Strategic Risk 2:
Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences, and reputational damage.

Strategic Objective: Work with communities to deliver personalised care / To embed equity in all that we do

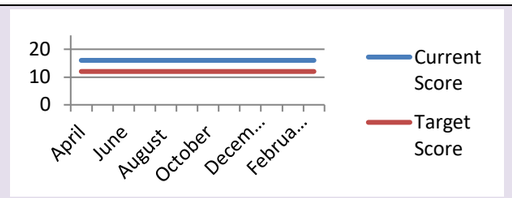
Risk Appetite: Minimal (low) to **cautious (moderate)** appetite to risk that could compromise the delivery of high quality, safe services.

Lead Director/risk owner: Executive Director of Operations

Committee with oversight: Quality and Business Committees

Date last reviewed: 27 February 2025

Risk Rating
(likelihood x consequence)
Current score:
4 x 4 = 16
Target score (end of 2024/25):
3 x 4 = 12



Rationale for current risk score:
Waiting lists have backed up during covid and there is increased demand for most services. The Trust has been unable to make significant impact on waiting lists. NHSE has mandated that there should be no 52-week waiters which increases the risk in relation to financial consequences and reputational damage.
Score not reduced, there remain areas with long waits and some require system support. The key mitigation is the Q&V programme, and this is a three-year programme.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Ultimately the risk appetite is 3 – the identified mitigations will begin to reduce the waiting lists over three years however tactical actions to improve financial position may have consequence on waiting lists.

Controls *(what are we currently doing about the risk?)*:

- Waiting list management and clinical triage within each service
- Communication with patients
- Incident monitoring and analysis
- Demand and capacity planning tool
- Continued support of 'harder to engage' populations through existing services
- Cancelled and rescheduled visits monitoring and action
- Commissioner involvement at Contract Management Board
- Performance panels
- Business continuity plans
- Winter plan 2024/25
- Review of capacity in Neighbourhood teams
- Front of House training for awareness of hearing and sight impediments – 4 sessions / year
- Neurodiversity assessments waiting list – right to choose offered to parents
- Patient Access Group

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

Action	Owner	Due by
Waiting list audit action plan (2023) Patient access group looking at action plan, service by service – notes and tracker	Executive Director of Operations	~~2024/25~~ Complete
Implementation of e-allocate – awaiting SystmOne changes roll out in May 25	Executive Director of Operations	~~March 2025~~ May 25
Transformation programme: improving prioritisation and flow (part of Q&V) Completed year 1 – moving to year 2 for different services	Executive Director of Operations	~~Year 1 complete~~ Year 2 Mar 2026
Service review as part of Quality and Value Programme, review of access criteria and ways of providing services, completed year 1 – moving to year 2 for different services	Executive Director of Operations	~~Year 1 complete~~ Year 2 Mar 2026
MindMate Single Point of Access – joint work with third sector re alternative single point of access BC 26/2/25 – agreement to move ahead	Executive Director of Operations	~~31 March 2025~~ 31 Oct 25
Accessibility data (diversity) – Manual Process in place to collect data through patient contact	Executive Director of Operations	To review progress at end of 25/26

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Service spotlight/focus (QC/BC) • Business cases (BC) • Change programme report (BC) • Performance panel (BC) – Sept 2024 BC position statement on waiting lists • Waiting List report (BC) • Access LCH project – (BC) • Organisation Strategy Update (BC/QC)	• Risk register report (QC/BC) • Patient Safety (including patient safety incident investigations) update report (QC) • Performance Brief (Responsive: waitlists) (QC/BC) • Cancelled and rescheduled visits report (QC) • Mortality report (QC) • Safe staffing report (QC/BC) • Significant contracts performance (BC) • Health Equity report (QC/BC)	• Patient Experience report (complaints, concerns, claims) (QC) • Internal audit (BC)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
Performance report reduction in numbers and reduction of people waiting in IMD1 – to go to BC	Executive Director of Operations	June 2025
Scrutiny Board minutes – to go to Board	Executive Director of Operations	June 2025

Link to Risk Register (material operational risks scoring 9 or above):

Risk 1048: Mind Mate SPA increasing backlog of referrals (system-wide risk) (15)
Risk 877: Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand (12)
Risk 1179: Impact/Management of Neurodevelopmental Assessment Waiting List (15)
Risk 1199: The impact and management of the CYPMHS therapies waiting list (12)
Risk 1198: Impact of ADHD medication waiting list (12)
Risk 1284: Staff capacity in children's speech and language therapy school age learning and dysphagia (SALD) service (9)
Risk 913: Increasing numbers of referrals for complex communication assessments in ICAN service risks breaching waiting time target. (9)
Risk 957: Increase in demand for the adult speech and language therapy service. (9)
Risk 954: Diabetes service waiting times (9)
Risk 994: Waiting times for community dental services (9)
Risk 1015: Delays in treatment for podiatry patients due to demand outstripping capacity (9)
Risk 1298: Patient missed appointments due to printing issues with new digital letters system (9)

Strategic Risk 3:
If the Trust fails to implement the agreed digital strategy, then, services could be inefficient, software may be vulnerable, and the impact will be delays in caring for patients and less than optimum quality of care.

Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do

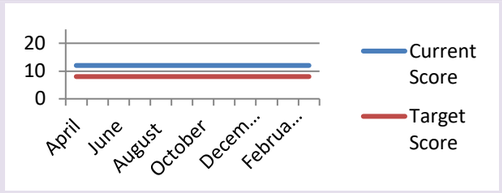
Risk Appetite: Open (high) risk appetite in pursuing innovation and challenging current working practices without compromising the quality of patient care. In the implementation of changes, the Trust has a **cautious (moderate)** risk appetite.

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

Committee with oversight: Quality and Business Committees

Date last reviewed: 10 March 2024

Risk Rating
(likelihood x consequence)
Current score:
3 x 4 = 12
Target score (end of 2024/25):
2 x 4 = 8



Rationale for current risk score:
3-year digital, data and technology strategy has been approved. Outputs from externally commissioned reviews will influence priorities and implementation plan. Timescales for implementation plan will be subject to affordability and will need to be considered alongside other competing priorities.
Actions not progressed sufficiently to reduce the score at this stage.
Needs review if correct strategic risk for 2025/26 – mitigation to demand / major incident / transformation resource risks.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Target score assumes mitigating actions are completed within the timelines identified below and implementation of the strategy is progressing against agreed milestones.

Controls *(what are we currently doing about the risk?)*:

- Board approved Digital, Data and Technology strategy and delivery plan.
- Established a new Digital Programme Board with links to Quality and Value Programme Data
- Secured Frontline digitisation investment to support implementation of a number of key priorities
- Commissioned external reviews to inform strategy refresh.
- Digital maturity assessment/ What good looks like assessment
- Independent IT resilience review completed
- IT Contracts register
- Business Case (Year 1 approved)

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

Action	Owner	Due by
Robust arrangements for the contract management of systems and services	Executive Director of Finance and Resources	~~Q4 2025~~ Q1 2025
Medium Term Financial Plan (to assess affordability of digital strategy beyond) – due date aligned to multi-year capital plan	Executive Director of Finance and Resources	~~Q3 2024~~ Q3 2025
Implement the recommendations of the IT Resilience review to provide a more comprehensive and reliable IT support strategy to underpin the Digital Strategy	Executive Director of Finance and Resources	Q4 25/26
Business Case (Year 2) in development	Executive Director of Finance and Resources	Q2 25/26

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Digital strategy progress report (BC / QC)	• Risk register (BC/QC) • Performance Brief (use of data to provide meaningful information) (BC/QC) • Digital maturity assessment analysis	• Internal audit (BC/QC)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
CCIO reports to Quality Committee and Associate Director of IT to Business Committee, to be agreed and developed as part of Digital Strategy Programme reporting arrangements - reporting measures to digital strategy	Executive Director of Finance and Resources & Executive Medical Director	~~Q3~~ Q4 2024/25
Leeds City Digital Board (PEG / PLT) and links to the Programme Executive Group for visibility and priority sharing. Not currently operating / functioning, but needs to have its role clarified and how it supports organisational strategies	Executive Director of Finance and Resources	~~Q3 2024~~ Q2 2025/26
WY CIO Council newly established under new WY CDIO for development and management of the WY Digital, Data Strategy and priorities	Executive Director of Finance and Resources	Q4 2024
Agree outcome reporting measures for the Digital Strategy Progress report	Executive Director of Finance and Resources	Q4 24/25 Due

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1217: Digital and BI teams have insufficient capacity (9)
Risk 1220: A large proportion of the population are digitally excluded (9)
Risk 1223: Inadequate wide area network infrastructure (9)
Risk 1224: Lack of permanent third line IT support (9)

Strategic Risk 4: Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation, and adverse media attention.

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

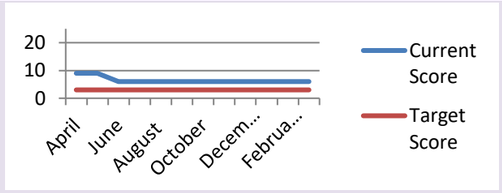
Risk Appetite: Minimal (low) to **cautious (moderate)** appetite to risk that could result in non-compliance and reputational damage. The Trust has no appetite for non-compliance with NHS Employers standards, fraud or financial loss.

