Leeds Community Healthcare NHS Trust

Trust Board Meeting Held In Public
Boardroom,
Ground Floor, White Rose Office Park, Building,
3 Millshaw Park Lane
Leeds LS11 0DL

Date 1 April 2025
Time 9.30am -12.45pm
Chair Brodie Clark CBE, Trust Chair

AGENDA			Paper
2025-26 1	9.30	**Welcome, Introductions and Apologies** *(Trust Chair)*	**N**
STANDING ITEMS			
2025-26 2	9.40	**Declarations of Interest** *(Trust Chair)*	**N**
2025-26 3		**Questions From Members Of The Public**	**N**
2025-26 4		**Minutes Of Previous Meeting, Action Log and Matters Arising** *(Trust Chair)* *For approval*	
4a		Minutes of the meeting held on: 6 February 2025	**Y**
4b		Action log: 1 April 2025	**Y**
2025-26 5	9.45	**Patient story: Health Care Management** *(Sheila Sorby)*	**N**
STRATEGY AND PARTNERSHIPS			
2025-26 6	10.05	**Chief Executive's Report** *(Selina Douglas)*	**Y**
QUALITY AND SAFETY			
2025-26 7	10.15	**Quality Committee Chair's Assurance Report:** 25 March 2025 *(Helen Thomson)*	**N**
2025-26 8	10.20	**Patient Safety Incident Response Plan (PSIRP) – ****For approval*** reviewed by Quality Committee March 2025 *(Sheila Sorby)*	**Y**
BREAK			
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2025-26 9	10.45	**Business Committee Chair's Assurance Reports:** 27 February 2025 (written) and 26 March 2025 (Verbal) *(Rachel Booth)*	**Y**
2025-26 10	10.50	**Audit Committee Chair's Assurance Report:** 11 March 2025 *(Khalil Rehman)*	**Y**
2025-26 11	10.55	**Charitable Funds Chair's Assurance Report:** March 2025 *(Trust Chair)*	**Y**
2025-26 12	11.00	**Performance Brief** *(Andrea Osborne)*	**Y**
2025-26 13	11.20	**Annual Plan 2025/26 – *For approval*** a. Operational plan 2025/26 (All Directors) b. Financial Planning and Operational Budgets 2025/26 *(Andrea Osborne)*	**Y**

WORKFORCE			
2025-26 14	11.35	**Staff Survey Full Results 2024** *(Jenny Allen/Laura Smith)*	**Y**
2025-26 15	11.45	**Guardian for Safe Working Hours** (Dr Nallapetta Nagashree)	**Y**
GOVERNANCE AND WELL LED			
2025-26 16	11.55	**Significant Risks and Risk Assurance Report** *(Selina Douglas)*	**Y**
2025-26 17	12.05	**Board Assurance Framework - quarterly update report** *(Selina Douglas)*	**Y**
2025-26 18	12.10	**Corporate Governance – end of year reports** a. Going Concern Consideration – *For approval* b. Declarations of Interest and Compliance With Fit and Proper Person Requirements Made By Directors for 2024/25	**Y**
2025-26 19	12.20	**Well-Led Development Review** *(Selina Douglas)*	**Y**
2025-26 20	12.30	**Senior Information Risk Officer - Annual Report** *(Andrea Osborne)*	**Y**
CLOSING BUSINESS			
2025-26 21	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 21.

***Blue Box**		
2025-26 22	**Patient safety (including patient safety incident investigations) update report – reviewed by Quality Committee March 2025**	**Y**
2025-26 23	**Infection Prevention Control Assurance Framework - reviewed by Quality Committee March 2025**	**Y**
2025-26 24	**Workplan**	**Y**

Agenda item:	2025-26 (4a)

Title of report:	Minutes Trust Board Meeting Held in Public: 6 February 2025

Meeting:	Trust Board Meeting Held in Public
Date:	1 April 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
	Sam Prince	Deputy Chief Executive and Executive Director of Operations
	Rachel Booth (RB)	Non-Executive Director
	Dr Ruth Burnett	Executive Medical Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Alison Lowe (AL) OBE	Non-Executive Director (Items 107-121)
	Lynne Mellor	Associate Non-Executive Director
	Andrea Osborne	Executive Director of Finance and Resources
	Khalil Rehman (KR)	Non-Executive Director
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
	Helen Thomson Deputy Lieutenant (DL) (HT)	Non-Executive Director
	Lynsey Yeomans	Executive Director of Nursing and Allied Health Professionals (AHPs)
Apologies:	Selina Douglas	Chief Executive
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
In attendance:	Helen Robinson	Company Secretary
	Laura Mason	Head of Service – His Majesty's Young Offender Institution (HMYOI) Wetherby and Adel Beck Secure Children's Home (For Item 111)
Minutes:	Liz Thornton	Board Administrator
Observers:	Rebekah Besford	Clinical Fellow, Leeds Community Healthcare NHS Trust
	Victoria Tate	Clinical Fellow, Leeds Community Healthcare NHS Trust
	Georgia Arnold	Clinical Fellow, Leeds Community Healthcare NHS Trust
	Kat Butler	Community Matron, Wetherby Neighbourhood Team
Members of the public:	None present	

Item 2024-25 (107)

Discussion points:

Welcome introduction, apologies, and preliminary business

The Trust Chair opened the Board meeting and welcomed members, attendees, and observers.

Apologies

Apologies for absence were received from Selina Douglas and Jenny Allen.

Trust Chair's opening remarks

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

He highlighted the big challenges facing the NHS**.** Staff were working harder than ever to get services back on track, to get waiting lists down and consistently deliver the best care. The consultation *Change NHS: help build a health service fit for the future* provided the Trust with the opportunity to ensure that there was more focus on delivering care in the community and many items for discussion by the Board today would relate to this shift in focus.

Item 2024-25 (108)

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 (109)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2024-25 (110)

Discussion points:

Minutes of the last meeting, matters arising and action log

a) Minutes of the meeting held on 6 December 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 actions. The following actions were due for review at this meeting:

2024-25 (87): Patient Story- access to paediatric occupational therapy services: it was noted that the family had been advised to contact Tim Ryley, Accountable Officer for Leeds. The Board requested an update on the outcome at the next meeting. **Action ongoing.**

Advocacy support: Carers Leeds had agreed to support the family and information had been sent to them. **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: the Executive Director of Nursing and AHPs informed the Board that a review was underway to develop a new process for Quality Walks and Board member service visits which served different purposes. Proposals would be shared with the Board when fully developed. **Action closed.**

2024-25(41):Clarification on the process for reporting details of claims made against the Trust to Board and Committees: this information was now included in the Patient Experience: Complaints, and Concerns Report presented to the Board. **Action closed.**

Item 2024-25 (111)

Discussion points:

Patient story:

The Board heard a patient story concerning a child's time at HMYOI Wetherby and how the Trust's integrated care team had worked to support her including her transition to Adult Secure Care. The Service Manager spoke about all aspects of the child's care including her health, emotional

wellbeing, importance of relationships, education, transition and working alongside partner agencies and external agencies. Consent had been given to share the story with the Board.

Non-Executive Director (IL) asked about the division of responsibilities between healthcare staff and staff at HMYOI Wetherby.

The Head of Service explained that the Trust delivered primary care services to children up until their 18th Birthday to ensure that all their health needs were identified and met while they were in custody.

There was a mixed team of nurses (including paediatric, mental health and learning disability, and adult nurses) healthcare assistants and pharmacy technicians who worked to provide healthcare 24 hours a day, 7 days a week. The aim was to provide healthcare equivalent to that provided in the community.

Prison staff at HMYOI Wetherby were responsible for safeguarding, welfare, ensuring the security and safety of children and supporting them day-to-day in a custodial environment.

The Board heard about the challenges to maintain staffing levels and retain staff. The Head of Service agreed that it could be a hard environment to work in long term. She explained that supervision had been adapted to support staff in this unique environment and development opportunities were on offer to encourage retention.

The Trust Chair thanked the Head of Service for presenting a complex story so powerfully. He encouraged members who had not visited HMYOI Wetherby or Adel Beck Secure Children's Home to do so and see the services for themselves.

2024-25 Item (112)

Discussion points:

Chief Executive's report

The Deputy Chief Executive presented the report which focussed on:

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

In relation to the CIVAS Service Non-Executive Director (IL) asked about the relationship between the Trust and Leeds Children's Hospital and the aspirations for developing the service more widely in future.

The Deputy Chief Executive explained that there were regular meetings with Leeds Children's Hospital to evaluate and revise processes for continuous improvement. The ambition was for this to be a city-wide service but facilitating the transfer of funding was a challenge.

