responsibilities

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by us should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Where information resulting from audit work is made public or is provided to a third party by the client or by Audit Yorkshire then this must be done on the understanding that any third party will rely on the information at its own risk. Audit Yorkshire will not owe a duty of care or assume any responsibility towards anyone other than the client in relation to the information supplied. Equally, no third party may assert any rights or bring any claims against Audit Yorkshire in connection with the information. Where information is provided to a named third party, the third party will keep the information confidential.

Public Sector Internal Audit Standards

Audit work undertaken by Audit Yorkshire conforms with the International Standards for the Professional Practice of Internal Auditing.

LCH 06/25 Mortality Rates and Learning from Deaths

Leeds Community Healthcare NHS Trust

Final Report

04 December 2024

Internal Audit Contacts

Helen Higgs, Managing Director and Head of Internal Audit
helen.higgs2@nhs.net
07931 224784

Jonathan Hodgson, Internal Audit Manager
Jonathan.hodgson@nhs.net

Bryony Harris, Senior Auditor
bryony.harris2@nhs.net

Contents

Final Report Distribution

Executive sign-off	Ruth Burnett, Executive Medical Director
Distribution	Geraint Jones, Chief Clinical Information Officer
	Caroline McNamara, Clinical Lead (Adults' Business Unit)
	Karen Otway, Quality Lead (Adults' Business Unit)
	Claire Gray-Sharpe, Clinical Lead (Children's Business Unit)
	Sarah Hemsley, Quality Lead (Children's Business Unit)
	Mandy Young, Clinical Lead (Specialist Business Unit)
	Francesca Skirrow, Quality Lead (Specialist Business Unit)
Committee	Audit Committee

Executive Summary

Objective	To gain assurance that the Trust has an effective system in place to learn from deaths.
Scope	This is a thematic review being undertaken across a number of Audit Yorkshire's NHS Trust clients. Mortality governance should be a key priority for Trust boards. Information provided to Executives and Non-Executive Directors about mortality rates should enable them to understand the issues affecting mortality in their Trust and provide necessary challenge. The Learning from Deaths (LfD) framework published in 2017 requires all organisations to have a mortality dashboard to aid the systematic recording of deaths, review and learning from the care provided following a patient death and mandated the requirement to publish outcomes from LfD within its Quality Accounts. This review identified the types and accuracy of mortality data being collected and reported and the mechanisms in place for monitoring and sharing learning as a result.
Opinion	
 **Limited Assurance** **Recommendations** **Major** 0 **Moderate** 6 **Minor** 0	An opinion of limited assurance is given, as the system to learn from deaths includes weaknesses in either design or operation that may mean that core system objectives are not achieved. While the Trust has a Mortality Review and Responding to Deaths Policy it is overdue for review and includes Standard Operating Procedures for the process as appendices which differ from those in place within the Business Units, which have been updated in the interim. While there are systems for undertaking mortality reviews for both Adults and Children, high levels of non-completion were reported for adult patient deaths in the course of this internal audit review. We were also advised of delays in the rapid review process for Children, with the SOP due to be amended to reflect achievable timescales. For adults the learning from deaths process depends on a system of staged reviews with cases requiring the most detailed scrutiny being presented to the Adult Business Unit and Speciality Business Unit joint Mortality Review Meeting. For children, the system requires the deaths of all individuals in scope are reviewed promptly and later reported to the Child Mortality Group. There is onwards reporting and escalation to the Quality Assurance and Improvement Group, and Quality Committee. However, we found weak administration in relation to the documentation and tracking of actions and escalations through the governance structure. We also found delays between updates against actions which were documented, without evidence of sufficient accountability for timely delivery. Mortality reporting is not a quarterly agenda item to the public Board of Directors meeting, which is a requirement of the National Quality Board's National Guidance on Learning from Deaths. We were also informed of known issues in the timeliness of mortality reporting for individuals where the Trust is not notified of the death by the patient's GP, and of delays in completing reviews of individual patient deaths, with trend reporting to mitigate the risk from delays planned but not implemented.

Key Findings	
	*No major findings.*
	• The Mortality Review and Responding to Deaths Policy is past its review date. The Business Units have revised their processes in the interim, and a number of contextual changes have also taken place. This includes the adoption of the Patient Safety Incident Response Framework. • There are known delays in completing the review of individual patient's deaths. This has been reported to the Quality Assurance and Improvement Group (QAIG) and has not been resolved. • There is a known lag in data for adult patients where reporting the death is dependent on the patient's GP making a timely notification. • The administration of actions and escalations between the Business Unit mortality review meetings, QAIG, and the Quality Committee does not support accountability, or evidence outcomes. • Mortality reporting to the Board of Directors is not in line with National Guidance on Learning from Deaths (2017).
	• There is a named Executive lead for the Learning from Deaths agenda in line with the National Guidance on Learning from Deaths (2017). • The governance of the learning from deaths process is through the Quality Committee hierarchy, in line with Enhancing Board Oversight: A new approach to non-executive director champion roles (2021). • The Mortality Review and Responding to Deaths Policy is published on the public website. • The 2023/24 Quality Account included a summary of the Trust's learning from deaths work. This is published online. • The Business Units have documented procedures for reviewing deaths. This includes review of all in-scope Children's Mortality Group, and as a minimum a 'level one' review of in-scope adult deaths with the opportunity to progress to case review at the Adult and Speciality Mortality Review Group. • For the Adult and Specialist Business Units, the system of staged reviews prioritises detailed case review for deaths where stages one and two have identified learning opportunities. The Business Unit mortality review meetings consider learning from the cases reviewed and consider how learning can be shared with teams or the wider organisation.

Findings and Recommendations

Finding 1: Mortality Review and Responding to Deaths Policy
The Mortality Review and Responding to Deaths Policy (the Policy) was last updated in April 2023, and became due for review in January 2024. The Trust has reviewed its processes in the interim, with the Business Units creating new process maps and Standard Operating Procedures compared to those published in the Policy. The Policy states that all deaths will be recorded on Datix, except where the individual was already recorded on the Electronic Palliative Care Coordination System, or if the death occurs in a service excluded from the process, or if the patient had been in hospital for more than 24 hours at the time of death. Adult Business Unit do not record all deaths on Datix, and therefore do not have this control for determining correct numbers for reporting purposes, or to benefit from the reporting capabilities on Datix. Other contextual changes, specifically adoption of the Patient Safety Incident Response Framework in place of the Serious Incident process and implementation of the Integrated Care Boards are also not reflected. We identified some gaps between the current Policy and the National Quality Board's National Guidance on Learning from Deaths (2017). Specifically, a process is not described for handling investigations into historic care which are recommended by partner organisations, and offering guidance to families, carers, or staff on obtaining legal advice. In addition, the policy does not set out the full rationale for including and excluding certain deaths. The rationale is included for specific cohorts but not all. This includes, but is not limited to, patients who are not included in the Trust's mortality data due to the lack of notification from the patient's GP. We acknowledge that a revised iteration of the Policy is in draft and is planned to incorporate the findings of the Internal Audit review, which assessed the historic policy. However, the draft version we have seen is not complete and does not address all gaps identified.

Risk
• The Trust is not compliant with obligations set out in the National Guidance on Learning from Deaths (2017).