Lead Director/risk owner: Trust Leadership Team

Committee with oversight: Quality and Business Committees

Date last reviewed: 12 March 2025

Risk Rating
(likelihood x consequence)
Current score:
2 x 3 = 6
Target score:
1 x 3 = 3



Rationale for current risk score:
Until the new CQC single assessment framework has been implemented and embedded, and an external well-led review undertaken, it is difficult to state how compliant the Trust currently is for 2024/25.
The Likelihood is 2 (unlikely) as the TLT considered that whilst the CQC single assessment framework implementation was in progress and a well-led review has been commissioned but not yet complete, the Trust has a CQC rating of Good and internal audit assurance has been provided in a number of areas of compliance.
Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The risk remains at 6, actions span the year end and as a result will not be reduced by 31 March 2025. New actions have been added relating to the implementation of the Well-led recommendations and the new CQC single assessment framework

Controls *(what are we currently doing about the risk?)*:

- Quality Challenge+ (action plans)
- Quality Account
- Premises Assurance Model
- Medical staff appraisal process
- Professional registration procedures
- Mortality review process
- Safeguarding Strategy
- Duty of candour monitoring process
- Information Governance compliance
- Care Act compliance
- Health and Safety management system
- Quality Improvement Plans - in response to external reviews
- Statutory & Mandatory Training compliance
- Compliance with Civil Contingency Act 2004 (EPRR arrangements)
- Seeking legal advice and acting upon it where needed
- People policies are compliant with employment law
- NICE guidance monitoring
- Recruitment and selection procedures
- Membership of collaboratives with system partners
- Code of Governance/Provider licence compliance
- Emergency Preparedness, Resilience and Response (EPRR) framework
- Patient safety incident response framework (PSIRF)
- Environment Act Compliance (Sustainability plan)
- HR conferences to review new case law impact on policies
- 2025/26 Trust priorities to capture business critical work

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

Action	Owner	Due by
To commission an external well-led review Procurement complete – review to take place Oct/Nov	Chief Executive Officer	Q4 2024/25 Complete
Implementation of the new CQC single assessment framework to align with Quality Challenge + programme In 25/26 We will begin implementing the new framework into processes. This will include a board development session and SLT session during financial year but official launch date by 31st March 2026.	Executive Director of Nursing and Allied Health Professionals	31 March 2026
Well-led action plan implementation	TLT	End of 25/26
Pull together a comprehensive list of legislative and regulatory requirements.	TLT	End of Q1 2025/26

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Clinical Governance report (QC) • Patient safety and serious incident report (QC) • Safeguarding report/minutes (QC) • Quality Strategy report (QC) • IPC BAF Report (QC) • Premises Assurance Model update (BC) • Health and Safety compliance report (BC) • Sustainability report (BC) • Workforce report (BC) • Information Governance Reporting (BC) • CEO report to Board (Board) • Employee relations report (Board) • Code of Governance compliance report (Board)	• Emergency Planning quarterly updates and annual report (BC) • Performance brief (statutory compliance) (QC and BC) • NICE guidance compliance (QC) • Mortality report (QC) • Medical Director's Report (appraisals info) (QC and Board) • Annual report to Board (Board) • MHLDA Committees in Common minutes and report (Board)	• CQC system assessment reports • Internal audit

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
6 monthly Board update on well-led	Head of Strategy, Change and Development	End Q1 2025/26

Link to Risk Register (material operational risks scoring 9 or above):
None

Strategic Risk 5:
There is a risk that the Trust will not be financially sustainable which will jeopardise delivery of all our strategic goals and priorities

Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do

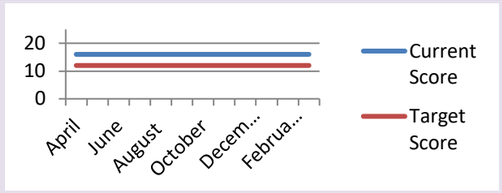
Risk Appetite: Open (high) appetite to the financial risk associated with new expenditure plans for existing services as the benefits for patient care may justify the investment. For investment in new services, the Trust's risk appetite is **cautious (moderate)** if the benefits to existing patients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

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

Committee with oversight: Business Committee

Date last reviewed: 7 March 2025

Risk Rating
(likelihood x consequence)
Current score:
4 x 4 = 16
Target score:
3 x 4 = 12



Rationale for current risk score:
The risk remains 16 until long-term sustainability is achieved. The scale of financial challenge across the NHS is significant, rising demand for services and inflationary cost pressures are increasing the levels of efficiency and productivity required of all organisations. The Trust has established a Quality and Value programme that has supported successful delivery of the financial plan in 24/25 however there remains an over reliance on non-recurrent savings. In addition, the Trust does not yet have an organisational strategy that is underpinned by long term financial plan, inclusive of a multi-year Q&V plan.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months)
By the end of the financial year 2025/26, we will have an organisation strategy that will be supported by financial plan

Controls *(what are we currently doing about the risk?)***:**

- Board Approved Annual Plan, revenue, and capital
- Financial controls including budgetary controls are in place with routine performance monitoring and assessment of financial risk/mitigations to inform achievement of the financial plan
- Staff Cost Controls including ECF Process, agency, and temporary staffing controls in place
- Financial Policies (incl. but not limited to SFIs/ Scheme of Delegation / Investment Policy)
- Training programme for Non-Finance Managers commissioned and being rolled out
- Quality & Value Programme Established & Embedded
- Budget Setting Process & Procedures clearly defined.
- Internal Audit assessment of Q&V programme structure (Part 1)
- Established process for Place /System Oversight supporting "difficult decisions"

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

Action	Owner	Due by
Establish a rolling Medium-Term Financial Plan and underpinning Q&V Programme rolling 3 year savings plan	EDFR	~~Jan 25~~ Q3 25/26
Commission Internal Audit review of effectiveness of Q&V Programme	EDFR	Q1 25/26
Consolidated workplan drawn from best practice "checklists" ensure no gaps in key controls that are required to underpin Financial Sustainability	EDFR	~~Q4 2024~~ Q1 2025
Investment policy. Note: Review has been undertaken, consideration needs to be given to the effectiveness of this as a standalone policy	EFDR	Q4 2024 Policy / process
Refresh of Performance & Accountability Framework - aligned to outputs from Well Led review	EFDR/ COO	Q3 25/26

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Procurement Strategy update report • Performance Panel process • Quality & Value Programme Board reporting • Organisation Strategy Update (BC/QC)	• In Year Financial reporting (performance against plan and forecast out-turn) • Financial performance summary report on formal partnerships • Risk register report • Audit Committee – Reporting of compliance with policies and self-assessment arrangements for financial sustainability	• Internal audit – incl. annual assessment of Key Financial Controls • External Audit – Value for Money Assessment • Benchmarking information e.g. Reference Costs, Corporate Benchmarking • ICS system oversight

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)***:**

Action	Owner	Due by
Review and strengthening of sources of assurance required:		
Enhanced financial performance reporting including progress against the Q&V programme, risk-based forecasting and underlying financial position to support oversight assurance	EDFR	End Q3 – Complete – financial reporting will continue to be reviewed and developed during 25/26
Refreshed strategic implementation plan for Procurement to support service level assurance	EDFR	Q3 – Complete
Improve service level assurance based on the refresh of the Performance and accountability framework. Due date amended to align with the action to refresh the framework and outputs from well led review	EDFR/COO	~~End 24/25~~ Q2 25/296

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1226: Quality and Value – financial balance not achieved (9)

Strategic Risk 6:
Failure to have sufficient resource for transformation programmes: If there is insufficient resource across the Trust to deliver the Trust's priorities and targeted major change programmes and their associated projects then it will fail to effectively transform services and the positive impact on quality and financial benefit may not be realised.

Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do

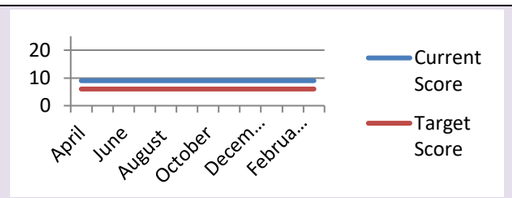
Risk Appetite: Open (high) appetite to the financial risk associated with new expenditure plans for existing services as the benefits for patient care may justify the investment. For investment in new services, the Trust's risk appetite is **cautious (moderate)** if the benefits to existing patients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

Lead Director/risk owner: Executive Director of Operations

Committee with oversight: Business Committee

Date last reviewed: 27 February 2025

Risk Rating
(likelihood x consequence)
Current score:
3 x 3 = 9
Target score (end of 2024/25):
2 x 3 = 6



Rationale for current risk score:
We are now satisfied that we have the right skills and capacity, however a risk remains relating to the prioritisation of local, system and national schemes. The risk score remains at 9.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Resourcing will be prioritised during 2025/26.

Controls *(what are we currently doing about the risk?)*:

- Estate Strategy
- Quality Improvement Strategy
- Third sector strategy work
- Quality & Value Programme and timeframes
- Digital strategy
- Greener plan
- Partnership arrangements
- Change Board oversight of major change programmes
- Business Development and Change Service
- Environmental impact assessments
- Systems working – intermediate care redesign
- Alliance Board – LCH and Leeds City Council
- Review process for response to tenders (includes opportunities for transformation resource)
- Quality & Value Vacancy Control Panel
- Funded establishment for transformation resources (in year)
- Additional posts funded for 25/26

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

Action	Owner	Due by
Business case for recurrent transformation resource Approved for 25/26 – resource to be in place by beginning of 25/26	Executive Director of Operations	~~November 2024~~ Complete

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Estates Strategy update reports (BC) • Digital strategy update reports (BC) • New business cases (QC/BC) • Major change programme updates on individual programmes (BC) • Priorities report (Board) • Business development report (BC) • Sustainability reports (BC) • Organisation Strategy Update (BC/QC)	• Consolidated reports on all major projects (Change Board) (BC)	• Internal audit report (BC) • IA review of Q&V programme (significant assurance) (BC)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
Require assurance we are focussing on the right priorities / conflict between local/system/national priorities	Executive Director of Operations	Q2 2025/26

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1229: Quality and Value – impact on corporate staff (9)

Strategic Risk 7:
Failure to maintain business continuity (including response to cyber security): If the Trust is unable to maintain business continuity in the event of significant disruption, then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.

Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

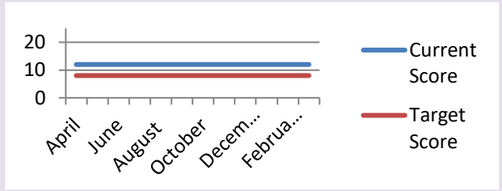
Risk Appetite: Cautious (moderate) appetite for risks relating to its reputation, the Trust's appetite is to ***avoid* risk *(*zero appetite*)*** of financial loss and **minimal (low)** to **cautious (moderate)** appetite to risk that could compromise the delivery of high quality, safe services.

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

Committee with oversight: Business and Audit Committees

Date last reviewed: 27 February 2025 (Executive Director of Operations) 7 March 2025 (Executive Director of Finance and Resources)

Risk Rating
(likelihood x consequence)
Current score:
3 x 4 = 12
Target score (end of 2024/25):
2 x 4 = 8



Rationale for current risk score:
Risk score assessed against the Number of High Severity Alerts received in the last quarter, the number of CSOC Cyber notifications indicating potential threats detected on the LCH infrastructure, the results from the most recent Phishing campaigns and penetration test (no of highs).
No change to the score at the year-end, the risk in relation to EPRR has reduced to 9, however the risk relating to cyber continues to be 12 due to the high threat level. – working towards compliance with the NHSE EPRR annual assurance process and implementation of the actions arising from the IT resilience review.
Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Ability to test Business Continuity plans with clinical services to test for prolonged service loss.
Deployment of the revised Cyber Incident Response Plan.

Controls *(what are we currently doing about the risk?)*:

- ICS wide command structure (OPEL)
- Critical services prioritisation
- ICS mutual aid support systems
- Trust command structure (Gold, Silver, Bronze)
- Business Continuity Plans (and IT disaster recovery plans)
- Information Governance Approval Group (data use and cyber related matters)
- Annual review of cyber resilience
- Data back-up systems (means of data recovery in the event of an attack)
- Technical controls secure the IT estate and data from unintended disclosure, theft or ransom: Software patching regime, smooth walls and firewalls, NHS Digital Advance Threat Protection Service, Multi Factor Authentication
- Annual data security statutory/mandatory training for all staff
- CareCert Weekly plus High Severity Alert Notifications for up-to-date alerts from NHS Digital to highlight risks
- Cyber response service contract with Jumpsec Ltd in place until September 2025 (recovery from attack) plus access to NHS England Cyber Incident Response Team.
- Major incident plan
- System testing / desk top exercises
- On-call rota and on-call escalation procedure

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

Action	Owner	Due by
EPRR compliance level -risk added to Risk Register in relation to non-compliance with NHSE EPRR annual assurance process. IA assurance on the workplan to achieve compliance by 2025/26 Further IA provide significant assurance on track re action plans, Trust to obtain assurance on BCPs (end Q2 25/26)	Executive Director of Operations	2025/26
Establish and implement target operating model for IT function, responding to findings from IT resilience review (risk 1187)	EFDR	Q2 2025/26
Maintenance of Cyber Essentials Plus Certification, including regular scanning and patching of all software and hardware Cyber Essentials Plus Certification expired 6/3/25 – non-compliant mobile devices being recalled (operational risk 1303)	Executive Director of Finance and Resources	~~March 2025~~ May 2025

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Emergency preparedness (annual) including self-assessment (BC then Board) • EPRR quarterly compliance updates to Business Committee and Board • Cyber Security Report (AC)	• Scrutiny of Major Incident Plan (annual) (BC then Board) • Reports regarding major incident exercises and deep dives (included in Emergency preparedness report (annual) (BC then Board) • Performance Brief (Responsive) (BC) • Information Governance Approval Group minutes (AC) • Statutory/mandatory training compliance (Performance Brief) (BC)	• Internal audit (BC/AC) • Data Security & Protection Toolkit audit (AC) • Cyber Essentials Plus Certification • Assurance from external contractors re: cyber security resilience recovery • Penetration Tests Results (AC)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
EPRR Quarterly updates and annual assessment	Director of Operations – (Accountable Emergency Officer)	~~Dec 2024~~ Complete
Updated Cyber Incident Response Plan Plan has been updated – Pending Internal Audit report and SLT approval	Executive Director of Finance and Resources	~~Dec 2024~~ End of Q1 2025
Engagement with contractor "Dark Armour" to provide assurance around cyber security / resilience	Executive Director of Finance and Resources	Mar 2025

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1187: Insufficient IT Resilience leading to the risk of extended outages of the infrastructure (12)
Risk 1230: Non-compliance with NHSE EPRR Annual Assurance process (12)
Risk 1296: Non-compliance with Data Security Protection Toolkit (DSPT) (9)
Risk 1303: Out of compliance mobile devices- there is a significant cohort of Android mobile phones (~130) which do not have a compliant O/S (12)

Strategic Risk 8:
Failure to have suitable and sufficient staff resource (including leadership): If the Trust does not have suitable and sufficient staff capacity, capability and leadership capacity and expertise, within an engaged and inclusive workforce then the impact will be a reduction in quality of care and staff wellbeing and a possible misalignment with the objectives of the Q&V programme.

Strategic Objective: Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

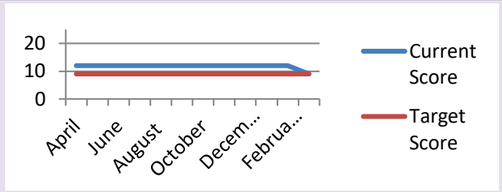
Risk Appetite: Avoid (zero risk appetite) noncompliance with NHS Employers Standards, employment fraud or lapses in professional qualifications. The Trust has an **open (high)** risk appetite to for learning and development opportunities which allows it scope to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work. **Minimal (low)** appetite to risks to staff safety and non-compliance with statutory and mandatory training requirements.

Lead Director/risk owner:
Director(s) of Workforce (DoW)

Committee with oversight: Business Committee

Date last reviewed: 6 March 2025

Risk Rating
(likelihood x consequence)
Current score:
3 x 3 = 9
Target score (end of 2024/25):
3 x 3 = 9



Rationale for current risk score:
As at the end of March 2025 the score has reduced to target of 9 as the Trust has achieved the financial savings for 2024/25, turnover is low, and sickness is in line with previous years. This corresponds with the score of operational risk 1227.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
By the end of 2024/25 we will have more certainty of the progress of the Quality and Value programme, and controls will have had the opportunity to take effect.
The target score will be reduced for 2025/26 when there is more clarity on the financial challenge (external environment / additional financial savings).

Controls *(what are we currently doing about the risk?)*:

- Workforce strategy – implementation and monitoring
- Workforce planning, including the maintenance of long-term talent pipelines, including BME programme
- Enhanced Vacancy control process – safeguards clinically essential roles
- Business unit workforce plans
- Apprenticeship scheme
- Guardian for safe working hour's role
- Digital tools for efficiency: e-rostering, e-Allocate
- Performance panel scrutiny and case conferences for longest standing/highest complexity absence cases
- Workforce and staff side expertise on Q&V programme board and relevant workstreams
- Staff side engagement through JNCF and JNC
- Engagement with staff networks
- Ask Selina – online questions to CEO
- Series of health and well-being initiatives
- Freedom to Speak Up Guardian and Champions
- WRES and WDES action plans
- Staff survey locally owned action plan and corporate actions
- Coaching and mentorship schemes
- Leaders Network
- Approach to leadership development
- Approach to Talent Management
- Organisational change policy
- Quality and Value Panel (vacancy review)
- People Task Group - cross cutting group across the Quality and Value programme

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

Action	Owner	Due by
Watching brief on sickness in 2025/26 – e.g. causes of stress / anxiety	Ann Hobson	Ongoing through 25/26

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Workforce report (3 x per year) • Q&V assurance report • Annual Equality and Inclusion Report • Employee relations activity report • Freedom to Speak Up Guardian reports • CEO report to Board • Service spotlight/focus • Organisation Strategy Update (BC/QC)	• Performance Brief (staff turnover figures, recruitment timescales, sickness absence, appraisal rate) • Safe staffing report • Guardian for safe working hours report • Priorities Quarterly Report • Quarterly and annual staff survey results • Business Committee workforce workshops	• Internal audit • Staff survey results report – leadership • Internal Audit of Q&V programme

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
Well-led quarterly reports	Head of Strategy, Change and Development	End Q1 2025/26

Link to Risk Register (material operational risks scoring 9 or above):
Risk 1227: Quality and Value – negative impact on staff (9)

Strategic Risk 9:

Failure to prevent harm and reduce inequalities experienced by our patients. If the trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently causing harm, delivering unfair care and exacerbating inequalities in health outcomes within some cohorts of patients.