Outcome: the Board

- received and noted the report.

Item 2024-25 (113)

Discussion points:

Reducing Waiting Campaign

The report was presented by the Deputy Chief Executive and provided details on the waiting list campaign running in the Trust between January and March 2025. The three-month focus on reducing waiting lists aimed to make the Trust's services safer and more responsive by ensuring no-one waited more than 40 weeks to enter the Trust's services as a standard. The maximum wait standard would be reduced further during 2025-26.

It was noted that the report had been considered by wide group of stakeholders including the Trust Leadership (TLT) and Senior Leadership Team (SLT), Business Managers, Health Equity Lead, and the Consultant in Public Health.

The Board welcomed the development of the initiative and noted that since September 2024 the overall waiting list had reduced by 2,000 patients.

The Board sought assurance that any changes to the waiting list criteria would not impact on equity.

The Deputy Chief Executive provided assurance that the campaign was not about changing the criteria. She said that the internal EQIA process was robust and the Trust was pushing to ensure that this was replicated where decisions were made about commissioning services in the city.

Non-Executive Director (KR) observed that it was important for the Trust to fully understand any changes to the commissioning criteria and how this impacted on waiting lists.

Non-Executive Director (HT) stressed the importance of developing a long-term plan to sustain the progress made during the current campaign particularly to manage service "hot spots."

Outcome: the Board

- noted the approach to improving patient experience through the reduction in waiting times.

Item 2024-25 (114)

Discussion points:

Workforce Headlines and Strategy Update

The Director of Workforce, Organisational Development and System Development (LS) presented the update which provided the Trust's Board with information about key headlines linked to the Trust's Workforce portfolio including an update on the progress made against the Workforce Strategy's outcome measures at the end of Quarter 3 of 2024/25; and overall position against the Strategy's outcome measures to date.

Non-Executive Director (AL) asked whether the 'I Thrive/We Thrive' programme aimed at improving workplace equity and career progression for employees from Black and Minority Ethnic (BME) groups would continue.

The Director of Workforce, Organisational Development and System Development (LS) explained that a process was underway to gather further evaluation material, to inform thinking and decision-making about the design and delivery of future similar development initiatives for 2025/26.

The Board welcomed the 360-degree assessment undertaken by the SLT to address any gaps and / or opportunities for improvement and the development of individual development plans. It was suggested that outcomes should be tracked to ensure equity in accessing training and development.

The Trust Chair welcomed the report and the plans for the future. He raised two points:

- He sought assurance that the rules on home working were applied consistently across the organisation.
- Whether the number of staff accessing training and development had decreased as a result of the introduction of the Quality and Value Programme.

The Director of Workforce, Organisational Development and System Development (LS) provided assurance that homeworking was covered by the Trust's Flexible Working Policy. A variety of different arrangements were in place based on the need in individual services.

In relation to training and development, cross directorate work was underway to ensure that a coherent approach to funding was in place. She provided assurance that appropriate training and development opportunities had remained available to staff during the Quality and Value Programme.

Outcome: the Board

- noted the Workforce Headlines presented in the report
- noted the progress achieved in pursuit of the target measures set out in the Trust's current Workforce Strategy.

Item 2024-25 (115)

Discussion points:

Quality Committee Assurance Report: January 2025

Non-Executive Director (HT), Chair of the Committee provided a verbal update and highlighted some of the key issues discussed including measuring effectiveness, Safe staffing, and two limited assurance Internal Audit reports (Mortality rates and learning from deaths, and Health equity).

The Board was informed that reasonable assurance overall had been agreed for strategic risks 1, 2, 4 and 9, although it was acknowledged that the two internal audit reports had provided limited assurance but progress was underway on the recommendations, and although currently assurance was limited regarding measuring effectiveness, work was again underway. There was insufficient information provided from the agenda items to assign an assurance level against strategic risk 3 (failure to invest in digital solutions).

Outcome: the Board

- noted the assurance provided and the matters highlighted.

Item 2024-25 (116)

Discussion points:

Internal Audit Reports

The Executive Medical Director drew the Board's attention to two Internal Audit Reports :

- Health Equity
- Mortality Rates/Learning from Deaths

Both were limited assurance reports which had been considered in detail by the Quality Committee on 28 January 2025.

The Board agreed that both reports were welcome as examples of how internal audit reports provided a good measure of progress whilst highlighting areas which needed to be addressed. The management responses to both reports were strong and addressed the issues raised and future actions.

In relation to the Health Equity audit Non-Executive Director (KR) observed that it was important for the Trust to reflect on how the Quality and Value Programme had impacted on equity/inequity and this information should be included in future Health Equity reports to the Quality Committee and the Board.

Outcome: the Board

- noted the reports and that the finding from the reports had been fully considered the Quality Committee.

Item 2024-25 (117)

Discussion points:

Mortality Report - Quarter 3

The Executive Medical Director presented the report which covered the Mortality data for Quarter 3 of 2024/25. It was noted that the data included in the report covered 1 October to 15 December 2024, due to submission timelines.

The key points highlighted were:

- Whilst adult deaths remained within normal variation, the overall increase in deaths this quarter would be monitored.
- Child deaths had increased in October and November 2024, as well as the quarter overall. Early discussions with the Consultant Paediatrician identified no immediate escalations, though communication between teams remained an area for improvement.
- An updated Mortality Review Policy was scheduled for panel review this month. The policy would incorporate internal audit recommendations to ensure alignment with Trust standards.

The Board noted the disparity in data relating to Preferred Place of Death (PPD) which indicated a potential equity gap in PPD achievement, which warranted further investigation and targeted intervention. A Trust-wide review of 2024/25 ethnicity data was planned for Quarter 1 2025/26.

Non-Executive Director (LM) noted the data on child deaths in Quarter 3 and the risk associated with a limited number of Paediatricians covering the service.

The Executive Medical Director said that it was evident from the data that the deaths had increased within month (October and November), and the quarter (overall), and this would be monitored to determine whether this was a cause for concern. Workload and training in the Sudden Death in Childhood (SUDIC) Team would be reviewed.

Outcome: the Board

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

Item 2024-25 (118)

Discussion points

Patient Experience: Complaints and Concerns Report

The Executive Director of Nursing and AHPs presented the report which provided a review of complaints and concerns, feedback via surveys, engagement activity, and wider feedback for the six-month period 1 July 2024 to 31 December 2024. It also provided an overview of themes, learning and action and compared the data and qualitative information with previous years.

It was noted that information about claims was now included in the report. The Trust had received two confirmed claims and one potential claim between 1 July and 31 December 2024, three claims were also reported for the reporting period between 1 January and 30 June 2024.

Non-Executive Director (LM) suggested that future reports should map complaint “hot spots.”

Non-Executive Director (IL) noted that the top three subjects for complaints closed during period 1 July – 31 December 2024 were:

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

He suggested that more information about the rationale underpinning closure should be included in future reports.

Outcome: the Board

- received the report and note the updated information.

Item 2024-25 (119)

Discussion points

Business Committee Chairs Assurance Report – January 2024

Non-Executive Director (KR), Deputy Chair of the Committee provided a verbal update and highlighted some of the key issues discussed including:

- Quality & Value Programme
- Procurement and Third Sector Strategies
- Enhance Business Case
- Performance Brief

Reasonable assurance had been received for all strategic risks overseen by the Committee.

Outcome: the Board

- noted the assurance provided and the matters highlighted.

Item 2024-25 (120)

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 – 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 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.

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 (121)

Discussion points:

Charitable Funds Chair's Assurance Report : December 2024

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

- Ongoing work on promoting Microhive (previously Pennies from Heaven) through local communications.
- The Charitable Funds Officer was developing local networks to support the further development of the Charity.
- The Hannah House forward plan had been approved.
- Bid for 2026-2029 London Marathon Charity Trust Places was approved and the further work required to secure places.
- Discussion concerning continued financial support for the Charitable Funds Officer post were under consideration.

Outcome: the Board

- noted the assurance report and the matters highlighted.

Item 2024-25 (122)

Performance Brief

The Executive Director of Finance and Resources presented the highlight report which provided the Board with a summary of performance, and highlighted where performance improvements were being realised, and the key risks.

The format of the report was still under development and the full pack had been shared with the Board for this meeting. The new report format had been well received by both the Quality and Business Committees at their meetings in January 2025.

The Board reviewed each domain and overall, it was agreed that the new reporting format was an improvement.

The Executive Director of Finance and Resources provided a brief verbal update on finance. She reported that the Trust's finances were on track for 2024/25 and continued to forecast delivery of the plan. This was mainly due to the grip and control measures in place through the Quality and Value Programme.