Recommendations		Priority
3702.	The Trust should revise the Mortality Review and Responding to Deaths Policy to ensure all processes reflected are current, meeting arrangements are up to date, and references to supporting processes such as incident management are also current.	**Moderate**

Management Response		Responsible Officer	Target Date
3702.	The Mortality Review and Responding to Deaths Policy is in the process of being updated. The current version of the update is an interim before a full new version of the	Geraint Jones	31 March 2025

Management Response		Responsible Officer	Target Date
	policy will be written to include updates to related policies and recommendations from this audit. A full rewrite of the policy will ensure tighter processes, inclusion/exclusion criteria, review compliance and governance structures as highlighted in the other recommendations of this report.	*Chief Clinical Information Officer*	

Finding 2: Mortality Data
Accurate, timely data must be available to allow trend analysis and identification of anomalies in deaths occurring amongst the Trust's patients. SystmOne is the primary feeder system for PiP, and mortality reporting produced for the Quality Assurance and Improvement Group (QAIG) meeting. There is a known issue with the data on SystmOne, with the death of Adult patients who die at other hospitals not being reported to the Trust and recorded on SystmOne by the GP in a timely manner. There is therefore a known time lag in the outputs from this system being up to date. The Trust plans to improve data reporting to the QAIG meeting, so that trends are reported from live data that will retrospectively reflect the number of deaths. The recommendation is assigned a 'moderate' rating as there are other measures in place which provide safety netting from the failure of the system of oversight. In particular, the process of undertaking a 'level one' review for all deaths in scope means there is a level of oversight at an individual level. The 'level one' review should be undertaken by a clinician and if there are any concerns a more in depth 'level two' review will be undertaken. 'Level two' reviews are seen by the Quality and Clinical Leads for the Adult Business Unit (ABU) and Specialist Business Unit (SBU). However, there are known delays in this process. Compliance rates for ABU of 49% for 'level one' and 54% for 'level two', and for SBU 37% and 52% respectively were reported to QAIG in July 2024, and it was confirmed to us that compliance rates remained low in at the end of quarter two. Current Standard Operating Procedures imply expected compliance at 100% for patient deaths in scope, however the criteria for compliance are not defined.

Risk
• The Trust does not have adequate data to identify issues relating to mortality amongst patients. • There is a delay in identifying issues affecting mortality rates.

Recommendations		Priority
3658.	The Trust should continue working to resolve the known issue with completeness and timeliness of adult mortality data, where there are delays in being notified of the death. This should include mitigation where the issue originates outside the authority of the Trust to resolve, including retrospective analysis and comparison of mortality data related to the date of death.	**Moderate**
3699.	The Trust should define criteria for assessing compliance with the mortality review process and address delays evident.	**Moderate**

Management Response		Responsible Officer	Target Date
3658.	Clarification of the process of the notification of death process will be included within the updated policy. Clarification will include whether deaths are recorded within the data to align dates of reviews or with dates of death. Data will need to be available monthly at a minimum to achieve greater visibility of trends to enable retrospective analysis. Plan to be developed on how to optimise data for visualisation, reporting and analysis.	Geraint Jones *Chief Clinical Information Officer* Geraint Jones *Chief Clinical Information Officer*	31 March 2025 31 March 2025

Management Response		Responsible Officer	Target Date
3699.	Clarification of the levels of compliance with reviews will be included in the new policy. This will include definitions of terminology such as “notification”, “review” and “reporting” which are currently unclear and lead to further lack of clarity regarding compliance with mortality reviews and timelines for the review.	Geraint Jones *Chief Clinical Information Officer*	31 March 2025

Finding 3: Reporting and Administration of Mortality and Related Learning
The National Quality Board's National Guidance on Learning from Deaths (March 2017) emphasises the role of governance arrangements and processes in implementing Learning from Deaths obligations. This includes facilitating investigation and reporting of deaths, and ensuring Trusts share and act upon any learning derived. For this Internal Audit we reviewed meeting records for the Adult Business Unit (ABU) and Specialist Business Unit (SBU) joint mortality review meeting, as well as the Child Death Review Meeting records, Quality Assurance and Improvement Group (QAIG) records, and the QAIG report to Quality Committee. We found weaknesses in the administration of these meetings which limits assurance that they effectively facilitate investigation and learning. In particular, actions did not consistently have target dates and there was evidence of significant delays between actions being assigned and updates being received. In addition, escalations between the meetings involved did not have a documented purpose and outcome. We also reviewed reporting to the public Board meetings in 2024/25 to October 2024, to ascertain compliance with the National Quality Board's expectation that *From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards)…Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.* We did not find evidence of quarterly reporting in line with the above, with Mortality being a specific agenda item on 7 June 2024 only. The June quarterly report is brief, and the Board minutes note that the annual report would be shared via email and is therefore not in the public meeting pack.

Risk
• There are delays to identifying and addressing issues in the quality of care, leading to patients experiencing avoidable harm.

Recommendations		Priority
3657.	The Children's Business Unit and the joint Adults Business Unit and Specialist Business Unit Mortality Review Meetings should ensure actions agreed to address developing and confirmed learning opportunities are clearly documented to include target date, expected outcomes, and actual outcomes.	**Moderate**
3700.	The Quality Assurance and Improvement Group, Child Death Review Group, and the joint Adult Business Unit and Specialist Business Unit Mortality Review Meeting, should clearly document escalations and expected outcomes to support and evidence accountability and timeliness of action.	**Moderate**
3701.	The Board should ensure the mortality reporting is received and published quarterly in line with National Guidance on Learning from Deaths 2017.	**Moderate**

Management Response		Responsible Officer	Target Date
3657.	Although learning and actions are shared, we recognise a lack of consistency in documenting and reporting on the impact of the actions. A standardised approach to recording learning and actions will be developed to support this. The processes for	Geraint Jones *Chief Clinical Information Officer*	31 March 2025

Management Response		Responsible Officer	Target Date
	recording of actions, learning and impact will be included within the Policy and through improvements to the QAIG reporting and governance structure review.		
3700.	Through the "making data count" approach the Trust is taking the Quality Assurance and Improvement Group is reviewing and updating its report templates to be more data driven using a "What, So what, Now what" model which includes actions, escalations and impact. Target dates for action completion and feedback will be included within the reports.	Geraint Jones *Chief Clinical Information Officer*	31 March 2025
3701.	The process of reporting including frequency, report content and governance will be included in the updated policy. This will align with the latest NHS Learning from Deaths guidance. This will ensure the right information is shared in the right way at the right time to the right people.	Geraint Jones *Chief Clinical Information Officer*	31 March 2025

Appendix A: Internal Audit Brief

Audit Objective	To gain assurance that the Trust has an effective system in place to learn from deaths.		
Audit Background and Scope	This is a thematic review being undertaken across a number of Audit Yorkshire's NHS Trust clients. Mortality governance should be a key priority for Trust boards. Information provided to Executives and Non-Executive Directors about mortality rates should enable them to understand the issues affecting mortality in their Trust and provide necessary challenge. The Learning from Deaths (LfD) framework published in 2017 requires all organisations to have a mortality dashboard to aid the systematic recording of deaths, review and learning from the care provided following a patient death and mandated the requirement to publish outcomes from LfD within its Quality Accounts. This review will identify the types and accuracy of mortality data being collected and reported and the mechanisms in place for monitoring and sharing learning as a result.		
Key Risks	• Policies/procedures are not in place for the collection of mortality data and/or do not align to national guidance. • Data is not collected relating to inpatient deaths and/ or mortality data is inaccurate and/or misleading. • Missed opportunities to improve patient care due to insufficient or ineffective monitoring and interpretation of mortality data and/or failure to take appropriate action in response to issues identified.	**Methodology**	• Discussions with key staff to gain an understanding of the Trust's systems and processes for collating, validating, reporting, and monitoring mortality data. • Review of relevant policies/procedures and other documentary evidence to ensure they meet current national guidance. • Confirm data is collected and reported in compliance with relevant Trust policies and national guidance. • Validating the accuracy of a sample of data metrics being reported. • Confirming arrangements are in place for monitoring and identifying themes and trends in mortality data at local level. • Identifying and obtaining evidence of learning from themes and trends and sharing of best practice within the organisation.
Client Contacts	Caroline McNamara, Clinical Lead (Adults' Business Unit) Karen Otway, Quality Lead	**Internal Audit Contacts**	Helen Higgs, Managing Director and Head of Internal Audit helen.higgs2@nhs.net

	Claire Gray-Sharpe, Clinical Lead (Children's Business Unit) Adele Archer, Clinical Effectiveness and Compliance Manager		Jonathan Hodgson, Internal Audit Manager jonathan.hodgson@nhs.net Bryony Harris, Internal Auditor bryony.harris2@nhs.net
Executive Sign off	Ruth Burnett, Executive Medical Director	**Committee Reporting**	December 2024

Appendix B: Basis of our Classifications

Opinion

 **High Assurance**	There is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met. The controls in the system are clear and if followed would work effectively in practice. Note this does not mean 100% compliance, there could be some minor issues relating to either systems design or operation which need to be addressed.
 **Significant Assurance**	The system is generally well designed but there may be weaknesses in the design of the system that need to be addressed. Whilst any weaknesses may be significant, they are not thought likely to have a serious impact on the likelihood that the system's overall objectives will be delivered.
 **Limited Assurance**	There are weaknesses in either design or operation of the system that may mean that core system objectives are not achieved. Multiple weaknesses across a range of core areas would suggest a limited assurance opinion level is applicable. However, it also true that one weakness can suggest a limited assurance opinion if it is fundamental enough to mean that core system objectives will not be achieved.
 **Low Assurance**	There is a weak system of internal control and significant improvement is required in its design and/or operation to effectively meet the system's objectives. It should be borne in mind that Low Assurance is not 'No Assurance.' The key point here is that there is a good chance that the system may not be capable of delivering what it has been set up to deliver – either through poor systems design or multiple control weaknesses.

Key Findings

	Action required, the issues present risk of significant damage or loss to the organisation, or problems with the safe or effective operation of the system under review.
	Review the benefits of taking action, these may be minor completeness or improvement issues which do not mitigate significant organisational risks.
	Key positive assurance highlights on the design, operation and effectiveness of the system of internal control in place.

Prioritisation of Recommendations

Grading	Definition
Major	Recommendations which address fundamental weakness in system design that presents a significant risk to achievement of objectives, or widespread major non-compliance with the internal control framework.
Moderate	Recommendations which address significant weakness in system design that presents a risk to achievement of some objectives, or limited areas of non-compliance with the internal control framework.
Minor	Recommendations relating to good practice, improvement, or completeness with low impact on overall system of internal control.

Appendix C: Limitations and responsibilities

The report is based on the review work undertaken and is not necessarily a complete statement of all weaknesses that exist or potential improvements. Whilst every care has been taken to ensure that the information provided in this report is as accurate as possible, no complete guarantee or warranty can be given with regard to the advice and information contained. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by us should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Where information resulting from audit work is made public or is provided to a third party by the client or by Audit Yorkshire then this must be done on the understanding that any third party will rely on the information at its own risk. Audit Yorkshire will not owe a duty of care or assume any responsibility towards anyone other than the client in relation to the information supplied. Equally, no third party may assert any rights or bring any claims against Audit Yorkshire in connection with the information. Where information is provided to a named third party, the third party will keep the information confidential.

Public Sector Internal Audit Standards

Audit work undertaken by Audit Yorkshire conforms with the International Standards for the Professional Practice of Internal Auditing.

Agenda item:	2024-25 (117)

Title of report:	Mortality Report Quarter 3 2024-25

Meeting:	Trust Board Meeting Held in Public
Date:	6 February 2025

Presented by:	Executive Medical Director					
Prepared by:	Chief Clinical Information Officer					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	

Executive Summary:	This paper covers the Mortality data for Quarter 3 of 24.25. Data for this report covers October 1 to December 15, 2024, due to submission timelines. **Key observations:** While adult deaths remain within normal variation, the overall increase in deaths this quarter will be monitored. Child deaths have increased in October and November, as well as the quarter overall. Early discussions with the Consultant Paediatrician identified no immediate escalations, though communication between teams remains an area for improvement. An updated Mortality Review Policy is scheduled for panel review this month. The policy will incorporate audit recommendations to ensure alignment with Trust standards. **Equity Considerations** Preferred Place of Death (PPD): Stable achievement of PPD for white patients continues at 80%. However, a decline in PPD achievement for Asian and Black patients has been observed this year to date and requires monitoring and investigation. Learning from Temba Ndirigu's frailty fellowship is being built into EoL and Palliative care case management and Q&V improvement work.

Previously considered by:	Quality Committee January 2025

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

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

Recommendation(s)	Approve this report. Endorse efforts to address Preferred Place of Death equity disparities and other data quality concerns. Note intent to align changes to the Mortality Review Policy with internal audit recommendations.

List of Appendices:	Appendix 1 Adult Deaths Q3 flash report Appendix 2 Child Deaths Q3 flash report

Quarter 3 Mortality Report:

Key Mortality Data

Adults (Appendix 1)
Total Adult Deaths: The total number of adult deaths reported in Q3 was 735, this figure is within normal variation. However, a significant number of deaths are unclassified as expected or unexpected, 70% and 50% not classified in SBU and ABU, respectively.

Action: Data review and system updates are underway to address this issue. National definitions of expected and unexpected deaths have been recirculated to teams, the classification of deaths will continue to be monitored. Additional training and comms may be required to improve the recording of death classification.
Discharge Pathways: Changes in hospital discharge pathways are increasing frailty among community care patients, impacting bed stays. This may have an impact on LCH mortality data and is being closely monitored for any new trends. Updates will follow in Q4.

Action: Close monitoring of Adult Mortality data continues and will be triangulated with data from the changes to the discharge pathways and frailty data.

People with Learning Disabilities
Total deaths: The mortality rate for people with learning disabilities remains stable at approximately 2 deaths per month, from 2019, with 5 individuals with learning disabilities dying this quarter. A review of Level 1 and 2 data was not possible due to system inaccessibility and will be included in Q4 reporting.

LeDeR Reviews: Inclusion of the LD Lead within the quarterly review process has enhanced oversight. Plans are underway to bring a Trust case to the LeDeR Network for shared learning.

Action: Review of level 1 and level 2 data to be completed for Q4 to include Q3 data. An LCH case will be presented at LeDeR Network.

Children (Appendix 2)
Total Deaths: An increase in deaths was noted, with 36 cases requiring review (up from 27 last quarter). Both expected and unexpected deaths were included. Early learning identified communication gaps between teams when a child's health status changes. These cases are scrutinized at the Trust Child Death meeting and Citywide Child Death Overview Panel.
Rapid Reviews: A growing number of child death reviews are pending due to increased deaths this quarter. Teams are reviewing 6–8 cases every two months to address the backlog.

Action: Changes to the Child Death Group format, following discussions with the Critical Incident Staff Support Pathway (CrISSP) team, have enhanced the process by allowing more time for reflection and support for participants. Limited Paediatrician capacity remains a concern (Risk ID 1121), though coverage for notifications is maintained.

Equity
Preferred Place of Death (PPD): Patients are achieving their 1st or 2nd PPD in 79.6% of cases. However, there does appear to be some disparity in achievement based on ethnicity data. The white patient population achievement of PPD is stable at approximately 80%. However, both Asian and Black populations appear to have had a decline in achieving PPD.

- Asian or British Asian: YTD 55%, down from 77% last year and 86% the year before.
- Black or British Black: YTD 56%, down from 79% last year and 86% the year before.

IMD deciles continue to demonstrate an impact on PPD but there has been minimal change across all deciles. IMD decile 1 consistently has 1–2% lower PPD achievement than the overall average.

Action: These disparities indicate a potential equity gap in PPD achievement, warranting further investigation and targeted intervention. A Trust-wide review of 2024/25 ethnicity data is planned for Q1 2025/26.

The BUs are building the knowledge about the cultural beliefs related to EoL care from Temba Ndirigu's frailty fellowship. Temba is providing clinical leadership support into the new approach to more effectively jointly case manage with Primary Care the Proactive palliative/ EoL respiratory patient cohort within 3 test site PCNs (inner south, Seacroft, Crossgates). Also applying learning into Q&V review of how EoL and palliative care is delivered to the NT cohorts across the NT core and Homeward.

The implementation of an "About Me" workflow within SystmOne is planned for 2025/26, clarification of which quarter is required in line with Trust Business Planning. Benefits include improved ethnicity and reasonable adjustments data recording which is hoped to impact DNA rates and patient experience.

Mortality Review and Learning from Deaths Policy Updates
The Mortality Review Policy, currently under Policy Panel review, will incorporate:

- Clear definitions for notifications and reviews.
- Processes for timely death notifications and reporting inclusion.
- Clarifications on data inclusion (e.g., month of death, notification, or review).
- Alignment with the Trust's "Making Data Count" strategy for improved accessibility and real-time updates.

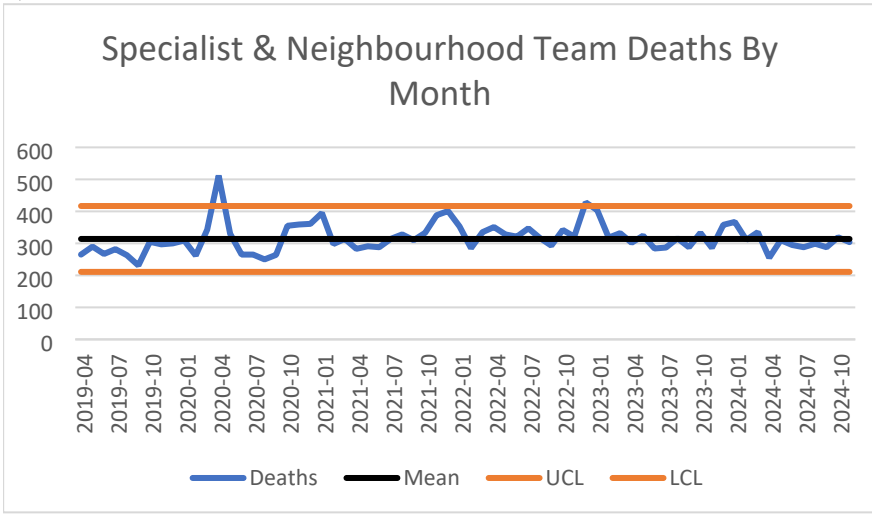
These enhancements incorporate the recommendations from the Mortality Review Internal Audit and will ensure robust, actionable, and timely learning across the Trust.

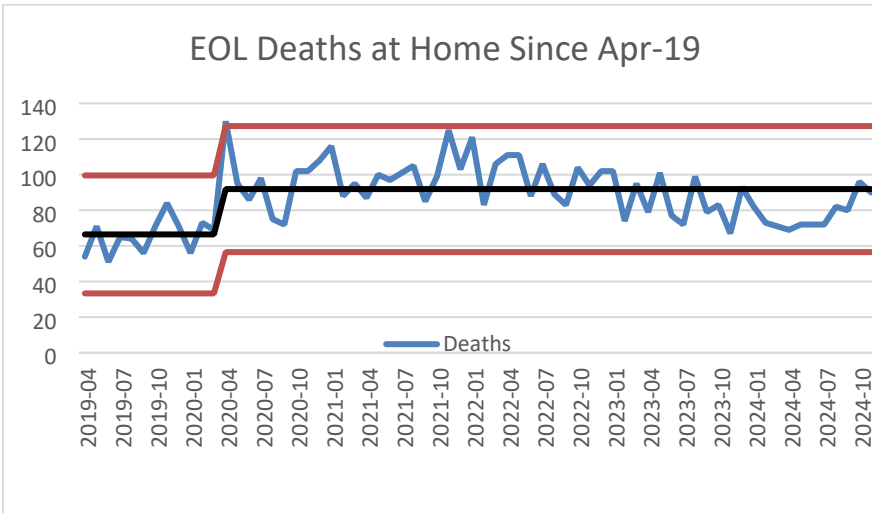
Board is recommended to

- Approve this report.
- Endorse efforts to address Preferred Place of Death equity disparities and other data quality concerns.
- Note intent to align changes to the Mortality Review Policy with internal audit recommendations.

Key Opportunities Risks and Successes Adult Mortality Report flash report, Q[3] 24/25

Quantitative Data:





Plan to include: Further exploration to take place to review to include more SPC charts for quality data. Ready for Q1 25/26.

Analysis/Narrative:*** Data for this report is from 1st Oct-15th Dec due to timescales required for submission***.
There were a Total of 735 Adult Deaths in Quarter 3 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

There has been 5 people with a learning disability (LD) who died in Q3 open to LCH. Due to the timing of the report and systems been inaccessible, it has not been possible to review the level 1 and level 2 mortality data for learning. This was low last quarter and will therefore be completed as soon as possible and highlighted in the next report with Q4 data. There have not been any focused reviews from LeDeR from Leeds, generic themes across west Yorkshire continue to be shared.

Preferred place of Death: The numbers of patients dying at home continue to move towards pre pandemic levels. (PIP report) PPD achieved for patients included on EPaCCS: November 24

- 1st choice 73.8%
- 1st or 2nd choice 79.6%

Reason PPD is not achieved isn't routinely recorded, where it has been recorded the most common factors are clinical or environmental risks requiring admission, and reflecting the increasingly complex nature of some EoL Care patients wishing for their care to be provided in the community. Recent examples include risks around drug misuse, safeguarding concerns or clinical factors such as potential sepsis, acute bleed etc.

Leeds Citywide Planning Ahead report from the Leeds Palliative Care Network shows a similar figure for all deaths of patients included on EPaCCS. Understanding the factors for different population groups and how they may impact on end of life care is being increasingly explored within the network. This will be considered for LCH reporting for Q1 25/26.

Ethnicity data: There were no new ethnicity trends identified for preferred place of death. We will review 24/25 ethnicity data in Q1 25/26 as this is supplied annually from BI.

ReSPECT: Progress is being made in the number of patients that have an up-to-date ReSPECT document and planning discussions are taking place earlier. This has been a common theme identified in learning within mortality case reviews in both BU's.

Expected/Unexpected deaths.

SBU = 63 Expected and 5 unexpected deaths. (Lower due to partial reporting in Dec)

ABU = 274 Expected and 48 Unexpected deaths 322 were not recorded.

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 = 50% and SBU 70%) Further exploration to take place to understand the data quality which will inform. Meeting arranged with BI and clinical systems to understand whether it's a recording or reporting issue. Further information will be available in Q4.

Clinical Leads have re circulated the National definitions for Expected/Unexpected death to all Teams and services to promote accurate recording.

SBU: Open Serious and Internal Concise Investigation Status: 1: LMWS PCMH: 99238: Moderate harm reported in May: PSII led by LYPFT. Timescales overdue due to LYPFT capacity.

ABU: Delay in audit of New Mortality questionnaire level 2 due to sickness. Update to be provided in Q4.

Inquests: Increase in inquests noted this year trust wide. SPC chart completed for 2 years and reported 7 data points above mean, consistently above mean since May 2024. Patient safety team have been in contact

S1 Systems, processes & practices to keep people safe	*S4 Medicines management*	*S5 Track record on safety*	*S6 lessons learned & improvements made*	*E1 Standards, legislation & evidence-based practice*	*E2 Outcomes of care & treatment*	*E3 Staff skills, knowledge & experience*	*R4 Listening & responding to concerns & complaints*

Key Opportunities Risks and Successes Adult Mortality Report flash report, Q[3] 24/25

Opportunities/Successes (Making Stuff Better/Celebrations)

[info relevant to subject area] PLEASE INDICATE WHICH BAF RISK IS MITIGATED

Opportunity/Success

Business units and QPD have been working together to develop an improved mortality review process and are now piloting and developing as one integrated team. Within ABU the palliative clinical quality leads are providing a significant contribution to the ABU mortality reviews which includes more sharing of thematic learning. Chairing of Mortality care review meeting has been shared which has provided development opportunities and resilience within the clinical leadership across ABU/SBU. Review of Adult mortality case review meetings underway. Part of this will be to think about how we can incorporate inclusion for reporting requirements. Further update in Q4.

*BAF RISK 1	BAF 2	BAF 3	BAF 4

Opportunity/Success

Inclusion on the LD Lead within the mortality quarterly review process. LD website underway for staff support and learning from LD deaths will be included.

LD Lead reviews every LD death recorded by LCH and has plans to bring an LCH LD death to LeDeR Network. Generic themes across west Yorkshire continue to be shared.

BAF 1	BAF 2	BAF 3	BAF 4

ReSPECT column in appendix embedded shows an increase this year in completion of ReSPECT plans for patents not included on EPaCCS. This is likely to be a mix of patients in hospital and more completion of the planning ahead documentation with patients, who present with a more uncertain prognosis e.g. those with LTCs, frailty, and dementia. A further community audit of ReSPECT completion is planned for Q1 2024-25. See appendix.

Appendix for Q3 24 25 mortality flash re

BAF 1	BAF 2	BAF 3	BAF 4

Risks/issues

PLEASE INDICATE WHICH BAF RISK THIS LOCAL RISK RELATES TO (LIST ON PAGE 3)

RISK

RISK/Opportunity

LTHT discharge pathways 1 & 2 means there are changes in the proportion of discharges from hospital to home and therefore more poorly patients are being discharged home and community care beds are seeing more frail patients that are not for active rehabilitation. This is affecting the length of stay in CCB beds. This remains an escalation for Q3.

Mitigation

To be closely monitored and update to be shared in next report.

*BAF 1	BAF 2	BAF 3	BAF 4

RISK

Difficulty in obtaining data due to submission timescales, this is ongoing. Data can be pulled on the first working day of the month after the quarter and this is usually the submission date for QAIG. This means that completing analysis of data is difficult to include. In Q3 data has been pulled earlier and therefore goes up until 15th Dec only.

Mitigation

In Q3 data has been pulled earlier and therefore goes up until 15th Dec only due to bank holidays and deadline dates.

BAF 1	BAF 2	BAF 3	BAF 4

RISK

Potential data inaccuracies in some of the mortality data i.e., level 1 and 2 completions and expected or unexpected deaths. A large amount state 'unknown' and therefore rates are expected to be higher.

Mitigation

Business unit's have requested a review of data to ensure accurate and sensitive reporting.
This came out as a recommendation from internal audit.
Further exploration to take place to understand the data quality which will inform.
Meeting arranged with BI and clinical systems to understand whether it's a recording or reporting issue. Further information will be available in Q4.

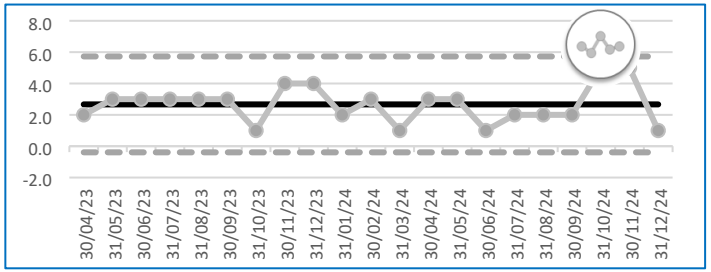
BAF 1	BAF 2	BAF 3	BAF 4

S1 Systems, processes & practices to keep people safe	*S4 Medicines management*	*S5 Track record on safety*	*S6 lessons learned & improvements made*	*E1 Standards, legislation & evidence-based practice*	*E2 Outcomes of care & treatment*	*E3 Staff skills, knowledge & experience*	*R4 Listening & responding to concerns & complaints*

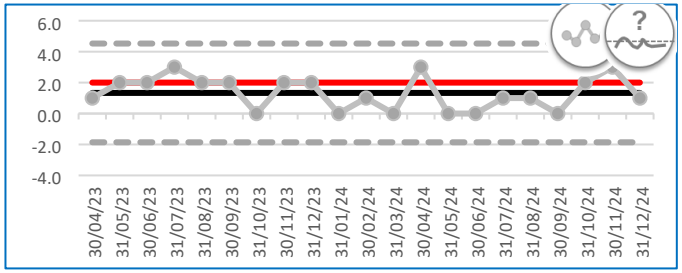
BOARD ASSURANCE FRAMEWORK (BAF) – QUALITY COMMITTEE RISKS		
Risk 1 Failure to deliver quality of care and improvements: If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm. **Quality Committee (Exec Director of Nursing and AHPs)**	**Risk 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 3** Failure to invest in digital solutions. If the Trust fails to invest in improving core technology and in new digital solutions, then resource may not be utilised effectively, services could be inefficient, software may be vulnerable and the impact will be delays in caring for patients and less than optimum quality of care. **Quality, Business and Audit Committees (Exec Director of Finance and Resources, Exec Medical Director)**
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. (Senior Management Team)**	**Intentionally Blank**	**Intentionally Blank.**