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

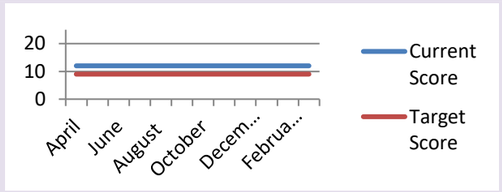
Risk Appetite: open (high) risk appetite for collaboration with people and communities to ensure their experience influences equitable approaches to change, such as for the Quality and Value Programme. Priority will be given to changes that protect equity and the Trust has a **cautious (moderate)** risk appetite for risk that may compromise the delivery of outcomes but are inclusive of an equity focus.

Lead Director/risk owner: Medical Director

Committee with oversight: Quality Committee / Trust Board

Date last reviewed: 4 March 2025

Risk Rating
(likelihood x consequence)
Current score:
4 x 3 = 12
Target score (end of 2024/25):
3 x 3 = 9



Rationale for current risk score:

- Likely (4) as inequity is (inadvertently) embedded within existing systems and processes and therefore continuation of business as usual is likely to create inequity.
- We have identified some areas where inequality exists in our current services and processes but do not yet have a full understanding of all areas and therefore cannot yet take action to reduce inequality in these areas.
- Consequence is both outcomes for population at risk of inequity and consequence for the Trust (e.g. for failure to comply with statutory duties relating to equity)
- Work has begun to embed action to address inequity, but change is slow for such a pervasive issue

The risk is unchanged as Q&V still underway, and actions are not business as usual / embedded. The Health Equity resource has reduced. The Internal Audit report suggests the risk has not reduced, and actions have been agreed to strengthen controls in several areas. These actions have been incorporated into the tables below.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
With financial factors at play it will take concerted effort to maintain the current risk score, but we should be aiming to reduce the likelihood of inequity.

Controls *(what are we currently doing about the risk?)***:**

- Elevation of the equity agenda to a Trust strategic objective
- We have a strategy and action plan and links with Quality and Value programme
- Programmes of work delivering on statutory duties
- Development of measurement framework for equity

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

Action	Owner	Due by
Further embedding equity in Quality and Value Programme • To ensure equity is a key consideration in the Quality and Value methodology from the very start and regularly revisited through 'equity pauses' in the work. • To start EQIAs as early as possible in the idea's generation phase of the QV service redesign methodology • To establish and monitor a QV EQIA tracker that support the iterative review of QV related EQIAS	Health Equity Lead	Ongoing
Strengthen governance and process for EQIA through implementation of Internal Audit recommendations.	Clinical Effectiveness and Compliance Manager	Q1 25/26
All-level sign-up to implement action plans around statutory duties (Equality Delivery System, Armed Forces Covenant, NHSE statement on inequalities, Patient and Carer Race Equality Framework (PCREF)) Equality Delivery System (EDS) and Armed Forces Covenant requirements met, and Veteran Aware accreditation achieved. EQIA processes reviewed and refined following Internal Audit. PCREF aligned with wider racial equity work, with oversight to come from a newly established Racial Equity in Care group and feeding into Heath Equity Leadership Group, along with other statutory requirements. There is an ongoing risk around our ability to consistently meet / fully understand our current position relating to reasonable adjustments and accessible information. The mitigation is a new person-centred care template, requiring the successful outcome of a business case for capacity to develop and implement the clinical systems solution.	Medical Director	Complete
Consistency in availability, analysis, and use of data: Board and Committee reporting include equity analysis and mitigating action; revised equity data dashboard/provision, to meet the requirements of the NHSE statement on inequalities. To strengthen the monitoring of the current strategy a measurement framework has been developed and, with support from the BI team, prioritised measures will be reported on to measure progress. Examples	Chairs of relevant Committees Head of Business Intelligence and Performance	~~2024/25~~ 1 Jan 2026

of good practice for metrics are well noted and will be used to develop quantifiable metrics within a future health equity strategy (standalone or equity elements integrated into the broader trust strategy)		
Co-ordination of the programme and associated activity to address inequity and deliver statutory duties needs to be sufficiently resourced Business case being developed	TLT	30 April 2025
Establish a Health Equity Working Group to report into the Governance Structure of the Trust with a joint action plan on health equity.	Consultant in Public Health	30 April 2025

Assurances *(how do we know if the things we are doing are having an impact?)*:

4. Service Level Assurance	5. Specialist Support / Oversight Assurance	6. Independent Assurance
• Equity report (statutory duties) to QAIG • Service/Business Unit performance reporting including focus on equitable approaches to waiting lists • Organisation Strategy Update (BC/QC)	• Report to Board including equity measurement framework	• Internal audit • External reporting on statutory duties • CQC

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)***:**

Action	Owner	Due by
Output from EQIAs to be developed to provide assurance to QAIG / QC	Head of Clinical Governance	End Q2 2025/26

Link to Risk Register (material operational risks scoring 9 or above):
None

Strategic Risk 10: Failure to collaborate. If the Trust does not work in partnership with other organisations, then systems will not provide a single offer for patients or achieve the best outcomes for all.

Strategic Objective: Collaborating with partners to enable people to live better lives / To embed equity in all that we do

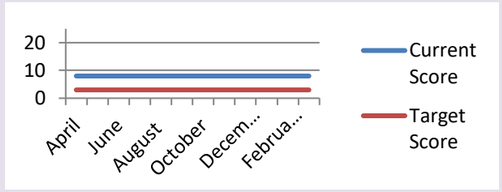
Risk Appetite: Open (high) risk appetite for developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with its statutory duties.
The Trust is supportive of innovation and has an ***open*** **(high)** risk appetite in pursuing innovation and challenging current working practices without compromising the quality of patient care. In the implementation of changes, the Trust has a ***cautious*** **(moderate)** risk appetite.

Lead Director/risk owner: Chief Executive

Committee with oversight: Trust Board

Date last reviewed: 11 March 2025

Risk Rating
(likelihood x consequence)
Current score:
2 x 4 = 8
Target score (end of 2024/25):
1 x 3 = 3



Rationale for current risk score:
Current financial planning suggests a possible impact on the Trust's ability to collaborate with others.
The risk score remains at 8 as actions are in progress.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Once due diligence has been undertaken and the best frameworks for collaboration established, both the consequence and likelihood are anticipated to reduce.

Controls *(what are we currently doing about the risk?)***:**

- Work with Local Care Partnerships
- Involvement in Leeds Clinical Senate
- Integrated nursing programme
- Leeds One Workforce Strategic Board
- NHS Oversight framework
- Third Sector Strategy
- PCN offer
- Involvement in projects for WY ICS
- MHLDA collaborative (and CiC)
- Leeds Committee of the ICB member
- Register of partnerships/contracts
- Community Services Collaborative
- Attendance at Primary Care Partnership, which oversees joint working in City
- Leading response to intermediate care procurement model
- TOR and MOU for major partnership arrangements
- Standards for Partnership Governance (framework)
- Social Care Alliance Board – chaired by LCH CEO and Social Services
- Leeds MWB alliance
- Board to Board meetings with Leeds Teaching Hospitals – agreement to work together on key strategic projects

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

Action	Owner	Due by
Establish the Trust's role in collaborations with other organisations	Chief Executive Officer	~~End of 2024/25~~ Continue into 25/26
Further work on the Social Care Alliance Board and legal framework	Chief Executive Officer	Ongoing
Establish LCH role in Neighbourhood model	Chief Executive Officer	Ongoing

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• CEO report to Board (TB) • 6 monthly financial performance summary report on formal partnerships (part of Performance Brief) (BC/TB) • Third Sector Strategy update reports (BC/TB) • Organisation Strategy Update (BC/QC)	• Minutes and updates from Mental Health Committees in Common (TB) • Reports from ICB (when available) • Reports from Leeds Committee of ICB (when available) • Risk register (QC/BC/TB) • Scrutiny of new partnerships arrangements at committees (QC/BC)	• Minutes from Scrutiny Board (TB) • CQC system assessment reports (QC/TB)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)***:**

Action	Owner	Due by

Link to Risk Register (material operational risks scoring 9 or above):
None

Agenda item:	2025-26 (18a)

Title of report:	Going Concern Consideration

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

Presented by:	Andrea Osbourne – Executive Director of Finance					
Prepared by:	Annette Clough – Assistant Director of Finance – Financial Control					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	√

Executive Summary:	In preparing the annual accounts those charged with governance are specifically required to consider whether the Trust is a going concern so that financial statements are prepared on that basis. This report has been prepared to assist the Board with this consideration.

Previously considered by:	Audit Committee 11 March 2025

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

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

Recommendation(s)	The Audit Committee reviewed the consideration on 11 March and recommends to the Board that it approves the preparation of the 2024/25 annual accounts on a going concern basis.

List of Appendices:	

1.0 PURPOSE OF THIS REPORT

1.1 In preparing the annual accounts those charged with governance are specifically required to consider whether the Trust is a going concern so that financial statements are prepared on that basis. This report has been prepared to assist the Board with this consideration.

2.0 BACKGROUND

2.1 The going concern concept forms part of the completion of the Trust's accounts. It enables the external auditors to properly assess the Trust's accounts to ensure they are a "true and fair" reflection of the financial position at the end of the reporting period.

2.2 NHS trusts are considered to be going concerns unless there are plans to dissolve them. There are no plans to dissolve Leeds Community Healthcare and therefore the 2024/25 accounts should be on the basis of a going concern.