There remained considerable financial pressure across the West Yorkshire system; during December and early January the Integrated Care Board (ICB) had undertaken in depth reviews of potential improvements within every organisation to ensure the system was doing all it could to

manage the financial deficit. The outcome of these reviews would inform any potential changes to the system forecast for 2024/25.

To ensure that the views of Board members were fully considered in the further development of the Performance Brief it was agreed that comments and suggestions be sent to the Executive Director of Finance and Resources by email following the meeting. Volunteers would be sought to join a Task and Finish Group to finalise development of the Performance Brief.

Outcome: the Board

- received and noted the report.

Item 2024-25 (123)

Discussion points:

Freedom to Speak Up Guardian – Six Monthly Report

The Director of Workforce, Organisational Development and System Development (LS) presented the report on behalf of the Freedom to Speak up Guardian which covered the period 3 September 2024 to 6 February 2025. It offered a record of the work of speaking up at Leeds Community Healthcare NHS Trust and wider work across the health and care system.

The key points were highlighted:

- Overall, 62 concerns had been raised.
- 16 concerns had been raised formally by staff members concerning the Trust or its services through the Freedom To Speak Up Guardian (FTSUG).
- 45 concerns were informally discussed or resolved via the FTSUG. The Speaking Up Champions had three concerns (two of which came to the FTSUG).

Non-Executive Director (KR) noted the intensity and volume of the work and stressed the importance of ensuring that steps were taken on succession planning with a view to providing more support for the FTSUG.

The Director of Workforce, Organisational Development and System Development (LS) provided assurance that regular meetings were held with the FTSUG to check on his health and wellbeing and to discuss the management of his workload. This included managing the increasing number of requests for support from external organisations.

Non-Executive Director (HT) was worried that concerns about patient safety might not be reported through the FTSUG process.

The Executive Director of Nursing and AHPs said that she was working with the FTSUG to ensure that any concerns raised about patient safety were reflected in the reports and escalated to executive directors as appropriate.

Outcome: the Board

- noted the report and supported the embedding of this work across the Trust
- noted the discussion on workload and succession planning.

Item 2024-25 (124)

Discussion points:

Safe Staffing Report

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

The Board received assurance that safe staffing had been maintained across both in-patient units.

Outcome: the Board

- received and noted the report.

Item 2024-25 (125)

Discussion points:

Significant Risks Risk Assurance Report

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

She highlighted the following key points:

- three risks on the Trust's risk register had a score of 15 or more (extreme)
- a total of eight risks scored 12 (very high)
- there were a total of 68 open risks.

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.

Non-Executive Director (IL) suggested that consideration should be given to including risks associated with the future changes to the NHS proposed by the Secretary of State for Health and Social Care on the BAF and Risk Register.

The Executive Director of Nursing and AHPs informed the Board that the Trust would shortly be establishing a Risk Management Group where these issues could be considered in more detail.

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 (126)

Discussion points:

Register of Sealings

In line with the Trust's standing orders, the Chief Executive was required to maintain a register recording the use of the Trust's corporate seal.

The Board noted that the corporate seal had been used once in January 2025 and a copy of a section of the register was presented to the Board as part of the report.

Outcome: the Board

- noted the use of the corporate seal.

Item 2024-25 (127)

Discussion points:

Enhance Business Case

The Deputy Chief Executive presented the Business Case for the future funding of the Enhance Programme. She explained that the programme was now in its third year. During the current year, a full evaluation had been completed by Leeds Beckett University (LBU) which had demonstrated the return on investment both for the Trust and the wider system

The paper detailed the findings of the evaluation and made a recommendation on next steps.

It was noted that the paper had been considered by the Trust Leadership Team (TLT) and the Business Committee, and both were recommending that the Board approve the recommendation to provide £300k funding for the financial year 2025-2026 and to retain elements of the service within five neighbourhoods with a view to maximising impact and return on investment for the Trust. The Executive Director of Finance and Resources confirmed that the funding was affordable within the context of achieving a balanced financial plan for 2025/26.

The Board noted that the investment of £300k would mean that only certain elements of the service would be retained in 2025/26 in five neighbourhood teams.

The Deputy Chief Executive explained that decisions on where to target the programme would be underpinned by the LBU evaluation and were likely to be focussed on areas of deprivation in the city.

Non-Executive Director (IL) asked about funding from 2026 onwards.

The Deputy Chief Executive said that the Trust intended to undertake a further evaluation of the benefits of the programme around November 2025 which would mirror that undertaken by LBU but be less intensive. It was hoped that this would clearly evidence the value of the programme. She added that the programme was recognised as a good offer but the current financial climate in the NHS had impacted on the availability of funding for more than one year.

The Board discussed the merit of raising the profile of the programme by sharing case studies about its impact with NHS Providers.

Outcome: the Board

- approved the proposal to provide £300k funding to support the Enhance Programme for the financial year 2025-2026 and to retain elements of the service within five neighbourhoods with a view to maximising impact and return on investment for LCH.

Item 2024-25(128)

Discussion points:
Any other business Blue Box Items and Close
One item was raised.

Non-Executive Director (IL) referred to the changes to the structure of the West Yorkshire Integrated Care Board and the Trust's representation and role on the Leeds Health and Care Partnership committees.

Action: It was agreed that director and non-executive director representation on the various committees which formed part of the governance structure at Leeds Health and Care Partnership should be reviewed and clarified.

Responsible Officer: Chief Executive.

The Trust Chair closed the meeting at 12.45pm

Date and time of next meeting
Tuesday 1 April 2025 9.00am-12.00 noon

2024-25 129	**Workplan**

AGENDA ITEM 2024-25 (4b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) action log: 1 April 2025

Key		Key colour code
Total actions on action log	2	
Actions on log **completed** since last Board meeting on 6 February 2025 with a **proposal to close**	2	
Actions not due for completion before 1 April 2025: **progressing to timescale**	0	
Actions not due for completion before 1 April 2025: agreed timescales and/or requirements **are at risk or have been delayed**	0	
Actions outstanding at 1 April 2025**: not having met agreed timescales and/or requirements**	0	

Agenda Item Number	Action Agreed	Lead	Timescale/Deadline	Status
6 February 2025				
2024-25 (87)	**Patient Story – access to paediatric occupational therapy services:** to raise this with ICB commissioners, Family advised to contact Tim Ryley, Accountable Officer for Leeds. **On 6 February 2025 the Board requested an update on the outcome of the meeting or contact at the Board meeting on 1 April 2025.**	Chief Executive	Post meeting	Update on 1 April 2025 **Propose close**
2024-25 (128)	**Any other business:** Trust's representation and role on the Leeds Health and Care Partnership committees to be clarified.	Chief Executive	Post meeting	Update on 1 April 2025 **Propose close**

Agenda item:	2024-25 (6)

Title of report:	Chief Executive's report

Meeting:	Trust Board Meeting Held in Public
Date:	1 April 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: • National and Regional NHS • Quality and Value Programme • Strategy • System Flow • Business Unit Updates • Spotlight on…Education Health Care Plans • Research & Development news

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 National and Regional NHS

On the 13 March, Keir Starmer announced that NHS England is to be disbanded and that the Department of Health and Social Care (DHSC) will take forward a transformation plan that aims to reduce red tape and improve frontline services. Last week too, Integrated Care Boards (ICBs) were told they must cut operating costs by a further 50% by December. We are working within an intense period of change; the impact of which is not yet fully understood, but which must be considered within our own planning. Discussions are therefore taking place at Board, Place and Regional level as to the best next steps.

On Wednesday of last week, I, along with other Chief Executives in the Leeds System, received a letter from the ICB lead at regional level (Rob Webster). He asked us to draw together a joined-up plan for how we propose to deliver a neighbourhood health service that brings together health and social care for the people in our communities. A formal agreement is to be submitted by September and will look at operational delivery of services.
It will include:

- NHS and social care working together to prevent people from spending unnecessary time in hospital or care homes
- Providing better alternatives to accessing primary care closer to people's homes.

So, much of the work we need to do now will be working within the wider system to plan how we approach this. LCH is central to the neighbourhood model for Leeds and we have already started to discuss our leadership in this space.

3 Quality & Value Programme

The first year of our cost improvement programme 'Quality and Value' is drawing to a close with great success. Not only have we achieved financial balance by saving the target of £15.8m, but we have also had some great feedback from services about how transformational and supportive our 'bottom-up' and 'service-led' redesign methodology has felt.

We are now well underway with planning for year 2, which has an equally challenging financial target. Taking learning from the last year we are focusing on reviewing our Equity and Quality Impact Assessment (EQIA) process – we have a vast number of EQIAs coming through the pipeline now, as a result of the scale of change, and we need to make sure we use this process as effectively as possible to give assurance that changes will minimise negative impacts on quality, safety, equity and effectiveness. There will also be a more concerted effort to create financial savings that are recurrent, underpinned by new workforce plans.