Key Opportunities Risks and Successes – Child Deaths Q3 2024/2025

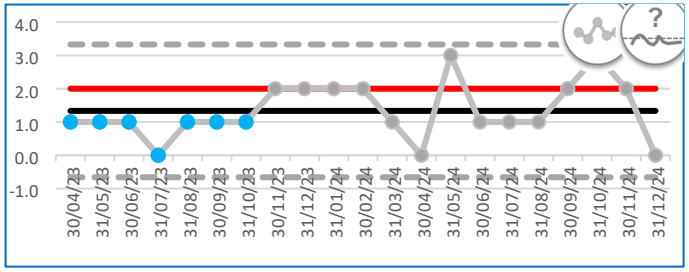
All Child Deaths



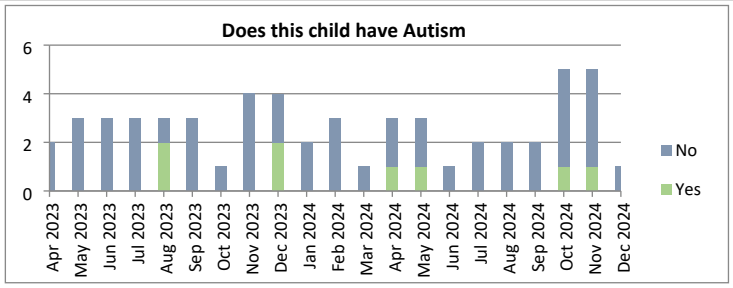
Unexpected Child Deaths

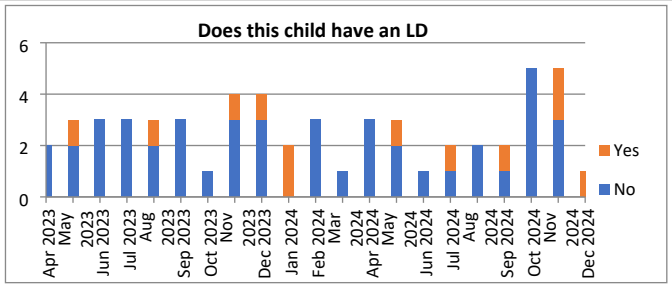


Expected Child Deaths



It is evident the deaths have increased within month (October and November), and quarter (overall), this will be monitored to determine whether this becomes a cause for concern. There has been an early conversation with the Consultant Paedatrcian who chairs both LCH Child Death Review Group and the Leeds Child Death Overview Panel to consider immediate learning, no escalations at this time. All deaths have been subject to the Trust Rapid Review process. There is some early learning in relation to communciation between teams when there is a known change in the childs health which could impact on another service. The information is scrutinised at the LCH Child Death meeting and Citywide, Child Death Overview Panel.



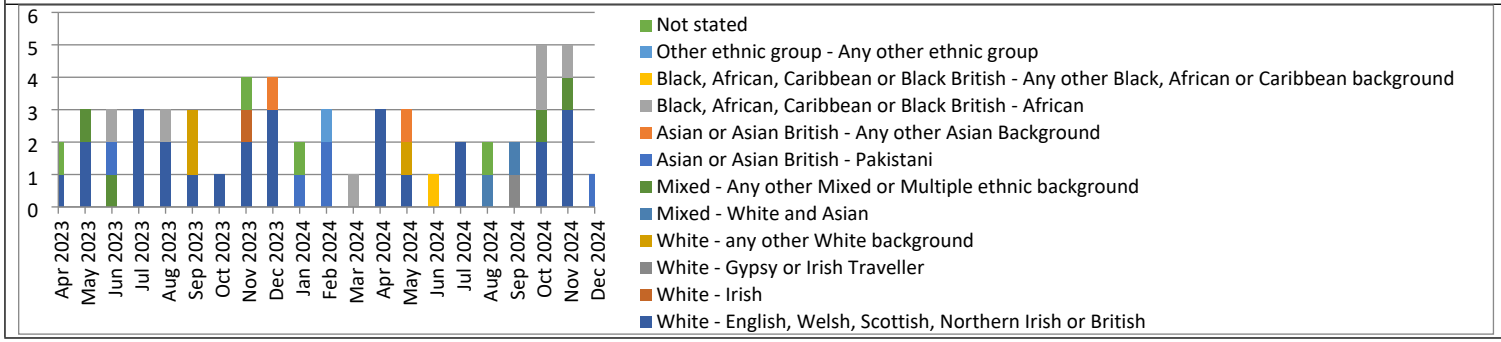


This information needs to be considered in relation to

- Both expected and unexpected deaths are included
- All age children are included
- Children awaiting diagnosis are not identified.

Therefore, it is limited in its usability.

Ethnicity



The ethnicity of the children who have died has been reviewed, this has been compared to the national data, to note the national data has a different data set (also includes neonatal deaths) to the Trusts EPR therefore it not possible to compare like for like. CDOP review ethnicity with a Leeds wide approach, and this is included in their annual report. Therefore, this will not be included in future reports. Ethnicity data is considered as part of the Trust EQIA process when making any changes to service delivery.

HIGHLIGHT & RAG RATE THE PRIMARY CQC DOMAIN BEING MET	*SAFE*	*EFFECTIVE*	*CARING*	*RESPONSIVE*	*WELL LED*

Key Opportunities Risks and Successes – Child Deaths Q3 2024/2025

Opportunities/Successes (Making Stuff Better/Celebrations)

Opportunity/Success
Data has been reviewed in line with the Trust direction to included SPC charts.

*BAF RISK 1	BAF 2	BAF 3 √	BAF 4

Opportunity/Success
Following a conversation with the CrISSP (Critical Incident Staff Support Pathway) Team the Child death group has changed its format. This allows more time for reflection, camera's on / off if needed, heads up about which child will be presented next, having deputies if people need to opt out of specific cases, finishing the meeting earlier to allow time to decompress before finishing work.

BAF 1 √	BAF 2	BAF 3	BAF 4

Opportunity/Success
There is a new immunisation template for the 2-to-2.5-year check within the 0-19 PHINS template, this aids conversation/information sharing and support in receiving the necessary immunisations. This had previously been identified as missing during a child death review.

BAF 1 √	BAF 2	BAF 3	BAF 4

Opportunity/Success
There is work underway for children missing from education, there is now a code where if the school is unknown, then the child will be classed as missing in education.

BAF 1 √	BAF 2	BAF 3	BAF 4

Risks/issues

RISK
There are currently thirty-six child deaths to review, this has increased from last quarter (27) due to an increase in deaths this quarter.

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. **No change from last quarter.**

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*

Leeds Community Healthcare NHS Trust

Agenda item:	2024-25 (118)

Title of report:	Patient Experience Six Monthly Report

Meeting:	Trust Board Meeting held in Public
Date:	6 February 2025

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

Executive Summary:	The report provides a review of complaints and concerns, feedback via surveys, engagement activity, and wider feedback for the six-month period 1 July 2024 and 31 December 2024; providing an overview of themes, learning and action. It compares the data and qualitative information with previous years.

Previously considered by:	Quality Committee

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

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	/	Why not/what future plans are there to include this information?	We now have access to the Spine system, enabling us to link complainant demographics. This will provide insights into who is raising complaints and identify communities from whom we are not receiving feedback. BI Team does not have resources to allocate

				to this work to enable the data for reporting and monitoring purposes.

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

List of Appendices:	N/A

Executive summary

Purpose:

1. This report provides the six-monthly update of Patient Experience within Leeds Community Healthcare NHS Trust (LCH) between 1 July 2024 and 31 December 2024.
2. The report incorporates the information required for the complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).
3. The report provides a review of complaints and concerns, feedback via surveys, and wider feedback for the six-month period 1 July 2024 to 31 December 2024; providing an overview of themes, learning and action. It compares the data and qualitative information with previous years.
4. The report includes Friends and Family Test (FFT) information.

Main points:

1. There has been an increase of 27.5% in complaints (88 complaints) received between July and December 2024, compared to the 69 complaints received between January and June 2024. There has been a slight decrease of 14.9% in complaints received from the same period between July and December 2023, where 57 complaints were received.
2. The two main themes of complaints received in this period were, clinical judgement and treatment and attitude conduct and cultural and dignity issues.
3. LCH has received 2 confirmed claims and 1 potential claim between 1 July and 31 December 2024, 3 claims were also reported for the reporting period between 1 January and 30 June 2024.
4. Work continues to focus on review of the process of managing concerns and complaints in line with national best practice.

Recommendations

The Board is recommended to:

- Receive this report
- Note the updated information

PATIENT EXPERIENCE (Complaints and Concerns) SIX MONTHLY REPORT

1. INTRODUCTION

1.1. This report provides the six-monthly update of Patient Experience within Leeds Community Healthcare NHS Trust (LCH) between 1 July 2024 and 31 December 2024.

1.2. The report incorporates the information required for the complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).

2. BACKGROUND

2.1. This report will focus on the themes and learning emerging from patient feedback, and how this is shared across the Trust to ensure continuous quality improvement.

3. LCH PATIENT EXPERIENCE

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

4. COMPLAINTS, CONCERNS & COMPLIMENTS

4.1. From 01 July to 31 December 2024, LCH received 88 complaints which were managed under the 2009 regulations. There has been an increase of 27.5% in complaints received (from 69 to 88) since the period between 01 January and 30 June 2024.

4.2. There has been a slight decrease in complaints received, complaints (12.5%) from the same period in the previous year, between 01 July 2023 and 31 December 2023.

4.3. The highest number of complaints were from services in the Children's Business Unit 36.3% (32), Specialist Business Unit 34% (30) and Adult Business Unit 26.1% (23). Operational Support Services received 2 (2.2%) and Corporate services received 1 (1.1%).

4.4. Of the 88 complaints received between 1 July and 31 December 2024, 46 have been closed. All closed complaints were responded to within 180 days of receipt.

4.5. The average length of time to provide a response to a complainant was 51 days. A number of complaints were responded to well within the internal 40-day timeframe, (16/42) of closed complaints were closed within 40 working days of receipt, the Trust standard. Of the 26 complaints closed after 40 days all timeframes were negotiated and agreed with the complainant, and were either due to staff leave within services, time for the service to meet with or speak to the complainant in line with best practice, the complaint being on hold for a period of time or at the request of the complainant and service pressures.

4.6. The Trust has received 198 concerns between 1 July to 31 December 2024, this is an increase of 32% compared to the number of concerns received in the same period in 2023.

4.7. The Trust has received a total of 576 compliments between 1 July and 31 December 2024. This shows a decrease compared to the previous reporting period where 480 compliments were received between 1 January and 30 June 2024.

4.8. The Patient Experience Team now has access to NHS Spine, which enables them to search for and record patient numbers. This data collection supports efforts to understand health equity within patient experience. Discussions with the Business Intelligence Team have highlighted that while they currently lack the resources to support this work, they plan to allocate resources for monitoring and reporting once they become available.

5. PATIENT EXPERIENCE (COMPLAINTS) TRAINING

5.1. Local tailored complaints training was developed and launched for services in April, achieving strong attendance. However, this training is currently on hold due to limited resources within the Patient Experience Team. It will resume when sufficient capacity and resources become available. Support continues to be provided to teams where needed and guidance given, bespoke training sessions are offered where requested.

6. OVERARCHING THEMES FROM CLOSED COMPLAINTS

6.1. The top three subjects for LCH's complaints closed during period 1 July – 31 December 2024 were:

- Clinical judgement/Treatment
- Attitude, conduct, cultural and dignity issues
- Access and availability

Two of the three themes are consistent with the previous six months however, appointment appears as the third highest subject for complaints between 1 July - 31 December 2024.

6.2 Complaints citing Clinical judgement and treatment

6.2.1 The most complaints citing clinical judgement and treatment were closed within the Specialist Business Unit with 6 out of 10 of the closed complaints. Adult Business Unit accounted for 3 out of 10 of the

complaints closed citing clinical judgement and Children's Business Unit 1 out of these complaints.

6.2.2 An example of learning and improvement in this area comes from the Podiatry Service. A complainant raised concerns about the time taken to assess her foot after toenail removal, which led to an infection. Upon investigation, no issues were found with the clinical judgment or care provided. However, the service identified a need to enhance the telephone training guide to ensure safety netting advice is consistently communicated during such calls.

6.3 Complaints citing attitude, conduct, cultural and dignity issues

6.3.1 Of received complaints closed between 1 July- 31 December 2024, 8 out of 46 cited issues concerning attitude, conduct, cultural and dignity, and was the second most common area for complaints received.

6.3.2 The Children's Business Unit and Specialist Business Unit both had 3 out of the 8 complaints citing Attitude issues, and the Operational Service Unit had 2 out of 11 of these complaints.

6.3.3 An example of learning from a complaint in the Leeds Mental Wellbeing Service involved a patient who expressed concerns about what she perceived as a refusal to continue her appointment because her baby was present. Upon investigation, the service explained that having babies in therapy sessions is generally discouraged, as it can shift focus away from the individual's emotions, disrupt the therapeutic process, and potentially affect the baby due to exposure to emotional distress. However, the service does have a policy to support patients with babies in such situations. It was identified that the clinician was unaware of this policy. As a result, the therapist has since reviewed the policy and now has a clear understanding of how to support patients with newborns in the future.

6.4 Complaints citing Access and Availability

6.4.1 For the period 1 July- 31 December 2024 9 out of 46 of all complaints received highlighted access and availability issues, this was the third most common area for complaints received.

5 out of 9 complaints citing appointment issues were in the Children's Business unit. 4 out of 9 were Specialist Business Unit and 1 out of 9 Adult Business Unit.

6.5

6.5.1 An example of learning comes from a complaint made to the Children and Young People's Mental Health Service (CYMPHS). The mother of a young person raised concerns about her son being on the waiting list for over a year. During this time, he turned 18 without receiving an appointment and was subsequently referred to adult services. The

service explained that appointments are offered to those who have been waiting the longest. However, the investigation identified the need for improved communication with young people and their families regarding waiting times. Reassurance was provided that new processes and systems are being reviewed to ensure regular updates are shared with young people and their families in the future.

7. CLAIMS

7.1. LCH has received 1 confirmed claim and 2 potential claims between 1 July and 31 December 2024.

7.2. The 3 new claims two are being handled by the Clinical Negligence Scheme for Trusts and are related to clinical care provided by Community Continuing Nursing Service, Community Gynaecology and The Neighbourhood Teams.

8. FRIENDS AND FAMILY TEST

During the reporting period of 01 July and 31 December 2024 there have been 6619 Friends and Family Test (FFT) responses, this is a 16.5% increase on the previous six months (5524). The overall percentage of patients or their carers reporting a very good or good experience was 6200 which is a 1.7% decrease in satisfaction from the previous reporting period. Responses reported the experience was poor or very poor and 5.9% neither good nor poor. 0.4% answered ‘Don’t know’ to this question.

8.1 We continue to receive comments within the FFT that praise staff members for the care and support provided these comments include:

Speech and Swallowing Team - This was the NHS at its very best. From GP discussion I was seen within a few days, and the sessions were immediately helpful. I was given clear explanations of the block, and staff had just the right approach to make me feel confident and relaxed, and her encouragement made the sessions something to look forward to. I felt that I was gaining skills and insight, and this was reinforced by comments from people around me who saw instant improvements. I would recommend this therapy wholeheartedly.

Tier Three Weight Management Service - Absolutely amazing, always gave exceptional advice again personal to me. The follow up emails were great to reflect on. Tips & tricks relevant to my circumstances.

Enhance Service - Because the staff are very kind and lovely to talk to. They have helped me learn different things and come when they say they will. They encourage me to engage with services when I might not have done before. I always enjoy speaking with them and they have been very helpful.

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

9 **NEXT STEPS**

9.1 The Patient Experience Team has benchmarked LCH complaint processes against the Parliamentary and Health Service Ombudsman (PHSO) Complaint Handling standards (2022) and developed a improvement plan. A Clinical Fellow has been assigned to review and embed two of PHSO standards within the trust.

9.2 Work to support the implementation of the Health Equity and Third Sector Strategies is ongoing and will include a review of processes and systems to help improve access and experience of vulnerable communities and those at highest risk of health inequalities.

10 **RECOMMENDATIONS**

The Board is recommended to:

- Receive this report
- Note the updated information.

Committee Escalation and Assurance Report

Name of Committee:	Audit Committee	**Report to:**	Trust Board 6th February 2025
Date of Meeting:	13th December 2024	**Date of next meeting:**	11th March 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.

Alert	Action
• N/A	

Advise

- Two limited opinion Internal Audit Reports were received and reviewed by the Committee – Health Equity and Mortality Rates/Learning from Deaths. It was agreed that these would be discussed in more depth at the Quality Committee in January 2025 and then Board in February.
- Significant progress was noted in terms of the number of overdue recommendations, and this work would continue into 2025.
- The Committee heard that no changes to the Standing Orders and Standing Financial Instructions were proposed at the present time, but an in-depth review would be undertaken when the findings from the well-led review were known.
- Significant changes to the NHS Data Security and Protection Toolkit (DSPT) were noted, along with the possibility that the DSPT would be submitted with an "Action Plan" that detailed how the Trust aimed to meet the requirements.

Assurance

- Planning work for the 2024/25 external audit had commenced.
- The Committee recommended that the final Charitable Funds annual report and accounts be presented to the Charitable Funds Committee on 17 December 2024 for formal adoption ahead of submission to the Charity Commission.
- Committee received and noted the Tenders and Quotations Waiver report, the Losses, Compensations and Special Payments report, Over and Under Payments and Off-Roll Payments report, Contracts Register report, and the Schedule of Receivables and Payables.
- The Committee received an update on the ongoing development of the Trust's risk management processes and progress made in the management of risk in the last 12 months. The establishment of the Risk Review Group as part of the Senior Leadership Team meeting was welcomed, and Committee would receive updates as to the output of this in 2025.
- Committee discussed the review of the management of Trust Information Assets and received assurance that approved policies were followed when determining destruction dates and risks were considered carefully.

Committee Escalation and Assurance Report

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:	19/12/2024

Committee Escalation and Assurance Report

Name of Committee:	Charitable Funds Committee	**Report to:**	Trust Board 4 October 2024
Date of Meeting:	17/12/2024	**Date of next meeting:**	13 h March 2025
Chair:	Alison Lowe	**Parent Committee:**	Trust Board

Introduction

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

Alert	Action
No alerts	

Advise

- Ongoing work on promoting Microhive (previously Pennies from Heaven) through local communications
- The Charitable Funds Officer is developing local networks to support the further development of the LCH Charity
- Hannah House forward plan approved
- Bid for 2026-2029 London Marathon Charity Trust Places approved and further work to secure
- Discussion concerning ongoing financial support for the Charitable Funds Officer, DON and DOF to discuss and bring back.

Assurance

- The committee were very grateful to hear of a recent legacy donation for the charity, a review on the next steps to use funds in place
- The committee heard about the pipeline of partnerships and fundraising events being explored for the forthcoming 12 months and discussed further consideration of providing updates to the steering group and Trust Board.
- Finance report covering June –November 2024 received and accepted
- Annual report and accounts received and accepted.

Risks Discussed and New Risks Identified

No new risks identified

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

Committee Escalation and Assurance Report

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

Author:	Lynsey Yeomans
Role:	Director of Nursing and Allied Health Professionals
Date:	28th January 2025

Leeds Community Healthcare NHS Trust

Agenda item:	2024-25 (122)

Title of report:	Performance Brief

Meeting:	Trust Board
Date:	6 February 2025

Presented by:	Andrea Osborne, Director of Finance					
Prepared by:	Head of Business Intelligence					
Purpose: (Please tick ONE box only)	Assurance	√	Discussion		Approval	

Executive Summary:	This report gives a summary of performance for the months of September and October 2024, and highlights where performance improvements are being realised, and key risks

Previously considered by:	Trust Leadership Team – 22 January 2025 Quality Committee – 28 January 2025 Business Committee – 29 January 2025

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	X	What does it tell us?	More than 95% of patients have an ethnicity recorded. This target is being consistently achieved.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	- None

List of Appendices:	Appendix 1 – Data Pack Appendix 2 – Performance Brief Development Update

LCH Performance Brief

December 2024 and Q3

Introduction

This report highlights key areas of performance; including areas that are performing well, areas where improvement work is underway, and early warning of deteriorating performance.

This report uses Statistical Process Control as the analytical foundation for such judgements, as work continues to improve assurance, and the ability of this report to highlight statistically significant areas of focus and celebration. A more detailed update on the progress of these developments is given in **Appendix 2.**

Performance is split across six Domains, and a summary of overall performance and improvement initiatives is given for each domain, followed by a focus update into specific indicators that meet criteria for inclusion in the narrative section of this report.

The selection criteria are:

- Areas of recently recovered performance
- Areas of inconsistent performance with a deteriorating or unchanging trend
- Areas of failing performance with a deteriorating or unchanging trend

Performance Summary

Tables 1 and 2 give an overall summary of all indicators where data is currently available, highlighting which indicators meet these criteria (indicated by the shaded areas on the grid). This includes indicators that have not yet been developed using SPC methodology, and indicators not appropriate for SPC methodology, however to note the judgement about long term trend in these cases is based on a non-statistical assessment of the trend.

A full data pack of all indicators is provided in **Appendix 1.**