2.3 Accounting standard IAS 1, Presentation of Financial Statements, requires management to make an assessment of the Trust's ability to continue as a going concern and this paper considers the risks to the Trust's financial stability. The Treasury's Financial Reporting Manual (FReM) interprets IAS 1 in such a way that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern.

2.4 In the UK, the period used by those charged with governance in making their assessment is usually at least one year from the date of approval of the financial statements.

2.5 The financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

2.6 Where management are aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the Trust, these should be disclosed.

3.0 CONTENT

3.1 There are several areas of risk to be considered when assessing an organisation's financial standing and sustainability separate to the going concern consideration. Those applicable to a NHS Trust are considered below.

3.2 The Trust's financial monitoring throughout 2024/25 provides evidence that financial duties and targets will be met. The Trust is forecasting to achieve a £1.9m surplus agreed with WYICB by the end of March. Historically, the Trust has achieved all its regulatory financial duties.

3.2 The Trust's financial performance is monitored externally by NHS England through monthly reporting. The West Yorkshire ICB receives monthly high-level updates on the financial position, revenue and capital, and there are monthly Director led meetings to discuss the West Yorkshire ICB overall position. Internally, the Trust's financial performance has been monitored monthly by the Trust Leadership Team and by the Business Committee and the Board at each of their meetings.

3.3 The Trust expects to have a detailed income and expenditure revenue budget for the year approved by the Board by 31st March 2025. A source and application capital plan will also be presented to the Board for approval.

3.4 The Trust's liquidity remains very strong with circa £45m forecast to be in the bank at year-end; £48.3m was held at the end of January 2025. The Trust is confident it has sufficient cash resources to meet all its liabilities in 2025/26.

3.5 The Board has inherently considered the matter of the Trust as a going concern, through its ongoing assessment of sustainability and the resources needed to ensure it continues in operational existence for the foreseeable future.

3.6 The management team has no intention of applying to the Secretary of State for dissolution of the Trust.

3.7 The planning and contracting processes for 2025/26 have commenced and are being led by West Yorkshire ICB and the Trust is participating fully in the revenue and capital planning for 2025/26. NHS contracts are due to be signed with Commissioners by the end of March 2025. Whilst we remain in a recurrent financially challenged system, and face a number of risks and uncertainties, there is clear evidence of continued provision of services being planned by Commissioners.

3.8 The Trust successfully won the tender with the Local Authority for Sexual Health Services and the contract commenced on 1 July 2024 and runs until 31 March 2030.

3.9 The contract with the Police Commissioners was extended in 2022/23 for three years until the 25 March 2025. The Trust has agreed an extension to the

current Police Custody contract for eighteen months with a further six months potential.

3.10 The Trust is due to enter into a collaborative contract to provide dental services with Bradford District Care Trust as lead provider and Mid Yorks and Locala for a seven year contract with the option to extend for another three years. This is due to be signed in March 2025 and service delivery will commence in April.

3.11 The Trust was successful in its bid to retain the physical healthcare contract for Wetherby Young Offenders Institute; this new contract starts on 1 April 2025 and runs for four years with the option to extend for up to an additional three years.

3.12 The most recent CQC assessment of the Trust's service delivery rated services to be Good overall.

3.13 The management team is not aware of any operating or other issues that would prevent the annual accounts being prepared on a going concern basis.

4 CONCLUSION

4.1 Considering the matters in this paper and an awareness of all relevant information it is concluded that there are no material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern.

4.2 The final version of management's assessment of going concern will be presented to the Board at the meeting at which the accounts and annual report are approved.

4.3 If any material matters come to light between now and the approval of the accounts they will be disclosed in the accounts and drawn to the Board's attention.

5 RECOMMENDATIONS

5.1.1 The Audit Committee reviewed the consideration on 11 March 2025 and recommends to the Board that it approves the preparation of the 2024/25 annual accounts on a going concern basis.

Agenda item:	2025-26 (18bi)

Title of report:	Declarations of interest and compliance with fit and proper person requirements made by directors for 2024/25

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

Presented by:	Chief Executive					
Prepared by:	Company Secretary					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	This paper covers the declarations of interest and fit and proper person requirements for consideration on an annual basis.

Previously considered by:	N/A

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

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

Recommendation(s)	Board is asked to: - Note the declarations of interest made by directors for 2024/25. - Note that the Trust is fully compliant with the Fit and Proper Person Test and Framework as at the date of this report. - Note the statement regarding the independence of Non-Executive Directors.

List of Appendices:	Appendix 1 – Director's declarations of interests for disclosure 2024/25

Board members: declarations of interest

As part of the actions to prepare the Trust's annual report and accounts, the Trust is required to collate the data on any declarations of interest disclosed by directors during the course of the year. The full schedule of disclosures is then included as part of the annual report.

The Trust's policy on declarations of interest requires directors to declare any significant financial or personal interests that each member, or a close relative or associate (such as partner, child, or sibling) has in any business or other activity or pursuit which may compete (or intends to compete) for any contract or agreement to supply goods or services to the Trust. In addition, directors are asked to declare: any other substantial connection or position of trust with related organisations; any other commercial interest; any area of potential conflict and details of hospitality or gifts in excess of £35.

All directors have reviewed and updated their declarations of interest and a schedule of disclosures for 2024/25 can be found in Appendix 1 to this report.

Board members: fit and proper person requirements

The Health and Social Care Act 2008 (regulated activities) Regulations 2014 set out requirements by which all directors should be, and continue to be, fit and proper persons by nature of the fact they hold positions of significant responsibility and can maintain the confidence of public, patients and staff.

Following the 2019 Kark Review of the original Fit and Person Test, a Fit and Proper Person Test (FPPT) Framework was introduced in Summer 2023 with the aim of strengthening and reinforcing individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. The new framework introduced a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

The regulations require directors to:

- be of good character
- have the necessary qualifications, competence, skills and experience
- be able by reason of their health (subject to reasonable adjustments) to properly perform tasks intrinsic to the position
- not have been responsible for, contributed to or facilitated any serious misconduct or mismanagement while carrying out a regulated activity
- not to be unfit to hold office on a range of grounds (eg undischarged bankruptcy, criminal convictions, inclusion on barred lists, serious misconduct in the course of carrying out a regulated activity etc).

During February and March 2025, all directors have provided a self-attestation to confirm that they are in adherence with the FPPT requirements. In addition, annual checks have been conducted to confirm former satisfactory background checks are still current, these include Google and social media searches, health and social care regulators' checks, disqualified directors, insolvency and bankruptcy registers. As

per the guidance, checks have not been required where an interim director arrangement was in place for less than six weeks. Board Member References have been supplied for departing directors during the year.

Independence of Non-Executive Directors

All NEDs are regarded as independent, evidenced through the Board's Register of Interests, Board & Committee minutes, and their individual annual appraisals.

Recommendations

- Note the declarations of interest made by directors for 2024/25.
- Note that the Trust is fully compliant with the Fit and Proper Person Test and Framework as at the date of this report.
- Note the statement regarding the independence of Non-Executive Directors.