4 Strategy

With so much change happening in the wider NHS, Leeds system, and within LCH, it is extremely important that we have a clear direction of travel in the short, medium, and long

term. LCH had been planning to develop a new organisational strategy, to be in place by September 2025. Instead, we are reframing this to be more about influencing what the role of community services could be, in terms of delivering more innovative, preventative, and responsive care, in a transformed health and care system.

A cross-organisational task group has been set up, and work is being prioritised around extensive engagement with patients, the public, and staff. We want the patient voice at the heart of Leeds' future and are currently firming up plans to work with an engagement partner who will support us in speaking to as many people as possible about the potential for community health services.

5 System Flow

Overall winter has been managed well across the system in Leeds. There was greater emphasis on managing and improving processes as opposed to reacting to daily pressures. System connectivity improved with fewer named people responsible for predicting, monitoring, reporting, and managing pressures.

From an LCH perspective having a lead at Head of Portfolio level involved in the system meetings provided continuity and consistency. Regular daily reporting into the Head of Portfolio and clear, measured actions led to tangible results and more timely discharge for patients. There was less 'noise' in the system with a team approach to resolving challenges across the whole system.

Although the number of people in hospital with 'no reason to reside' remains high and requires further work, there were minimal system escalations compared to previous years when 'silver command' was called for days and weeks at a time. LCH has supported system flow by maintaining high occupancy and throughput on the Home Wards; Frailty and Respiratory, preventing unnecessary admission and facilitating timely discharge from hospital. Improved ways of working at Wharfedale including the introduction of a daily huddle and new discharge co-ordinator role has resulted in a reduction in the 'no reason to reside' length of stay over the last month. Stroke and CIVAS have further developed their integrated clinical pathways with LTHT colleagues which have improved understanding, sharing of information and supported timely discharge.

Improvements to business continuity plans and action cards has resulted in less time spent in OPEL escalation, less time spent in escalation meetings and more efficient and effective ways of working. These will be maintained and further improved in 2025/26 with a plan to focus on reducing unplanned admissions and long-term admissions to residential and nursing home care for people over 65.

➢ 6 Specialist Business Unit Update

The Liaison and Diversion (L&D) service will transfer to Practice Plus Group on 1 April 2025 following a regional procurement, so a morning of celebration was held with the service on 6 March to reflect on their achievements over the last 6 years whilst they have been with LCH. During that time, the service has grown from a staff team of 9 to 35 covering north and south of the Humber, and went on to include a dedicated worker in the Crown Court and the introduction of the RECONNECT service.

L&D has been delivered in partnership with Community Links and won the LCH Team of the Year award in 2023. The team developed a strong peer support and volunteering programme, and case studies shared on the day included staff who have progressed from being service users to volunteers and then employed as peer support workers. Their

testimony as to how the service changed their lives was incredibly powerful and exemplified the values of LCH.

This work was also recognised when the service was awarded the Lived Experience bronze award in 2024. Whilst sad LCH didn't retain the contract, we wish the team well for the future and thank them for their hard work and dedication over the last 6 years.

We are delighted to have been awarded an extension to the current Police Custody contract for a further 18 months + (6 months) during which time the police will go out to tender as required under the new provider procurement regime.

Plans are well underway for mobilisation of the new Wetherby Young Offenders contract from 1 April with a request from NHSE commissioners to retain the LCH dental element of the old contract for a further 6 months.

The HHIT service was also recognised at the Leeds City Council Quality and Care Awards winning the award for "Most Innovative approach to supporting independence choice control". Further recognition of the work the Specialist Business Unit does in supporting people experiencing the greatest health inequalities.

7 Childrens Business Unit Update

As part of the Fair Days programme the Children's Business Unit has been undertaking service assessments across all the services in the business unit. An outcome of the service assessments was the identification of four priorities to ensure the services were efficient and productive in their service delivery, one of which was to reduce the DNA/.

A standardised process was completed in collaboration with administration colleagues and clinicians across the business unit. This has been rolled out and embedded into practice with very positive results across the business unit.

A deeper dive into the children's Speech and Language service (SALT) was undertaken to try and understand the complexities of why families and young people do not attend clinical appointments. The students in the SALT service completed a research paper that identified some of the rational for non-attendances. Recommendations from the paper suggested a standardised process for all clinicians to follow. Also, a short video is to be produced to explain to parents and carers what the Speech and Language service offer is and what to expect when attending appointments.

The service has worked with enthusiasm in rolling out the standardised DNA/WNB process introducing it to all practitioners as their "obsession" to reduce DNA/WNB with very good initial results. The service has been intent to reduce DNA/WNB with a passion, understanding that with every lost appointment there is another child or young person waiting to be seen.

➢ 8 Spotlight on…Education Health Care Plans

An Education Health Care Plan (EHCP) is a legal document for children and young people aged up to 25, bringing together advice and information from practitioners from different agencies across the city to contribute to a single assessment and plan for the child or young person.

The Child Health Information Service (CHIS) team processes EHCP requests for all LCH services. Volumes of requests have grown since 2020, recent changes to the management of Funding for Inclusion (FFI) have significantly increased the number of Proceeds received

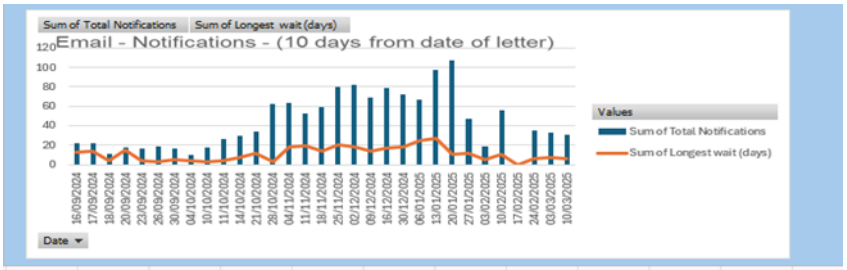
and will continue to do so over a proposed 3-year plan. Additionally, the citywide SEND inspection is imminent further increasing the workload of a busy team.

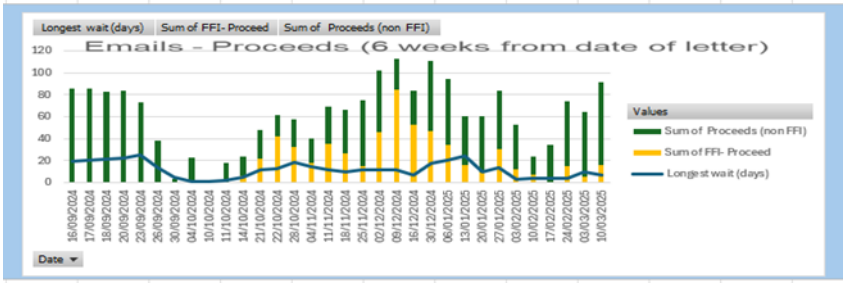
Work has been completed on efficiencies within the team with great results, reducing the timescale required to process EHCP requests and the return of information to SENSAP. Working in collaboration with Business Intelligence, Admin Leadership have designed and published a report on PIP that details volumes of requests received, service response rates and submissions for EHCP Proceeds. This information was not previously visible. The use of the report has enabled Trust-wide access to via PIP supporting CBU Clinical Leadership in the provision of accurate data for ICB reports.

Additionally, an excel dashboard has been created and used by CHIS Leadership to assist with workforce management, efficiencies and reporting to senior mgmt.

Current wait times for requests to be processed:

- Proceeds: reduced from 25 days in September to 7 days (current week)
- Notifications: reduced from 15 days in September to 6 days (current week)





9 Research & Development News

With support from the Trust, the LCH Clinical Lead for Research, Dr Jill Halstead-Rastrick, was successfully appointed as the Community Setting Lead for the Yorkshire & Humber Regional Research Delivery Network (RDN) and commenced in this additional role at the end of February 2025. Additional clinical leadership support has been provided to ensure she can continue to maintain the positive progress in the LCH Research & Innovation strategy whilst also fulfilling a key leadership role in the on-going development and performance of the RDN.

10 Recommendations

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

Selina Douglas
Chief Executive
March 2025

Agenda item:	2025-26 (8)

Title of report:	Patient Safety Incident Response Plan (PSIRP) v1.2

Meeting:	Trust Board Meeting Held in Public
Date:	1 April 2025

Presented by:	Executive Director of Nursing and AHPs					
Prepared by:	Deputy Director of Nursing and Quality					
Purpose: (Please tick ONE box only)	Assurance		Discussion	X	Approval	X

Executive Summary:	This paper is presented to Quality Committee for approval of the proposed 2025/6 Patient Safety Incident Response Plan (PSIRP). The PSIRP details the Trust approach to reviewing incidents in line with both nationally and locally defined patient safety priorities. The plan remains a live document so there is flexibility to consider new and emerging patient safety issues and will be formally reviewed annually. The plan takes account of the premise of PSIRF which is for a proportionate approach to reviewing patient safety incidents to ensure learning and improvement. It is intended that this PSIRP will be adopted from 1 April 2025 in place of the current plan.

Previously considered by:	Trust Leadership Team 19 February 2025/Quality Committee 25 March 2025

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	X
	Use our resources wisely and efficiently	X
	Enable our workforce to thrive and deliver the best possible care	X

	Collaborating with partners to enable people to live better lives	X
	Embed equity in all that we do	X

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	Equity is a golden thread throughout the PSIRP and is reflected as such within the document
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	Quality Committee are recommended to: • Read the paper • Discuss the content • Support the proposed PSIRP for 2025/26 and recommend for approval by the Board on 1 April 2025

List of Appendices:	

Patient safety incident response plan v1.2

Effective date: 1 April 2025

Estimated refresh date: 1 April 2026

	NAME	TITLE	DATE
Author	Sheila Sorby	Deputy Director of Nursing and Quality	
Reviewer	Claire Gray-Sharpe Sarah Hemsley Frankie Skirrow Sarah Yeomans Liz Grogan Emma Mallinson Delphine Arinze	Head of Clinical Governance Quality Lead Quality Lead Patient safety manager Head of IPC Tissue Viability Lead Medical Devices Safety Officer	
Authoriser	Lynsey Yeomans	Executive Director of Nursing and Allied Health Professionals	
Approved	Trust Board		

Contents

Introduction

The NHS Patient Safety Strategy available here was published in 2019 as a replacement for the NHS Serious Incident Framework (2015).

The PSIRF challenges us to think and respond differently when a patient safety incident occurs. PSIRF is best considered as a learning and improvement framework with emphasis placed on the system and culture that support continuous improvement.

PSIRF recognises the need to ensure we have support structures for patients and staff involved in patient safety incidents. A key part of this is fostering a psychologically safe culture, a 'Just culture' where our staff and patients feel confident to speak up when things don't go as planned.

This document is the Patient Safety Incident Response Plan (PSIRP) for Leeds Community Healthcare Trust (LCH). This version of the PSIRP provides the annual plan of how we will respond to patient safety incidents over the period of 1 April 2025 to 31 March 2026.

This plan details our approach to reviewing incidents in line with both nationally and locally defined patient safety priorities. The plan will remain a live document and will remain flexible to consider new and emerging patient safety issues. The plan will formally be reviewed annually and refreshed in line with future fiscal years.

There is no remit within this PSIRP, or indeed within PSIRF, to apportion blame or determine liability, preventability or cause of death. The responses we will conduct to patient safety incidents are for the purpose of learning and improvement. It is outside the scope of PSIRF to review matters to satisfy processes relating to complaints, Human Resource matters, legal claims and inquests.

Our services

Leeds Community Healthcare NHS Trust is proud to provide great care to our communities. The Trust provides and/or sub-contracts NHS services that include services from pre-conception to the end of life across many different specialities and professional disciplines. This includes services to promote and maintain health, and to provide care and treatment to manage existing conditions or ill health.

The Trust primarily serves the population of Leeds, in addition to some regional services. Services are delivered within the patient's home or from a range of sites including health centres, GP practices, hospital sites, schools, police custody suites and HM Prison and secure estates.

LCH is commissioned and registered with the Care Quality Commission to provide the following services:

Adult Business Unit	Childrens Business Unit	Specialist Business Unit
• Neighbourhood Teams (Community Nursing and Rehabilitation, Home Ward, Integrated Clinics and Self-Management) • Active Recovery • Community Discharge and Assessment Team • Palliative care Team • Health Case Management • Neighbourhood Night Service • South, North West and East Recovery Hubs • Transfer of Care • Bed Bureau • Wharfdale Recovery Hub	• Integrated Children's Additional Needs Service (ICAN) • Audiology • MindMate Single Point of Access • MindMate Support Teams • Childrens Community Nursing Service • Children's Speech and Language Therapy • 0-19 Public Health Integrated Nursing Service • Infant Mental Health • Children's Community Eye Service • School Aged Immunisations Service • Children and Young People's Mental Health Service	• Dental • Musculoskeletal • Adult Speech & Swallowing • Podiatry • Wetherby Young Offenders Institute (Physical health) • Adel Beck Secure Childrens Home and Aldine House (Physical health) • Leeds Sexual Health Service • Homeless & Health Inclusion Team • Long COVID Rehab • Gynaecology • Police Custody Suites • Leeds Mental Wellbeing Service • Tuberculosis • Community Stroke Rehabilitation • Community Neurological Rehabilitation • Community Intravenous Antibiotic Service • Diabetes

		• Respiratory • Dietetics • Tier 3 Weight Management • Cardiac • Leeds Community Pain Service • Continence, urology and colorectal service • Falls Team • Tissue Viability

Defining the LCH patient safety incident profile

It is recommended that this document be read alongside the Patient Safety Incident Response Framework (PSIRF) 2022, which sets out the requirement for this plan to be developed: PSIRF

To identify our Trust local priorities for 2025-26 a review was conducted of the data outlined below within the data section. As part of this we identified incident categories and then reviewed other data sources against this list. Once all the data had been reviewed, the information was then cross referenced to inform the priorities, identified in Appendix 1.

In accordance with NHS England guidance on developing a PSIRP, we also identified and compared the on-going quality improvement work and quality improvement priorities currently in place for the Trust to inform our decision making on the Trust's local patient safety priorities.

Patient Safety Priorities Profile

To inform the Trust priorities (Appendix 1) we have assessed a breadth of data from the LCH Incident Management system (RLDatix ®) and other Trust information systems, which included patient safety incidents, concerns, complaints, inquests, claims and mortality data (see Table Two and Data review summary). We also considered learning from incidents, causal and contributory factors from incident reviews, infection reviews and safeguarding reviews. This review also considered the evolution of learning from the three Trust Improvement Groups that were established as we embarked on the implementation of PSIRF into the Trust in January 2024.

A period of twenty-one months of data (1 April 2023- 31 December 2024) to run concurrently from the last PSIRP review was used to inform our priorities. The diagram below depicts the data reviewed.

Infographic one: Overview of data reviewed

Table two: Data review summary:

Incidents: There were 11,128 (21,353 incidents over preceding four-year period). This is broken down by business unit and year within the table below.

	2023 1/4/2023-31/3/2024 (12 months)	2024 1/4/2024-31/12/2024 (9 months)
Adult Services	3718	2906
Children's Services	391	408
Corporate & HQ functions	22	18
Operational Support Services	9	7
Specialist Services	1505	2144

The highest reported category of incidents, annually and in total, in order, was:

Skin Damage (Pressure Ulcer)	1808	1286
Abusive, violent, disruptive or self-harming behaviour	545	1135
Medication	778	659
Patient accident that may result in an injury (Falls)	600	533
Access, Appointment, Admission, Transfer, Discharge	499	516
Implementation of care or ongoing monitoring/review	351	361
Other - please specify in description	289	306

Information Governance / Records	260	228
Treatment, procedure	149	117
Clinical assessment (investigations, images and lab tests)	124	129
Medical device/equipment	131	95
Diagnosis, failed or delayed	52	26
Infrastructure or resources (staffing, facilities, environment)	34	41
Security, Fire & Theft	16	13
Non-Patient Incident	3	23
Financial loss	6	5
Non-Patient Accident		8
Sexual Safety		2

Pressure ulcers remain the highest reported patient safety incident category. Over the last 15 months, nine pressure ulcer incidents have progressed to a Patient Safety Incident Investigation (PSII) however there has been no new significant learning over this period. In the spirit of PSIRF and a focus on learning and improvement there is no data to suggest rapid reviews and PSIIs are adding any additional learning. Therefore, we agreed to:

- Continue to monitor pressure ulcer incidence through statistical process control (SPC) reporting and respond accordingly to any changes in this data i.e explore any data outside of normal variation. In addition, we will ensure subject matter experts have access to an agreed dashboard to review live data on pressure ulcers
- To cease rapid review investigations for pressure ulcers with an expectation that these will be managed locally in line with Trust policy by incident handlers (and training for handlers will be provided as the 2025/26 PSIRP is launched)
- To continue the Trust Improvement Group to progress the improvement activity in relation to the learning already identified
- To agree and apply a process for statutory Duty of Candour which provides a Trust statement about strategic improvement work and an invitation for individuals to approach the Trust if they wish to discuss their individual case further (awaiting CQC response regarding this and compliance with Duty of Candour).
- Quality assurance of incident management through random monthly audits by subject matters experts

- Conduct a 6 monthly clinical audit of pressure prevention care against the Trust policy.

Self-harm has increased from the fifth highest category in data for the previous PSIRP, to second highest in this data. These incidents are predominantly split between our Secure Estate provisions of Adel Beck Secure Children's Home / HMP Wetherby Youth Offending Institute and the Leeds Mental Wellbeing Service (LMWS) and are inclusive of violence / assault incidents as well as self-harm.

Of those related to the secure estate in 2023/24, 106/457 (23.1%) were violence / assault incidents and 351/457 (76.8%) self-harm. The 2024/25 data showed 259/729 (35.5%) violence / aggression incidents and 470/729 (64.4%) self-harm, so a reduction in the proportion of self-harm incidents. In the last PSIRP we agreed whilst most self-harm incidents are low harm, there can be a cumulative psychological effect on these children that results in moderate or severe harm and therefore this was included as a local Trust priority (this excluded all moderate harms and above as these fell under Priority 6). This was also supported by the introduction of a local safety panel within the secure estates to discuss all self-harm incidents prior to any further escalation.

During this time-period there has been 1 self-harm incident that has progressed to a PSII with limited learning for the Trust and as such it is felt that the current local safety panel is the most effective way to monitor and manage these. Therefore, this will be removed as a PSIRP priority.

A review of statistical process control reporting on other self-harm incidents in LMWS identified incidents have remained within normal variation and only one incident has been brought to a PSII. This related to prioritisation of referrals based on protected characteristics and this is being followed up by an EQIA process. Therefore, it was agreed that there was no data to suggest this needed to be included in this PSIRP.

Medication incidents have been reviewed by the Medicines Safety Officer for several years and the profiles have remained largely unchanged. Approx 80% of all medicine incidents occur in the Adult Business Unit. Of these, 99.5% are no / low harm with the remaining 0.5% of medication incidents resulting in moderate or major harm. This equates to approximately 1 or 2 incidents per quarter. During the 21-month period analysed, 2 medication incidents were progressed to a Patient Safety Incident investigation – one related to the route of administration and 1 related to a dose error

on changing a transdermal medication (medication administered across the skin e.g. a patch or ointment).

The learning themes related to medication incidents remain the same and whilst various improvements have been put in place a pattern has been noted that these improvements are embedded but not sustained, so a recurrence of incidents of the same nature are observed.

It was therefore agreed that reporting of medication incidents should remain the same. In addition, a Trust Improvement Group should be established within Adult Business Unit (given the highly weighted incidence of medication incidents in this Business Unit) to lead the improvement and assurance work around medications.

Falls are showing in the top four categories. Over the last 15 months, five fall incidents have progressed to a PSII however the learning remains consistent with no new significant learning over this period. In the spirit of PSIRF and to focus on learning and improvement there is no data to suggest rapid reviews and PSIIs are adding any additional learning. Therefore, we agreed to:

- Continue to monitor fall (with injury resulting in moderate or severe harm) incidence through statistical process control reporting and respond accordingly to any changes in this data
- To cease rapid review investigations for falls with an expectation that these will be managed locally in line with Trust policy by incident handlers (and training for handlers will be provided as the 2025/26 PSIRP is launched). In addition, we will ensure subject matter experts have access to an agreed dashboard to review live data on falls with harm.
- To continue the Trust Improvement Group to progress the quality / safety improvements around the learning already identified
- To agree and apply a process for statutory Duty of Candour which provides a Trust statement about the improvement work and an invitation for individuals to approach the Trust if they wish to discuss their individual case further
- Quality assurance of incident management through random monthly audit by subject matters experts
- Conduct a 6 monthly clinical audit of falls prevention care against the Trust policy.

A review was completed of the **access/ admission/ appointment/ transfer/ discharge** category in Children's Business Unit.
41% of these incidents were related to 'appointments' which made up the largest proportion of this multi-purpose category. 68% of these incidents are being handled by admin services and are therefore in relation to administrative processes.
Of the Data recorded, 37% relate to people who are white British and the remaining ethnicities are over 10 different groups, with work to do on ensuring this data is captured reliably. None of these incidents caused harm.
Given we are not causing harm and the main issue is in relation to administrative systems there is no data to support this being a PSIRP priority.

Other – a further review of the incidents reported under the category of 'other' has identified the majority of these are expected / unexpected deaths as there is no specific category for these. Whilst the Trust do not expected deaths to be reported as incidents unless there is some concern in the care delivery it is clear this is not happening. Given this category is in the top seven this has been considered under the learning from deaths section.

To ensure learning continues to be captured from incidents resulting in moderate or severe harm (excluding PU and falls as described above) a local priority will remain to capture a review of all other moderate or severe harm incidents for consideration at rapid review panel for further investigation requirements and against the statutory Duty or Candour regulation.

Patient Safety Incident Investigations (PSII, previously referred to as serious incidents): There were 44 (compared to 261 in preceding 4 years) PSII / serious incidents reported for the 21 month period. The breakdown of these incident categories is as follows:

- 10 x Unexpected death
- 9 x Pressure ulcers
- 8 x MRSA PIR / PSII
- 7 x Deteriorating patient (malnutrition in CBU x 1, catheter x 2, wound infection x 3, both catheter and wound infection x 1)
- 5 x Falls
- 2 x Self-harm (WYOI and LMWS)
- 2 x Medication (administration error, dose error when swapping medication)

- 1 x Delayed diagnosis of fracture (Wharfedale)

Concerns and Complaints: There were 627 concerns and 263 complaints during the period that have been reviewed. Both concerns and complaints were consistent in relation to the top 5 categories, which were:

- Appointment issues
- Clinical judgement / treatment
- Access / availability
- Attitude / conduct
- Communication

Claims: On review of the claims profile over the period, there were 36 claims, 2 of which have subsequently been rejected but the cause for the original claim has still been considered in this analysis.

The following were excluded from further review due to the nature of the claim:

- Road Traffic Accident x 3 (8.3%)
- Personal injury x 4 (11.1%)
- Covid positive x 1 (2.7%)
- Employee claims x 3 (8.3%) including assault on staff member

Of the remaining 23 claims, 9 are not yet in a formal process as we have only been approached for information at this stage. The remaining breakdown is as follows:

- Lack of parental consent for intervention x 1
- Fracture x 2
- Accident x 1
- Medication error x 1 (not receiving epilepsy medication whilst in custody)
- Delay in referral x 2 (1 to Gynae, 1 to secondary care)
- Treatment delay x 5 (MSK related to ruptured Achilles tendon, delayed cuboid fracture diagnosis and bladder issue, Neighbourhood Team related to vertebral fracture, Podiatry delayed identification of sepsis in foot ulcer)
- Side effect of treatment x 1 (Bladder issue after injection)
- Needlestick injury x 1

Inquests: There were 70 (39 last data review) inquests registered with the Trust during the period reviewed. 27 of these have been rejected because of no LCH involvement in the preceding 12 months.

- 4 related to Children and are therefore subject to other investigative / review processes. The remainder were adult or specialist business unit services
- We have had no Regulation 28's issued. A review of learning has taken place and areas that have been highlighted more than once are:

  - communication between organisations,
  - access to health care records across the system
  - record keeping.

There were also inquests with learning related to leg wounds and sepsis however it is not felt that these require capturing as an additional priority as this is captured within the existing deteriorating patient trust improvement group.

Learning from Deaths: From the Trust learning from death reports, the key themes from mortality review are early identification of the end-of-life phase for palliative patients, obtaining end of life anticipatory medication, and ensuring people's wishes are known for their end of life through advanced care planning. Whilst it is noted that there is a nationally changing picture with a significant increase in inquests across England and Wales this is believed to reflect the Chief Corners advice that there should be more scrutiny around deaths. The Trust have received no Regulation 28 prevention of future deaths reports and minimal learning.

However, considering the national data in relation to the premature deaths of adults with Learning Disability and the Trust commitment to understand and reduce this gap we have agreed to include a review of all unexpected deaths of adults with a learning disability and / or autism. This will compliment the LEDER review process which provides a more generalised learning approach.

Risk Register: A review was completed of the Trust wide active clinical and operational risks. There were 69 risks that were reviewed to understand our wider risk profile.
Patient safety risks had a theme in relation to incident management which will be someway addressed by this PSIRP. Compliance / Performance risks were in the main related to waiting lists and workforce related to capacity and demand.
Our patient safety priorities in this PSIRP will be added as risks to the register and the 2024/25 safety priorities remain on the risk register whilst the improvement plans are still being delivered.

Freedom To Speak Up (FTSUG):
Data was obtained from the Freedom to Speak Up Guardian.
Of 284 concerns, 40 were patient safety / clinical care related

The themes were broadly related to staffing levels, clinical competence of staff, out of date training, Quality and Value work, recruitment of staff without necessary qualifications, not recruiting to existing posts, systems and rotas, leadership, work with partners, value of specialist admin staff, no feedback on clinical issues raised. There has also been a significant increase in the last six months of reporting patient safety/ care issues via the FTSUG route.

Infection Prevention and Control (IPC) Post Infection Reviews:

MRSA Bacteraemia:

The Infection Prevention and Control (IPC) team continue to provide a review of community acquired MRSA Bacteraemia's on behalf of the Leeds system. In this period the team have undertaken 8 PSIIs. There has been minimal learning from cases that have had LCH involvement, and connections have been built with the ICB for sharing learning across out of hospital services for those with no LCH involvement. It has been agreed to continue with this approach for 2025/26 to continue to identify system wide learning.

MSSA Bacteraemia:

Despite an emerging trend of Meticillin-Sensitive Staphylococcus aureus (MSSA) bacteraemia last year, surveillance and a system wide approach to this is being managed in PLACE based forums and therefore does not need including in the 2025/26 PSIRP.

Escherichia coli (E. coli)*

All E.coli bacteraemia infections are currently reviewed further if they occur in line with the following criteria:

- the patient is residing in an LCH inpatient unit
- the bacteraemia is cited in Part One of a death certificate
- the Infection Prevention Control (IPC) team identify a specific trend in review findings.

This approach will continue and is captured within the priorities below.

Clostridium Difficile

Reviews for Clostridium Difficile (C. Diff)* over the preceding time period had identified an increasing trend both locally and nationally. Identified learning continues to reflect the pattern of national learning and therefore they will not inform a PSIRP priority at this stage. Reviews will continue within the IPC team as part of the Trust's contractual requirements.

Proposed changes from LCH PSIRP 2022-2024

Removal of priorities

2022-2024 Priority	Patient safety incident type or issue	Rationale	Continued improvement activity
1.	Pressure damage with learning causing moderate or major harm	Over the past 15 months we have continued to report pressure ulcers on Datix and undertake a rapid review for all Pressure Ulcers of moderate harm and above. Of these, 9 have progressed to a PSII with limited new learning. The areas for improvement have remained the same over the past 15 months (and for months / years prior to PSIRF) and therefore there is no evidence that we are improving care by undertaking these time onerous processes. Await CQC response re DOC response	Incident reporting on Datix will continue to enable us to monitor and report pressure ulcer incidence through SPC tools and track the impact of improvement activity. A standardised dashboard will be developed and accessible to quality leads and subject matter experts. This will enable variation to be noted and a deep dive undertaken to explore variation. As a result pressure ulcer incidents will not be subject to rapid review unless specifically requested by an incident handler. All pressure ulcers where self-neglect / neglect is identified as a causative factor should have a safeguarding referral made by the team. The Trust improvement group will continue to progress the improvement activity already identified. We are liaising with CQC to ensure Duty of Candour compliance is unaffected In the first 6 months a random audit of pressure ulcer incidents will be undertaken by our Tissue Viability Team to ensure adequate standards of review are continuing.

			For additional assurance we will undertake a 6 monthly clinical audit of pressure ulcer prevention care against the Trust policy, this will be added to the service clinical audit plan for 25/26
2.	Patient falls with learning and resulting in moderate or major harm	Over the past 15 months we have continued to report falls with moderate harm on Datix and undertake a rapid review for all of these. Of these, 5 have progressed to a PSII over the past 15 months with limited new learning. The areas for improvement have remained the same over the past 15 months (and for months / years prior to PSIRF) and therefore there is no evidence that we are improving care but undertaking these time onerous processes. Await CQC response re DOC response	Incident reporting on Datix will continue to enable us to monitor and report pressure ulcer incidence through SPC tools and track the impact of improvement activity. A standardised dashboard will be developed and accessible to quality leads and subject matter experts. This will enable variation to be noted and a deep dive undertaken to explore variation. As a result pressure ulcer incidents will not be subject to rapid review unless specifically requested by an incident handler. The Trust improvement group will continue to progress the improvement activity already identified. We are liaising with CQC to ensure Duty of Candour compliance is unaffected In the first 6 months a random audit of falls with moderate or above harm incidents will be undertaken by our Falls service to ensure adequate standards of review are continuing. For additional assurance we will undertake a 6 monthly clinical audit of falls prevention against the Trust policy this will be added to the service clinical audit plan for 25/26

4.	Successive minimal harm, self-harm incidents in children and young people within the Trusts secure estate	Over the past 15 months we have had 1 self-harm incident progress to PSII and this was related to the severity of self-harm and not as a result of successive low harm incidents.	All self-harm incidents will continue to be discussed at the weekly secure estate patient safety panel with HMP staff, LCH Quality Lead and SWYFT Mental Health staff. It is also to be noted that with the recent tender award LCH will no longer be responsible for mental health services to this cohort of young people and this will sit with SWYFT and follow their processes. Within the integrated governance arrangements of the new service delivery model (from April 2025) we will consider a clinical audit of the F213 forms (custody record of injuries to prisoners including those arising from assaults, accidents and unexplained injuries.
6.	Moderate and major harm incident relating to the clinical triage process in Neighbourhood Teams.	This was a service led improvement plan and was expected to be short-term. As there are no recurrent themes and trends continue this is not required to be included in the 2025-26	
8.	Moderate and major harm incidents relating to meatal tears	This was a service led improvement plan and was expected to be short-term. As there are no recurrent themes and trends continue this is not required to be included in the 2025-26	

Health Equity

At present we have reporting structures around falls, pressure ulcers, medication, access incidents and mortality reviews which consider the incidence in relation to deprivation, ethnicity, age, learning difficulty, autism spectrum disorder and communication requirements to understand if the risk of harm is greater for some groups of patients (are some patients less safe than others?). This is being explored also for incidents of deteriorating patient / sepsis. By reviewing the data we can then identify the causes of

inequity and put in place mitigation to address this increased risk. This will not only help reduce harm for marginalised and at-risk groups, but also reduce the overall rate of incidents.

We have traditionally looked at improvements and learning priorities from patient safety incidents, complaints, mortality reviews and inquests separately, but this year we will take a new approach by identifying if there are patients affected by multiple adverse care events and how vulnerabilities and risk of inequity may play a part in this. As such we have applied for an equity fellowship in the first instance. Learning from work to identify and reduce frequent attendance at A&E by taking a person-centred, equitable approach to understanding and addressing the causes and barriers this patient cohort faces, this project would:

- Analyse adverse event data using equity lenses (IMD decile, ethnicity, LD/autism and interpreter requirement)
- Engage with identified patients and staff to map the barriers and missed opportunities that contributed to those adverse care events
- Coproduce plans to reduce individual risks of further adverse care events
- Share learning based on common themes and actions that could proactively be put in place to reduce the risk of adverse care events for other patients at risk of inequity

Stakeholder Engagement
The identification and agreement of our patient safety profile / priorities was a collaborative process that involved the people described in Appendix 2.

The proposed priorities were shared with our stakeholders for their feedback. Our patient safety specialists clinical leads sought feedback from their respective areas in teams and with individuals including clinical and non-clinical staff.

Patient safety incident response plan: national requirements

The national requirements and how we will respond to these are detailed in Appendix 3.

Patient safety incident response plan: local focus

This part of the plan outlines our local priorities for the period 1 April 2025 to 31 March 2026. These priorities are detailed within Appendix 1 and are based on the review of local data as described above.

In relation to the local safety priorities, the Trust will apply one of three principles in the way we will respond to incidents:

1. Where safety issues are well understood and/or improvement plans are well developed, we will ensure the details of the patient safety incident is added to the improvement project and consider no further investigation, with time and people resource focussing on the improvement activity.
2. Where contributory factors are not well understood and/or where local improvement work is still being developed, we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning.
3. Where it is not clear if there is further learning in relation to an improvement plan OR where the incident highlights an area for future learning / improvement we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning.

For incidents that are not related to local safety priorities but warrant further review we will consider the most appropriate / proportionate learning response to explore the factors leading to the incident and provide meaningful learning, on a case-by-case basis.

For each local safety priority underpinned by a Trust wide improvement plan, we will assess the quality of the improvement plan ensuring it is systems based e.g. ensuring that all known contributory factors have been addressed, and using appropriate data to measure progress. The plans will be signed off by the relevant committee (e.g. QAIG) and executive lead.

Ongoing progress against the plans and tracking of subsequent incident trends will be monitored by the relevant improvement group and overseen by the relevant Trust committee.

The table below defines the criteria the Trust will use to decide which incidents require a Patient Safety Incident Investigation (PSII) to be undertaken.

Table Three – PSII criteria

Criteria for PSII response	Considerations
Potential for learning and improvement	• Increased knowledge: potential to generate new information, novel insights, or bridge a gap in current understanding

	• Likelihood of influencing healthcare systems, professional practice, safety culture. • Feasibility: practicality of conducting an appropriately rigorous PSII • Value: extent of overlap with other improvement work; adequacy of past actions
Systemic risk	• Complexity of interactions between different parts of the healthcare system

Appendix 1: Local patient safety priorities

Priority	Patient safety incident type or issue	Planned response / Sampling technique	Improvement route
1.	Implementing care / deteriorating patient resulting in delayed admission to hospital	Any incident with themes corresponding to the Trust Deteriorating Patient Improvement Plan will be managed via the associated improvement group. Any incident with themes not already captured on the Trust Improvement Plan will be managed in line with Priority 6 with an appropriate learning response tool e.g. PSII, After Action Review (AAR), SWARM huddle, Multidisciplinary Team (MDT) review, Patient Safety Learning Review (PSLR).	Trust improvement plan (based on Model for Improvement) monitored through Quality & Improvement Group (QAIG) and escalations through Chairs assurance report to Quality Committee. Escalations outside of this meeting regime will take place from the Head of Clinical Governance to Deputy Director of Nursing & Quality (DDoNQ). PSII actions will be added and monitored through Datix.
2.	MRSA bacteraemia with care involvement from LCH or other Leeds healthcare partner	A PSII will be completed where a PIR would have been completed	Learning and improvement to be determined by PSII and added to Datix to track actions. These will also be aligned with a Trust Improvement Plan if relevant Learning will also continue to be shared at IPC Committee with a resultant flash report to QAIG

3.	Review of all E.coli bacteraemia, where circumstance is any of the following: • LCH inpatient, • E. coli is specified on Part One of a death certificate • IPC Team identify a recurrent trend or significant safety concern related to LCH Care.	Initial IPC review against the relevant Trust Improvement Plan Where new learning is identified, further review will be through a Rapid Review. A review of legal Duty of Candour will be completed for all.	This will be dependent on learning and the system approach required
4.	Unexpected death of people with a learning disability	Given the national evidence of health inequalities and avoidable deaths, a rapid review will be undertaken on all unexpected deaths of people with a formally recorded learning disability	Learning and improvement to be determined by rapid review process and progressed as agreed. LD lead to attend rapid review meetings These will also be aligned with a Trust Improvement Plan if relevant.
5.	Medicine incidents in Adult Business Unit	Medicine incidents will continue to be reported through Datix. 80% of these incidents are reported by Adult Business Unit (ABU) with trends remaining in normal	Given that episodically incident themes recur an improvement group will be established with ABU to provide assurance in relation to the embedding and sustainability of the previously identified improvement activity.

		variation for several years and 99.5% of these being low or no harm incidents	Rapid reviews will be conducted for all medicine incidents that result in moderate or severe harm to inform further investigation / improvement activity
6.	Moderate and severe harm incidents excluding pressure ulcers and falls (outside of priority 1, 2, 3 and 4) will be reviewed for Patient Safety Incident Investigation consideration.	Rapid review and managed in line with principles described in the PSIRP. A review of the statutory requirement for Duty of Candour will be completed for all	
7.	Mortality review has identified that a rapid review report requires completion for Patient Safety Incident Investigation consideration.	This will provide a robust process before the national requirement for deaths caused by an incident.	
8.	Near miss or no / low harm incidents identified to be high risk by the team or via the Business Unit Quality Lead monthly report	Reviewed for learning through a Rapid Review	

9.	Near miss, no and low harm incidents	Service level review and response.	

Appendix 2: Stakeholders

Stakeholder	Involvement
Trust board	The proposed patient safety incident profile (within the PSIRP) was presented to the Trust board for comment and ratification
Quality Committee	The proposed patient safety incident profile (within the PSIRP) was presented to the Quality Committee for comment and approval
Clinical Business Unit Senior Leadership Teams	The proposed patient safety incident profile (within the PSIRP) was shared with local clinical leads for comment
Front line staff	
Patient Safety Specialists	All Patient Safety Specialists have contributed to the data review and analysis and considered the proposed patient safety incident profile (within the PSIRP)
Trust Improvement Group leads	All three Trust Improvement Group leads have contributed to the data review and analysis and considered the proposed patient safety incident profile (within the PSIRP)
Patient safety partners	Patient safety partners have considered the safety incident profile and the draft Patient Safety Incident Response Policy and plan.
Third Sector Partners	
Healthwatch Leeds / Forum Central	The proposed patient safety incident profile was shared for comment
Patients	
Leeds office of the West Yorkshire Integrated Care Board (ICB)	The proposed patient safety incident profiles (within the PSIRP) were presented to the ICB for comment and final approval.

Appendix 3: National patient safety requirements

Patient safety incident type	Response	Improvement approach
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation (PSII)	Local organisational actions and feed these into the quality improvement activity
Death thought more likely than not to be due to problems in care. This can be identified through an incident and / or the learning from deaths process.	PSII	Local organisational actions and feed these into the quality improvement activity
Deaths of person who has lived with a learning disability or autism	Refer to Learning Disability Mortality Review Programme (LeDeR) for independent review of events leading up to the death LeDeR programme.	Respond to recommendations from LeDeR programme
Child death	Refer to Child Death Review process. If incident meets the learning from deaths criteria undertake a PSII.	Respond to recommendations from external programme and feed these into the safeguarding strategy as required.
Deaths in custody (e.g. police custody, prison) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO – carry out independent investigations in to deaths and complaints in police custody) or the Independent Office for Police Conduct (IOPC – police complaints watchdog who investigate the most serious complaints and conduct matters) to carry out the relevant investigations.	Respond to recommendations from PPO or IOPC.
Safeguarding incidents in which: 1) babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic	Refer to local authority safeguarding lead via LCH designated professionals for child and adult safeguarding. LCH will contribute towards domestic independent inquiries, joint targeted area inspections, child	Respond to recommendations from external programme and feed these into the safeguarding strategy as required.

abuse/violence 2) adults (over 18 years old) are in receipt of care and support needs from their local authority 3) the incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	
Domestic Homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel. The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	Respond to recommendations from external programme and feed these into the safeguarding strategy as required.
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII, with consideration of any local learning response	Respond to recommendations from external programme and feed these into the safeguarding strategy as required.
Incidents that meet the statutory Duty of Candour threshold (Regulation 20)	Will be reviewed on individual incident basis to determine most appropriate response to undertake to meet regulation 20	

APPENDIX 4

Key points

Proposed removals:

- Pressure ulcers will be removed from the plan as a safety priority however the Trust Improvement Group will continue to monitor incident trends and continue to progress the improvement work
- Falls will be removed from the plan as a safety priority however the Trust Improvement Group will continue to monitor incident trends and continue to progress the improvement work
- Successive self-harm incidents in our secure estate will be removed from the plan as a safety priority however all self-harm incidents will continue to be discussed at the weekly secure estate patient safety panel with HMP staff, LCH Quality Lead and SWYFT Mental Health staff.
- There has been no evidence to suggest we need to progress either Neighbourhood triage or meatal tears on to the 2025/6 PSIRP and therefore they will both be removed from the plan
- A caveat to all of the above removals is that any patient safety incident in these categories that is identified within the standard service level review to be of concern will still follow a robust review process in line with priority 6 of the PSIRP.

Proposed remain:

- All three IPC priorities will remain unchanged
- Deteriorating patient / sepsis will remain a PSIRP priority as this was only introduced last year and the Trust Improvement Group will continue
- Priorities 6 – 9 remain unchanged

Proposed additions:

- Unexpected death of people with a learning disability: Given the national evidence of health inequalities and avoidable deaths, a rapid review will be undertaken on all unexpected deaths of people with a formally recorded learning disability to enhance our learning of how we can reduce premature death in people with learning disabilities.

- Given that episodically incident themes recur in relation to medicines incidents in Adult Business Unit (ABU) an improvement group will be established with ABU to provide assurance in relation to the embedding and sustainability of the previously identified improvement activity.