Helen Robinson
Company Secretary
14 March 2025

Date Declared	Employee	Role	Interest Type	Date Arose	Decision Making Groups	Interest Description (Abbreviated)	Provider	Value £'s	Approval
15/04/2024	Ian John Lewis	Non Executive Director	Nil Declaration	15/04/2024	Board of Directors			0	N/A
15/04/2024	Samantha Prince	Operational Director of Care Services	Outside/Secondary Employment	01/04/2024	Board of Directors	Justice of the Peace for England and Wales (West and North Yorkshire)	HM Courts and Tribunals Service	0	YES
16/04/2024	Ruth Burnett	Medical Director	Outside/Secondary Employment	01/04/2024	Board of Directors	Executive Medical Director and Caldicott Guardian	Leeds GP Confederation	0	YES
16/04/2024	Ruth Burnett	Medical Director	Outside/Secondary Employment	01/04/2024	Board of Directors	Sessional GP.Not in partnership, not salaried, no enumeration received but regular sessions as CPD	Crossley Street Practice	0	YES
16/04/2024	Alison Lowe	Non Executive Director	Outside/Secondary Employment	16/04/2024	Board of Directors	Trustee	Together Women	0	YES
16/04/2024	Alison Lowe	Non Executive Director	Outside/Secondary Employment	16/04/2024	Board of Directors	Trustee	Citizens Advice - Leeds	0	YES
16/04/2024	Alison Lowe	Non Executive Director	Outside/Secondary Employment	10/04/2024	Board of Directors	Director until 25th July 2024 when term of office ends	Blue Light Commercial	0	YES
16/04/2024	Alison Lowe	Non Executive Director	Outside/Secondary Employment	16/04/2024	Board of Directors	DMPC in West Yorkshire, employed by the Mayoral Combined Authority. We commission services within the CJS, e.g., the SARC and so on. There is a potential conflict if LCH I	Deputy mayor Policing and Crime	0	YES
17/04/2024	Stephanie Lawrence	Executive Director of Nursing	Outside/Secondary Employment	01/04/2024	Board of Directors	I work one day a week for CQC as the National professional advisor for community servcies	CQC	0	YES
17/04/2024	Stephanie Lawrence	Executive Director of Nursing	Outside/Secondary Employment	01/04/2024	Board of Directors	Work one day a week for GP Confederation in Leeds	GP Confederation	0	YES
17/04/2024	Stephanie Lawrence	Executive Director of Nursing	Loyalty Interests	01/04/2024	Board of Directors	I am a fellow of the QNI and as a result do some voluntary work within the organisation	Queens Nursing INstitute	0	YES
01/05/2024	Ruth Burnett	Medical Director	Loyalty Interests	01/04/2024	Board of Directors	Community and primary care representative on RSET (Rapid Service Evaluation Team)	NIHR	0	YES
09/05/2024	Jennifer Allen	Director of Workforce	Loyalty Interests	01/04/2024	Board of Directors	Husband is a partner at KPMG	KPMG	0	YES
09/05/2024	Jennifer Allen	Director of Workforce	Loyalty Interests	01/04/2024	Board of Directors	I volunteer regularly for Zarach a Leeds based charity.	Zarach	0	YES
09/05/2024	Jennifer Allen	Director of Workforce	Loyalty Interests	01/05/2024	Board of Directors	Husband is a Trustee for Age UK Leeds	Age UK Leeds	0	YES
09/05/2024	Jennifer Allen	Director of Workforce	Outside/Secondary Employment	01/04/2024	Board of Directors	I am also the Director of Workforce for the Leeds GP Confederation	Leeds GP Confederation	0	YES
16/05/2024	Ruth Burnett	Medical Director	Sponsored Events	08/05/2024	Board of Directors	Honorarium for chairing Leeds GP education event	Pulse 365	350	YES
23/05/2024	Laura Smith	Director of Workforce	Outside/Secondary Employment	01/04/2024	Board of Directors	I undertake some training & consultancy work on a self employed basis for the above organisation, as an Associate	Prospect Business Consulting and WellNorth Enterprises (also known as :	0	YES
23/05/2024	Laura Smith	Director of Workforce	Outside/Secondary Employment	01/04/2024	Board of Directors	Within my LCH role, I provide DoW support to the Leeds GP Confederation, which could at times represent a conflict of interest, eg if LCH and the Confed bid separately for th	Leeds GP Confederation	0	YES
24/07/2024	Helen Thomson	Non Executive Director	Nil Declaration	24/07/2024	Board of Directors			0	N/A
01/08/2024	Rachel Booth	Non Executive Director	Outside/Secondary Employment	01/04/2024	Board of Directors	Employed as a full-time Legal Director, managing legal affairs for UK provision and insurance businesses. The role is not a Board post.	Bupa UK	0	YES
16/09/2024	Robert Brodie Clark	Non Executive Director	Nil Declaration	16/09/2024	Board of Directors			0	N/A
03/10/2024	Khalil ur Rehman	Non Executive Director	Outside/Secondary Employment	01/04/2024	Board of Directors	NED role similar to LCH NED role & time committment	East Lancashire Hospitals NHS Trust Ltd	0	YES
03/10/2024	Khalil ur Rehman	Non Executive Director	Outside/Secondary Employment	01/05/2024	Board of Directors	Vice ChairSeacole is the NHS BAME NED network group	Seacole Group	0	YES
03/10/2024	Khalil ur Rehman	Non Executive Director	Outside/Secondary Employment	01/10/2024	Board of Directors	NED & Charity Trustee	Association of NHS Charities - NHS Charities Together	0	YES
03/10/2024	Khalil ur Rehman	Non Executive Director	Outside/Secondary Employment	04/08/2024	Board of Directors	part time IT & Digital consultant via TSI Caritas Ltd (see shareholding declaration)	Touchstone Leeds Ltd	0	YES
03/10/2024	Khalil ur Rehman	Non Executive Director	Shareholdings and other ownership int	01/04/2024	Board of Directors	100-ordinary	TSI Caritas Ltd	0	N/A
03/10/2024	Khalil ur Rehman	Non Executive Director	Outside/Secondary Employment	01/04/2024	Board of Directors	Board Member/NED on governing body.	University of Central Lancashire	0	YES
08/11/2024	Rachel Booth	Non Executive Director	Outside/Secondary Employment	22/10/2024	Board of Directors	Chief Risk Officer	BUPA UK	0	YES
21/11/2024	Selina Douglas	Chief Executive	Outside/Secondary Employment	15/04/2024	Board of Directors	Trustee of charity (formerly HumanKind)	Waythrough	0	YES
25/11/2024	Ruth Burnett	Medical Director	Outside/Secondary Employment	25/11/2024	Board of Directors	Specialist reviewer bid paperwork for musculoskeletal and pain services. South of England only, non-compete and NDA agreed.	Practice Plus Group	0	YES
02/12/2024	Samantha Prince	Operational Director of Care Services	Hospitality	12/11/2024	Board of Directors	I was a speaker at NHS Providers conference, sponsored by Newton who are our Leeds HomeFirst delivery partner and were also co-sponsors for event. Newton arranged x 2 nights' accommodation (approx. £80/night) and speaker pass for the 2 day conference including evening meal.	Newton	160	YES
04/02/2025	Lynne Mellor	Non Executive Director	Outside/Secondary Employment	18/09/2024	Board of Directors	Business Consultancy specialising in Cyber and AI	The Human Digital Collaborative Ltd	0	YES
14/02/2025	Andrea Osborne	Director of Finance and Resources	Nil Declaration	14/02/2025	Board of Directors			0	N/A
25/02/2025	Lynsey Ure (Yeomans)	Executive Director of Nursing	Nil Declaration	25/02/2025	Board of Directors			0	N/A

Agenda item:	2025-26 (20)

Title of report:	Annual Senior Information Risk Officer (SIRO) Report

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

Presented by:	Andrea Osborne, Executive Director of Finance & Resources					
Prepared by:	Steve Creighton Head of IG and DPO					
Purpose: (Please tick ONE box only)	Assurance	x	Discussion		Approval	

Executive Summary:	The report briefs the Board on the IG agenda progression, the activities of the IG team, and the responsibilities of the Office of DPO to provide assurance on the effectiveness of controls for Information Governance, data protection and confidentiality Key points to note are : • there have been a number of operational pressures which have impacted on the Trusts ability to respond in a timely way to information requests. • work has commenced on the 2024/25 DSPT however due to the change in requirements there is a probability that we will submit with an “Action Plan” that details how we aim to meet the requirements. • A recall of a number of mobile phones is underway to ensure the operating systems are updated, our CE+ accreditation will temporarily lapse whilst this work is completed. • There has been 2 reportable data breaches during the period, both have now been closed as the ICO is satisfied with the Trusts response,

Previously considered by:	Audit Committee- 11th March 2025

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

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

Recommendation(s)	The Board is asked to note the extensive work undertaken by the team during the year, the staffing challenges that have impacted on performance and the changes introduced to continually improve system and processes.

List of Appendices:	Appendix 1-DSPT 2024/25 Initial assessment

Introduction

The report briefs the Board on the IG agenda progression, the activities of the IG team, and the responsibilities of the Office of DPO over the 2024-2025 period.

In providing assurance on the effectiveness of controls for Information Governance, data protection and confidentiality it will focus on the following key areas :

- Staffing levels
- DSPT (and associated workstreams)
- Cyber Essentials/Cyber Essentials +
- Record of Processing Activities
- Training Compliance
- Statutory requests
- Data Breaches
- Policies
- The other functions of the IG Team and Office of DPO.

Main Issues for consideration

Staffing levels

The team is currently made up of 5 staff , 5 WTE :

- Head of IG and DPO
- Information Governance Manager and deputy DPO
- Information Security Specialist
- Information Governance Administrator (x2)

During the year there has been significant changes in personnel, including periods where posts were vacant for significant periods as well as long term sickness.

This has impacted heavily upon the volume of work that the team was able to complete during this period, particularly in regard to processing statutory requests when quarter 3 proved particularly challenging.

Despite this, and whilst demands on the team remain high, we do not anticipate that this has or will impact on the Trusts strategic risk.

Data Security & Protection Toolkit (DSPT)

Compliance with the DSPT is mandatory for all NHS Trusts & organisations which have access to NHS patient data and systems.

The DSPT for 23/24 was self-assessment based around the ten security standards developed by the National Data Guardian and consisted of thirty-four assertion areas with 108 required evidence items. This was successfully completed and, for the first time, the Trust achieved “Standards Exceeded”.

As a requirement of the DSPT submission we were subject to an independent DSPT Audit conducted by Audit Yorkshire, to the specification stipulated by NHSE. The Audit rated the Trust with a High assurance level and a Moderate Risk Rating

The High assurance level denotes the organisation's self-assessment against the Toolkit differs/deviates only minimally from the Independent Assessment.

The Moderate overall risk rating reflects there are no standards rated as 'Unsatisfactory' or 'Limited' but, not all the standards are rated as 'Substantial' as two were rated as "Moderate"

For 2024/25 there have been significant changes to the DSPT, the current version aligns with the National Cyber Security Centre's (NCSC) Cyber Assurance Framework[1] (CAF) and introduces a new layer of complexity, as CAF focuses on building resilience against cybersecurity threats with a set of requirements across four key objectives:

1. Managing Risk
2. Protecting against Cyber Attack and Data Breaches
3. Detecting Cyber Events
4. Minimising the impact of incidents
5. Using and Sharing Information Appropriately (not part of official CAF, specific to DSPT and created for this purpose)

Each objective contains sub-requirements ("principles" further divided into "objectives"), and achieving the required compliance levels in all areas will be challenging.

The 2024/2025 DSPT was released in September, a baseline submission was required and submitted in December and a final submission is due in June.

This workstream has become the most pressing and prominent in terms of the teams workplan.

Key findings from the baseline assessment are presented in Appendix 1 which outlines the specific challenges to the Trust, and what resources and mitigations will be required in achieving compliance with the new DSPT . If the Trust is unable to meet the required outcomes, then we will have to submit our DSPT with an "Action Plan" that details how we aim to meet the requirements.

Of note, most Trusts and organisations who have moved to the new DSPT are reporting significant challenges with the new format and there is limited confidence in achieving "all standards met". In addition NHSE have described the new DSPT as both "an evolution, not a revolution" and "a multi-year journey" indicating an acknowledgement of the impact of the change in process.

[1] NSCS CAF Guidance < https://www.ncsc.gov.uk/collection/caf#:~:text=The%20National%20Cyber%20Security%20Centre,guidance%20linked%20from%20this%20collection >

In line with requirements of previous years, our DSPT submission will be audited by Audit Yorkshire- the Audit Framework was released to the Trust on the 11/2/2025 and fieldwork will be carried out throughout March.

As with previous iterations of the Toolkit, the Audit uses the "Strengthening Assurance Framework", which requires a more detailed and robust response than the CAF DSPT toolkit itself. A review of the Audit framework also shows area where the Trust may struggle to achieve high assurance- a paper is in development regarding this. The results of the audit will be instrumental in deciding if the Trust will submit with an action plan.

Cyber Essentials ("CE") & Cyber Essentials + ("CE+")

Cyber Essentials is a Government backed certification scheme, which helps to keep data safe from cyber attacks through the implementation of a set of a set of controls and processes. Of note, very little of the CE+ framework maps over to CAF, however the application of both in conjunction will significantly reduce our cyber risk surface

Although not mandatory, work towards CE+ has continued, however due to more rigorous constraints in this year's assessment there is significant work to be done regarding a cohort of approx. 130 mobile phones still running outdated operating systems.

Work is ongoing to recall and replace these devices, but until this can be achieved, the Trust will not pass the CE+ audit and our certification may temporarily lapse.

Record of Processing Activities

To be legally compliant with data protection legislation, our organisation must keep a Records of Processing Activities ("ROPA") register of all the different types of information it stores, shares, and receives. The registers contain the detailed information relating to both information assets and data flows with content such as:

Information Asset

- Whether the Asset is a major/critical asset
- Owner details
- Description of Asset
- Legal Basis for Processing
- Retention period
- Source of the Data
- Whether a DPIA was carried out
- Whether there has been a known data breach
- Access Controls

Data Flows

- Date of last review
- Purpose
- Inward or outbound flow

- Origin of data
- Category of data & recipient
- Format (paper, electronic)
- End point
- Any international transfer
- Security Control measures
- Risk level

The management of Information Asset Register (IAR) should be a rolling process, reinforcing GDPR compliance and adding value to the Trust by ensuring we know what information we hold and who is responsible for it. It is acknowledged that further work is required to strengthen the process and build resilience in this areas as due to limited capacity the team has been unable to address the IAR reviews since summer 2024. Meetings are being established with services from March onwards to address this however will require all teams to engage and prioritise this important work.

A specific and very significant part of the review of Information Assets has been rationalising the mass of paper records the Trust has in storage, with a view to destroying data past retention (there has been very little destroyed since the inception of the Trust, with many records predating it), and the consideration of selectively digitising some records which may still have value to the organisation.

Before the review commenced there were over 200,000 paper record items held by Restore (our storage provider), in a variety of types of file and box level storage.

A sizable initial cohort of records are being destroyed (~ 47 000). A second cohort of records (~ 400 boxes has been identified however destruction will be subject to approval of resources (not yet quantified)

The next phase of this work is to approach services with proposed retention and destruction dates for the approx. 110,000 items for which this is absent, Initial review indicates a very high proportion of those records are likely also past retention- approx. ~ 50000 of these items now have an indicated destruction date, pending ratification with the service that owns them.

The team are continuing to engage with services to minimise the amount of legacy paper records we hold.

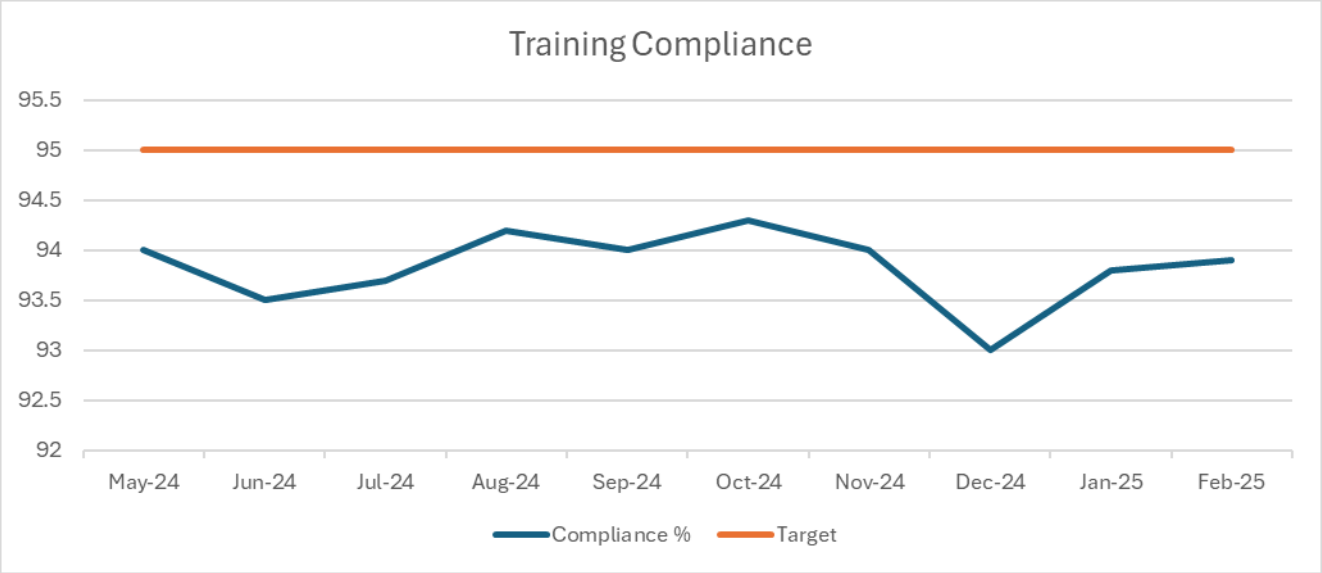
Training Compliance

The DSPT training requirement has changed from the traditional 95% target and now offers a greater degree of flexibility in regard to training that is relevant to the staff members role. The IG training matrix has been updated to include this.

Although the 95% threshold is no longer a requirement of DSPT, and other Trusts have lowered this to be in line with other stat/mand training, the Trust has continued to retain this target as a marker of good practice

The tables below show the current level of compliance, although this has reduced slightly the Trust continues to prioritise this training with Business Unit performance being monitored via the Performance Panel.

Assignment Count	Required	Achieved	Compliance %
3012	3014	2816	93.43%

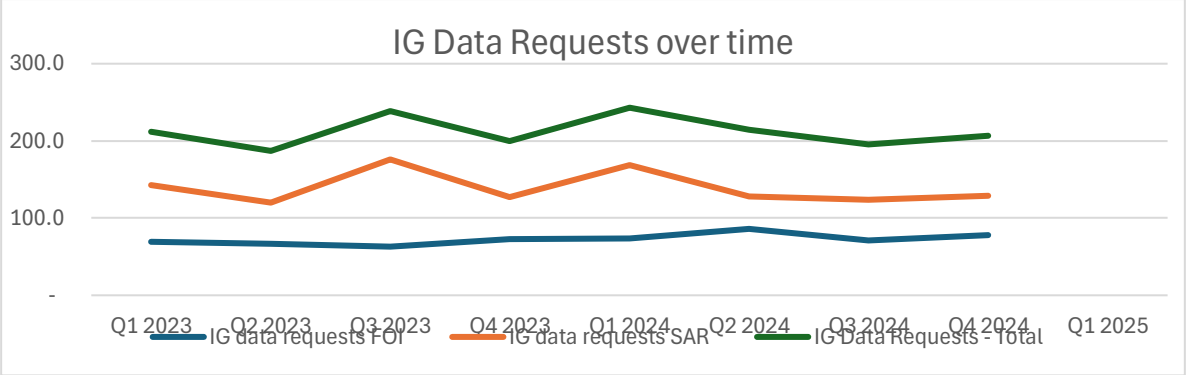


Business Unit	Assignment Count	Required	Achieved	Compliance %
833 Adult Business Unit	870	870	804	92.41%
833 Children's Business Unit	661	663	638	96.23%
833 Corporate Business Unit	278	278	250	89.93%
833 Operations Business Unit	469	469	419	89.34%
833 Specialist Business Unit	734	734	705	96.05%

Data Requests

The volume of requests for data continues to be high- the tables below highlight the number of overall requests received showing an increase of 114% for FOI and a slight overall decrease (caused by a relatively quiet July- September) of 3% against the prior year.

It is also noted that FOI requests in particular are increasing in complexity.



	2023	2024	Movement	%
FOI	272	309	37	14%
SAR	566	550	-16	-3%
Total	**838**	**859**	**21**	**3%**

In relation to FOIs a review has found that the Trust averaged an overall response rate of 66% within the expected 20-day time period, for 24/25 this dropped to 61%.The average timeframe for completion of an FOI request is:

- 2022/2023: 23 Days
- 2023/2024: 24 Days
- 2024/2025: 33 Days

Outstanding requests have been followed up and the backlog has been reduced from over 150 that were due to be addressed by December 2024, to less than 30 (largely with the Finance team who are continuing to prioritise dealing with the backlog).

A new tracking system has been implemented for both FOI and SAR which automatically creates appropriate dates for data to be retrieved from services, services to be chased, request to be released etc and allows “at a glance” RAG style reviewing of requests in progress – whilst this has significantly improved performance a number of residual issues remain and a review of the oversight and escalation process to support performance improvement is now being undertaken

Data Requests are shown below from January 2025, when we implemented a new tracking system for requests

	SAR	FOI
Qtr1	**78**	**64**
Jan	**41**	**36**
In Progress	3	12
On Time	38	22
Late		2
Feb	**37**	**28**
In Progress	33	18
On Time	4	10

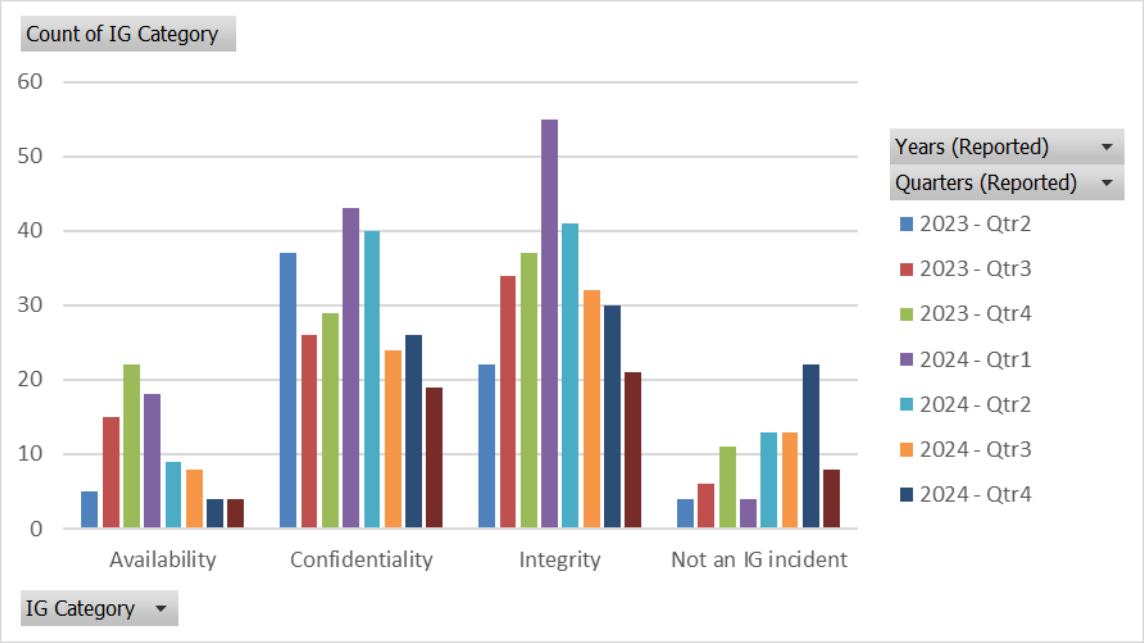
Noting that most FOI "in progress" from January (with the exception of those were there has been an extension) will inevitably exceed the statutory timescales as they have been in progress for 20+ days.

Data Breaches

All data breaches are evaluated by the IG team and graded by the IG Team against our NHS Digital aligned policy where they are categorised as "Confidentiality, "Integrity" or "Availability" breaches (The "CIA Triad") , and if they are found to meet the appropriate threshold, they are reported via DSPT to the ICO and/or DHSC as appropriate.

Figures showing changes year on year figures for each category are shown below:

	2023			**23 Total**	2024				**24 Total**	2025	**25 Total**
	Qtr2	Qtr 3	Qtr 4		Qtr1	Qtr 2	Qtr 3	Qtr 4		Qtr1	
Availability	5	15	22	**42**	18	9	8	4	**39**	4	**4**
Confidentiality	37	26	29	**92**	43	40	24	26	**133**	19	**19**
Integrity	22	34	37	**93**	55	41	32	30	**158**	21	**21**
Not IG incident	4	6	11	**21**	4	13	13	22	**52**	8	**8**
Grand Total	**68**	**81**	**99**	**248**	**120**	**103**	**77**	**82**	**382**	**52**	**52**



These patterns (and others within the data regarding e.g. the teams that report the most incidents) remain consistent with those found in previous years- the team carries out regular routine reviews to look at patterns within Datix received and although due to capacity issues within the team these have not been happening regularly since Q2 these have now been reinstated).

Certain services routinely report higher numbers of incidents (although not necessarily of greater severity)- the reasons for this are unclear but are likely to be either the services experience more incidents (and this may be purely because of their “size”), those services are particularly vigilant in noting and recording incidents, or the data that they routinely manage is of a higher level of risk.

Services that combined make up 90% of reported incidents are shown below:

	2023	2024	2025
Leeds Mental Wellbeing Service (LMWS)	37	63	11
0-19 PHINS	25	56	9
CAMHS	22	33	8
Patient Flow Services	17		
South Yorkshire Custody Suites	11		
West Yorkshire Custody Suites	10		

Reportable Data Breaches

Over the last year there have been three data breaches that the Trust has evaluated as reaching the threshold to report via the DSPT

Of these, only two have met the threshold to be reportable to the ICO:

Incident one:

This breach was as a result of a Leeds GP practice sharing a child's full record .

The Father approached The Child's GP surgery with a Subject Access Request, and the GP surgery also erroneously gave them The Childs data from LCH (for which they are not Data Controller) as well as the Primary Care data when printing off from TPP/S1

This occurred due to the functionality of the TPP/S1 Electronic Healthcare Record that allows the sharing of records between Community and Primary Care within Leeds (i.e. we can see their records, they can see ours) for purposes of Direct Care.

- The record contained references to domestic violence, which were disclosed to the father; we are supporting the family in regard to this matter.

- the breach was not perpetrated by LCH, but by another organisation in error. The ICO has been fully satisfied with our response to this data breach.

- The risk of this type of data sharing has been recognised however the risk of not sharing data between providers is also recognised as a significant risk e.g. as per Caldicott reviews.

- In response to the data breach the Trust approached the DPO for the GP Surgery who advised that he will carry out remedial training with the practice to prevent this error from reoccurring and will reinforce the message via information bulletins to all practices.

Incident Two:

We were made aware of a legacy staff directory from 2022 containing 300+ staff names and details from the Leeds Mental Wellbeing Service was available over the internet.

This was discovered by one of our partner organisations when using then Bing search engine and the search term: "iaptleeds.org.uk" (this was only visible using Bing, not other search engines).

The data disclosed included; Employing organisation, Team Name, Role, Work email, Office number, Pronoun, and in some cases there was also information regarding Sickness or maternity leave.

Actions were immediately taken to remove the directory and inform all affected staff, and as the data contained details of staff working for other organisations the DPOs of those organisations were also informed.

Dialogue is ongoing with affected organisations, and we have informed them of the details of affected users.

Data Controllership of the data is also being investigated as it appears the data, although maintained by LCH, was hosted on a domain owned by a partner organisation.

Our investigations have shown that the website used to host the data was insecure, and we are advising that appropriate security certification needs to be applied

The ICO have been satisfied with our response to both breaches and have closed the cases.

The ICO have also been satisfied with our responses to all previous breaches reported in the last update to committee.

Policies

All IG Policies are up to date and have been, or are currently being, ratified by the Clinical Corporate Policies Group (CCPG).

Over the last year the IG Team have developed two new Polices:

- PL397 N365 Usage Policy- The purpose of this policy is:
    - to provide the organisation's statement of intent on how it sets-up, secures and uses data used on N365.
    - to provide staff with additional detail and to advise on appropriate guidance when using solutions within N365 in order to reduce the risk associated with corporate use of the platform.
    - To provide employees with their obligations and expectations when using solutions within N365 in order to reduce the risk associated with corporate use.

Minimum requirement to be monitored / audited	Process for monitoring / audit
Data Usage	All instances where approval is required will be discussed by IG and wider Informatics Team
Security Controls	Ensure that when N365 entity is set up that appropriate controls are applied
User management	Ensure that appropriate owners are set up for each N365 entity. Management of Users, guests etc within the entity will be the responsibility of the Owner

- PL399 (draft) AI policy - The purpose of this policy is:

    - To outline the principles and guidelines for the responsible use of AI in all aspects of the Trust's operations, including clinical care, research, administration, and operational functions.
    - Align AI implementation with Data Protection regulations and Information Governance standards.
    - Ensure AI tools prioritise patient safety, dignity, and high-quality care.
    - Foster ethical adoption of AI, mitigating risks while capitalising on its benefits.
    - Support informed decision-making, emphasising clinical and professional judgment over AI outputs.

Minimum requirement to be monitored / audited	Process for monitoring / audit
Clinical safety case report for all AI systems used for clinical care	Review of the clinical safety case report
Review of all IT systems to confirm use (or not) of AI within the system	Review known systems used at LCH.
Incidents involving digital systems with AI or Machine Learning.	Review Datix reports and investigate
DPIA for each system using AI or Machine Learning	Review DPIAs for all systems using AI

More General adherence to policy will be measured and promoted by:

- The number of policy violation detected e.g. by Datix reporting
- Communications to staff re policy requirements
- Regular reviews of DPIAs and proposals to use the technology within the policy remit

<u>Other IG functions:</u>

The committee is asked to also consider the other work done by the IG Team and Office of DPO to support the Trust. This includes, but is not limited to: