Bundle Public Board Meeting 5 June 2025

Agenda
Final Agenda Public_Board_Meeting_5 June_2025 27 05 2025

25 09:00 - Welcome, introductions and apologies

26 09:05 - Declarations of interest

27 Questions from members of the public
Minutes adoption for approval

28 Minutes of previous meeting and matters arising

28.a Minutes of the meeting: 1 April 2025
Item 28a Draft Public Board Minutes 1 April 2025

28.b Action log
Item 28b Public Board Action log 5 June 2025

29 09:10 - Patient's story: Children's Business Unit Speech and Language Therapy Team

30 09:30 - Chief Executive's report (Dr Sara Munro)
Item 30 CEO report - 5 June 2025 sd

31 09:40 - Trust Priorities 2024-25 End Of Year Report – reviewed by Business Committee May 2025
Item 31i 2024-25 Year End Trust Priorities Report
Item 31ii TP Dashboard End of Year Update FINALv3

32 09:50 - People Headlines and Strategy Update -reviewed by People and Culture Committee May 2025
Item 32 People Headlines and Strategy Update May 2025 V1.0
Item 32i People APPENDIX 1 Workforce Strategy Measures Dashboard - Apr 25 (1)
Item 32ii People APPENDIX 2 Workforce Strategy Delivery Dashboard - April 25

33 10:00 - Quality Committee Chair's Assurance Report: 27 May 2025
Item 33 Chairs assurance report - Quality Committee May 2025 Final

34 10:05 - Mortality Reports Quarter 4 and Annual Report 2024/25 – reviewed by Quality Committee May 2025
Item 34i Q4 Mortality Report for QC v1.0
Item 34ii Adult Mortality Report Flash Reports Q4 24-25 FINAL PDF V
Item 34ii QAIG flash report CBU Child Death Q4 24 - 25 FINAL
Item 34iv Annual Mortality Report 2024-2025 v1.1

35 10:25 - Business Committee Chair's Assurance Reports: 30 April 2025 (Written) 29 May 2025 (Verbal)
Item 35 Business Committee Chair's Assurance report 30 April 2025

36 10:30 - Audit Committee Chair's Assurance Report: 15 April 2025 (Khalil Rehman)
Item 36 Audit Committee Chair's Assurance Report April 2025

37 10:35 - Charitable Funds Update Report (Jodie Collins, Charitable Funds Administrator)
Item 37 Charitable Funds Update Board Paper June 2025

38 10:45 - Performance Report (Andrea Osborne)
Item 38i Performance Report Cover paper_Board
Item 38ii Performance Brief - Q4 2024-25 & April 2025

39 11:00 - Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024/25
Item 39i EPRR Covering paper - Board and Committee reports - May 2025
Item 39ii App 1 - Emergency Planning Annual Report - April 2025
Item 39iii App 2 - EPRR Core Standards Improvement Plan - 2024-2025

40 11:10 - Guardian Of Safe Working Hours Quarter 4 2024-45 (Dr Nallapetta Nagashree)
Item 40 GoSWH- Quarter4 report June 2025

41 11:20 - People and Culture Committee Terms of Reference – For Approval
Item 41i Cover paper - P&CC Draft ToR
Item 41ii People and Culture Committee TOR May 2025 V1 DRAFT

42 11:25 - People and Culture Committee Chair's Assurance Report: 21 May 2025 (Rachel Booth)
Item 42 P&CC Chairs assurance report May 25

43 11:30 - Code of Governance Compliance (Helen Robinson)
Item 43 Code of Governance Compliance June 2025

44 11:40 - Audit Committee Annual Report 2024-25 (Khalil Rehman)
Item 44i AC Annual report_effectiveness review_TOR April 2025 FINAL
Item 44ii Audit Committee TOR April 2025 V13 Draft with track changes

45 11:50 - Significant Risks and Risk Assurance Report (Lynsey Yeomans)
Item 45 Board Significant Risks report 050625

46 12:00 - Board Assurance Framework - Update On Review Process 2025-26 (Helen Robinson)
Item 46i Board Assurance Framework Update on Review Process for 25_26 May 25 Cover
Item 46ii Appendix 1 2025_26_BAF Summary of Proposed Strategic Risks

47 12:10 - Register of Sealings March – May 2025 (Dr Sara Munro)
Item 47 Use of Seal March to May 2025

48 12:15 - 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.

49 Blue Box Item: Quality Strategy – presented to the Quality Committee May 2025 (Lynsey Yeomans)
Item 49i Cover page Quality Strategy implementation plan June 2025
Item 49ii Draft implementation action plan quality strategy Quality Committee May 25

50 Blue Box Item: Workplan – to note
Item 50 Public Board workplan 2024-26 v11 23 05 2025

Leeds Community Healthcare NHS Trust

Trust Board Meeting Held In Public
Meeting Room 1
Ground Floor, Seacroft Clinic
3 Seacroft Crescent
Seacroft
Leeds LS14 6JD

Date 5 June 2025
Time 9.00am -12.20
Chair Brodie Clark CBE, Trust Chair

AGENDA			Paper
2025-26 25	9.00	**Welcome, Introductions and Apologies** *(Trust Chair)*	**N**
STANDING ITEMS			
2025-26 26	9.05	**Declarations Of Interest** *(Trust Chair)*	**N**
2025-26 27		**Questions From Members Of The Public**	**N**
2025-26 28		**Minutes Of Previous Meeting, Action Log And Matters Arising** *(Trust Chair)* *For approval*	
28a		Minutes of the meeting held on: 1 April 2025	**Y**
28b		Action log: 5 June 2025	**Y**
2025-26 29	9.10	**Patient story: Children's Business Unit Speech and Language Therapy Team** *(Lynsey Yeomans)*	**N**
STRATEGY AND PARTNERSHIPS			
2025-26 30	9.30	**Chief Executive's Report** *(Dr Sara Munro)*	**Y**
2025-26 31	9.40	**Trust Priorities 2024-25 End Of Year Report – reviewed by Business Committee May 2025** *(Andrea Osborne/Lynsey Yeomans)*	**Y**
2025-26 32	9.50	**People Headlines and Strategy Update-reviewed by People and Culture Committee May 2025** *(Laura Smith)*	**Y**
QUALITY AND SAFETY			
2025-26 33	10.00	**Quality Committee Chair's Assurance Report:** 27 May 2025 *(Helen Thomson)*	**Y**
2025-26 34	10.05	**Mortality Reports Quarter 4 and Annual Report 2024/25 – reviewed by Quality Committee May 2025** *(Dr Ruth Burnett)*	**Y**
BREAK			
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2025-26 35	10.25	**Business Committee Chair's Assurance Reports:** 30 April 2025 (Written) 29 May 2025 (Verbal) *(Lynne Mellor)*	**Y**
2025-26 36	10.30	**Audit Committee Chair's Assurance Report:** 15 April 2025 *(Khalil Rehman)*	**Y**
2025-26 37	10.35	**Charitable Funds Update Report** *(Jodie Collins, Charitable Funds Administrator)*	**Y**

2025-26 38	10.45	**Performance Report** *(Andrea Osborne)*	**Y**
2025-26 39	11.00	**Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024/25** *(Sam Prince)*	**Y**
WORKFORCE			
2025-26 40	11.10	**Guardian Of Safe Working Hours Quarter 4 2024-25** *(Dr Nallapetta Nagashree)*	**Y**
2025-26 41	11.20	**People and Culture Committee Terms of Reference –Draft For Approval** *(Rachel Booth/Laura Smith)*	**Y**
2025-26 42	11.25	**People and Culture Committee Chair's Assurance Report:** 21 May 2025 *(Rachel Booth)*	**Y**
GOVERNANCE AND WELL LED			
2025-26 43	11.30	**Code of Governance Compliance** *(Helen Robinson)*	**Y**
2025-26 44	11.40	**Audit Committee Annual Report 2024-25** *(Khalil Rehman)*	**Y**
2025-26 45	11.50	**Significant Risks and Risk Assurance Report** *(Lynsey Yeomans)*	**Y**
2025-26 46	12.00	**Board Assurance Framework - Update On Review Process For 2025-26** *(Helen Robinson)*	**Y**
2025-26 47	12.10	**Register of Sealings March – May 2025** *(Dr Sara Munro)*	**Y**
CLOSING BUSINESS			
2025-26 48	12.15	**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 48.

***Blue Box**		
2025-26 49	**Quality Strategy – presented to the Quality Committee May 2025** *(Lynsey Yeomans)*	**Y**
2025-26 50	**Workplan – to note**	**Y**

Agenda item:	2025-26 (28a)

Title of report:	Minutes Trust Board Meeting Held in Public: 1 April 2025

Meeting:	Trust Board Meeting Held in Public
Date:	5 June 2025

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

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

Previously considered by:	N/A

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

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

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

List of Appendices:	None

Attendance

Present:	Brodie Clark CBE	Trust Chair
	Selina Douglas	Chief Executive
	Rachel Booth (RB)	Non-Executive Director
	Dr Ruth Burnett	Executive Medical Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Lynne Mellor	Associate Non-Executive Director
	Andrea Osborne	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Khalil Rehman (KR)	Non-Executive Director
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
	Sheila Sorby	Deputy Director of Nursing & Quality and Director of Infection Prevention & Control (Deputising for the Executive Director of Nursing and AHPs)
Apologies:	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
	Alison Lowe	Non-Executive Director
	Helen Thomson Deputy Lieutenant (DL) (HT)	Non-Executive Director
	Lynsey Yeomans	Executive Director of Nursing and Allied Health Professionals (AHPs)
In attendance:	Helen Robinson	Company Secretary
	Rebecca Brownley	Clinical Professional Service Manager, Health Case Management Service (Item 5)
	Suzy Brock	Clinical Team Manager (Item 5)
	Dr. Nagashree Nallapeta,	Guardian of Safe Working Hours(Item 15)
Minutes:	Liz Thornton	Board Administrator
Observers:	None present	
Members of the public:	None present	

Item 2025-26 (1)

Discussion points:

Welcome introduction, apologies, and preliminary business

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

Apologies

Apologies for absence were received from Jenny Allen, Alison Lowe, Helen Thomson and Lynsey Yeomans.

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 Trust and the wider NHS at a time of significant change. The Trust Board and staff were rising to the challenge and working tirelessly to deliver high quality healthcare across the city.

Item 2025-26 (2)

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 2025-26 (3)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2025-26 (4)

Discussion points:

Minutes of the last meeting, matters arising and action log

a) Minutes of the meeting held on 6 February 2025

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

b) Action log

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. **Action closed.**

2024-25(128): Trust's representation and role on the Leeds Health and Care Partnership committees to be clarified: this would be covered by a discussion in the Private Board meeting **Action closed.**

There were no other actions or matters arising to address.

Item 2025-26 (5)

Discussion points:

Patient story:

The Board heard a story presented by the Healthcare Management Team. The patient had given permission for her story to be shared anonymously. The story was about a 38 year old lady, originally living in the community but now in a care home.

This lady was diagnosed with multiple sclerosis in 2012 and had associated complex health and care needs which required around the clock care. A presentation was shared which detailed the complexity of her care needs, personal relationships and the challenges faced by the Healthcare Management Team in managing her journey through the care system.

The Trust Chair thanked the members of staff for presenting a complex story so powerfully and invited questions from Board members.

The Trust Chair asked if members of the Team felt they were supported effectively enough to manage such complex and challenging cases. The members of staff said that these cases were emotionally draining but the Team worked well as a unit to support one another, and members of the leadership team were aware of the challenges faced in managing individual patients.

The Chief Executive provided assurance that the Trust worked hard to ensure that the appropriate psychological support was in place for staff and de-briefs were scheduled to allow leaning from every case to be considered.

Non-Executive Director (IL) noted that the patient had been under the care of the Trust for several years and asked whether some of the issues which had added to the complexity of her case, for example personal relationships and financial management, could have been identified earlier. The staff said that this was a particularly complex and challenging case. All cases were reviewed regularly and as a minimum annually. No concerns had been raised and a number of health professionals had been involved in her care including her GP.

The Trust Chair observed that this case had raised a number of issues which the Trust might want to consider further and which might benefit from further discussion by the Quality Committee.

He thanked the members of staff for taking time to attend the Board and present the case in such detail.

2025-26 Item (6)

Discussion points:

Chief Executive's report

The Chief Executive presented the report which focussed on:

- National and Regional NHS
- Quality and Value Programme
- Strategy
- System Flow
- Business Unit Updates
- Spotlight on…Education Health Care Plans
- Research & Development news

The Chief Executive referred to the recent announcement that Integrated Care Boards (ICBs) had been told they must cut operating costs by 50% by December 2025. She said that this was an intense period of change; the impact of which was not yet fully understood, but which must be considered within the Trust's future planning. Discussions were taking place at Board, Place and Regional level as to the next steps.

All Chief Executives in the Leeds System had received a letter from the ICB lead at regional level asking for organisations to draw up together a joined-up plan for proposals to deliver a neighbourhood health service that would bring together health and social care for the people in the communities. A formal agreement would be submitted by September to look at operational delivery of services.

The Board agreed that the proposals for change offered the Trust an opportunity to input into the development of a range of regional services in the future, but more clarity was required on the Board's future role and its contribution to influencing regional developments.

Non-Executive Director (IL) noted the importance of future engagement with primary care services and the Leeds GP Confederation.

The Chair commented that the Board should have the opportunity to review and comment on the draft Terms of Reference for the Leeds Place Review.

Action: Terms of Reference for the Leeds Place Review to be circulated to Board Members for comment.

Responsible Officer: Company Secretary

Outcome: the Board

- received and noted the report.

Item 2025-26 (7)

Discussion points:

Quality Committee Assurance Report: February 2025

A verbal report was presented by Non-Executive Director (IL), Deputy Chair of the Committee. He highlighted some of the key issues discussed including:

- Patient story – safeguarding/unexpected death: the story had generated a wide-ranging discussion about lessons learned.
- Patient Safety Incident Response Plan: the Committee recommended approval by the Trust Board. It was noted that some measures had been removed for example, pressure ulcers and falls but these would still be monitored through Statistical Process Control (SPC) Charts, and some new areas added, for example unexpected deaths in people with learning disabilities. Sources of assurance would come from the Improvement Group work.
- Performance brief: format continues to develop. Measures of productivity would come through to Quality and Business Committees in future reports.
- Quality and Value Report: planning for year 2 has begun and programme risks updated
- Committee Annual Report: the report was approved, along with proposed changes to the Terms of Reference.
- Risk report: the Committee discussed learning from 'things going wrong' and whether this was an organisational risk.

The Board was informed that **reasonable** assurance overall had been agreed for strategic risks 1, 2, 4 and 9. 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 2025-26 (8)

Discussion points:

Patient Safety Incident Response Plan (PSIRP)

The report was presented by the Deputy Director of Nursing and Quality and Director of Infection Prevention & Control.

The PSIRP set out the Trust's approach to reviewing incidents in line with both nationally and locally defined patient safety priorities. The plan remained a live document to allow flexibility to consider new and emerging patient safety issues and would be formally reviewed annually.

The plan took account of the premise of PSIRF which was for a proportionate approach to reviewing patient safety incidents to ensure learning and improvement.

The PSIRP for 2025/26 had been reviewed by the Quality Committee and recommended for approval and adoption from 1 April 2025 in place of the current plan. It was noted that some measures had been removed and some new areas added.

Non-Executive Director (IL) asked if any national guidance had been issued on the measures which had been removed.

The Deputy Director of Nursing and Quality advised that the priorities contained in the national guidance were included and the Trust had taken a similar approach to other Trusts. Assurance would be provided via reports from the Quality Improvement Groups.

Outcome: the Board

- approved the PSIRF and its adoption from 1 April 2025 in place of the current plan.

Item 2025-26 (9)

Discussion points

Business Committee Chairs Assurance Report – 27 February 2025 and 26 March 2025

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

27 February 2025

- The Committee received a presentation from the Workforce team which set out some suggestions for the new People and Culture Committee (P&CC). It was agreed that the P&CC would meet quarterly. The first meeting was scheduled for 21 May 2025.
- Committee received a proposal to sub-contract delivery of the MindMate SPA service to Northpoint and to transfer the current annual cost of the service (£719k) to Northpoint. The Committee requested a fully costed business case, to include consideration of the impact on health equity to be provided at a future meeting.
- The Committee received an update on access to planned care and noted that the waiting lists had reduced by 3000 patients in the current year with particular progress in podiatry, urology and adult speech and language therapy.

26 March 2025

- The Committee received a presentation from the Children's Community Nursing (CCN) Service - Community Intravenous Antibiotic Service (CIVAS) for children and young people.
- West Yorkshire Community Dental Services - Collaborative Business Case. The Committee received a paper which included the business case produced by Bradford District Care Trust (BDCT) as the coordinating provider of the West Yorkshire Community Dental Services Provider Collaborative and approved progressing the agreement of a sub-contract with BDCT for the provision of services in Leeds as outlined in the business case from 1 April 2025.

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 2025-26 (10)

Discussion points:

Audit Committee Assurance Report: March 2025

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

- The Committee agreed that more detail should be included in future Internal Audit reports where the independent validation process had shown actions closed without sufficient evidence, and responsible Executive Directors to be invited to attend Committee in such instances.
- The Committee discussed the possibility of secondary risks due to delays in the implementation of Internal Audit recommendations, and the need to reflect this in future reports. This would be considered as part of the remit of the Risk Management Group when established.
- Progress on The Data Security and Protection Toolkit (DSPT) Baseline Assessment was reviewed and challenges noted, with the possibility of an 'incomplete compliance' submission and an action plan being required. An Internal Audit report on the DSPT, once published, would be used to determine if an action plan was required.
- The Committee noted the draft Head of Internal Audit opinion which was based on internal audit work completed between April 2024 and March 2025. Final opinion to be presented to the April Committee meeting.

- The Committee reviewed and commented on the draft Internal Audit Plan for 2025/26, further discussions to be held with the Trust Leadership Team.
- Committee approved the 2025/26 Counter Fraud Plan.

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 2025-26 (11)

Discussion points:

Charitable Funds Chair's Assurance Report : March 2025

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

- The excellent work of the Charitable Funds Officer was commended as she continued to develop local networks to support the further development of the Trust's Charity.
- A grant submitted to the West Riding Masonic Community Fund for the Hannah House sensory room had secured £20,000 in funding.
- The Committee received fundraising updates in relation to events in the next 12 months including the Leeds 10k, CPR-a-thon, Yorkshire 3 Peaks Walk, and the Giving Voice Choir.
- The Committee annual report, self-assessment and Terms of Reference were received and accepted.
- The Committee discussed how to increase the visibility of the charity and fundraising work across the Trust.

Outcome: the Board

- noted the assurance report and the matters highlighted.

Item 2025-26 (12)

Performance Brief

The Executive Director of Finance and Resources presented the report which provided a summary of performance for the months of January and February 2025, and highlighted where performance improvements were being realised, and 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 February and March 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 drew attention to Appendix 11 which contained the High-Level Indicators to be selected for the performance brief. These were agreed in 2024 and she informed the Board that a number were still in development and the proposal was to continue with these for 2025/26.

Non-Executive Director (IL) said that he was disappointed about how reporting on effectiveness was reflected in the performance brief which currently had a narrow focus, despite this having been the subject of a recent Quality Committee workshop, and there were a range of issues which were not reported on including outcomes, improvement and research and development. He was also concerned that Key Performance Indicators had not been presented to the Quality Committee in March 2025.

The Executive Director of Finance and Resources provided assurance that the work in progress to improve reporting on effectiveness had not been paused but a fundamental review of all the Key Performance Indicators was planned to ensure that capacity was focussed appropriately.

The Executive Director of Operations provided a verbal update on the latest data on waiting lists. The total number of people waiting for care to start was continuing to decrease towards more sustainable levels. A total of circa. 22,000 people were waiting for care to start compared to 28,000 in July 2024. Although the total number of people waiting for care to start was continuing to decrease, she acknowledged that patients were still waiting too long. The Trust was taking all possible action to address the challenge but significant change or funding was required to have an impact on this.

Outcome: the Board

- received and noted the report.

Item 2025-26 (13)

Discussion points: Annual Plan 2025/26

a) Operational Plan 2025/26

The Executive Director of Finance and Resources presented the Plan which provided a summary of the final plan submission for 2025/26 covering:

- LCH business planning priorities and wildly important goals
- Workforce Plan
- Operational performance plan including mental health narrative and planning metrics

The Plan had been discussed in detail by members at a Board workshop in March 2025.

Outcome: the Board

- noted the operational plan for 2025/26.

b) Financial Planning and Operational Budgets 2025/2026

The paper provided the Board with an update on the financial planning work and formally confirmed the budgets for 2025/26 that had been submitted to NHSE on the 28 March 2025.

The Executive Director of Finance and Resources provided a verbal update of the key changes made since the report had been prepared none of which constituted a material change to the submission.

Outcome: the Board

- noted the final financial plan for 2025/26 and the changes made since the report had been prepared.

c) The Provider Assurance Statement (PAS)

The statement was shared on screen noting that this had been a new request for the Trust to complete received after the Board workshop in March. Although it was felt that all aspects of the statement had been covered within the workshop on the 6 March 2025 the Board were asked to formally review the PAS noting this was post-submission but providing an opportunity for further assurance / clarification as needed at this meeting.

The Board agreed that it was essential that a process and plan was in place to monitor and ensure delivery of the operational and financial plans for 2025/26 and this would be monitored and discussed further through reports to the Business and Quality Committees.

Outcome: the Board

- formally approved the statement.

Item 2025-26 (15)

Discussion points: This Item was taken out of agenda order.

Guardian for Safe Working Hours (GSWH)

The GSWH presented the report for Quarter 3 to provide assurance that doctors and dentists in training within the Trust were safely rostered and that their working hours were consistent with the Junior Doctors Contract 2016 Terms & Conditions of Service (TCS).

The main issues for consideration in this report were:

- Ongoing grievance case related to CAMHS rota issue
- Appointment of new LNC resident doctor representative.

Outcome: The Board:

- continued to support the GSWH with the work in relation to community paediatric training opportunities
- noted the risk for the Trust from the grievance case raised by Junior doctors affected by CAMHS historic rota issue
- noted the appointment of new LNC resident doctor representative

Item 2025-26 (14)

Discussion points:

Staff Survey 2024

The Director of Workforce, Organisational Development and System Development (LS) presented the report which detailed how the Trust performed in the 2024 National Staff Survey compared to the results in 2023 and the benchmarked group of community trusts across England.

The Board reviewed the results. There had been the expectation of a decline in scores, given the context, but members were encouraged to see that this was modest and that scores had been maintained for the majority of survey questions. The results were higher than the regional and national average across all People Promise themes and the staff engagement and morale scores.

Business units were currently developing action plans and there would be opportunities for the various staff networks to discuss specific results at their meetings.

It was noted that the scores compared less favourably with the Community Trust comparator group. Locally the Trust remained the highest performer of the Leeds NHS Trusts, both in terms of results and response rate.

Non-Executive Director (KR) suggested that it would be helpful to have more detailed service level results by way of 'heat maps,' and he expressed disappointment that opportunities and developments related to WRES had not been taken forward to a greater extent given the investment in this area.

The Director of Workforce, Organisational Development and System Development (LS) provided assurance that 'hot spots' had already been identified and action plans were in place.

Non-Executive Director (LM) noted the strong engagement figures and suggested that these results should be publicised more widely along with other positive results from the survey.

Outcome: The Board:

- noted the release of the 2024 Staff Survey results and the findings to date and endorsed the proposed approach to the dissemination of information.

Item 2025-26 (16)

Discussion points:

Significant Risks Risk Assurance Report

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

She highlighted the following key points:

- two risks on the Trust's risk register had a score of 15 or more (extreme)
- a total of 10 new risks had been added to the register since February 2025
- there were a total of 76 open risks.

The Board was updated on two new risks which had emerged since the report had been written and the Trust Chair and Vice Chair had been made aware of.

One related to the Trust re-registering the Nominated Individual with the Care Quality Commission (CQC). The risk had been scored at 12. The Chief Executive provided assurance that steps were being taken to mitigate the risk and she was in contact with the CQC.

The other related to staffing levels in domestic services. The Executive Director of Finance and Resources provided some background and context to the risk and the mitigations in place.

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 and the additional risks identified after the report had been submitted.

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 2025-26 (17)

Discussion points:

Board Assurance Framework (BAF)- quarterly update report

The Chief Executive presented the report. Following the agreement of the Trust's strategic objectives and priorities for 2024/25, the BAF was reviewed on a quarterly basis and the outcome shared with the Board.

The updated BAF was reviewed. The changes annotated in red reflected the output of the final quarterly review which had taken place during March with the support of the Executive Directors and the Trust Leadership Team (TLT).

The Board was reminded that the BAF was presented to the Board for assurance on its completeness as of March 2025.

Outcome: the Board

- received the BAF and assurance of the appropriateness of updates, including risk scoring and mitigating actions.

Item 2025-26 (18)

Discussion points:

Corporate Governance – end of year reports

a) Going Concern Statement

The Executive Director of Finance and Resources presented the Going Concern Consideration. She explained that the paper had been considered by the Audit Committee at its meeting on 11 March 2025 and was recommended for approval.

Outcome: the Board**:**

- approved the preparation of the annual accounts for 2024/25 on a going concern basis.

b) Declarations of interest and compliance with the fit and proper person requirements made by the directors for 2024/25

The Company Secretary presented the report which contained the director's declarations of interest schedule of disclosures for 2024/25, and confirmation that the Trust was compliant with the Fit and Proper Person Test and other additional annual background checks.

Outcome: the Board

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

Item 2025-26(20)

Discussion points:

Well Led Development Review

The Chief Executive presented the paper and final report. Following an external review, based on NHS England's Guidance for NHS trusts and foundations trusts: assessing the well-led key question, the Trust was developing an action plan to address the key findings. The paper detailed the recommendations that would underpin the action plan and proposed that the Board would receive a progress report every six months and the Senior Leadership Team (SLT) every quarter.

Outcome: the Board

- approved the recommendations outlined in detail in appendix 1 of the well-led report and approved the proposals for progress updates to the Board.

Item 2025-26(21)

Discussion points:

Senior Information Risk Officer - Annual Report

The Executive Director of Finance and Resources presented the report which briefed the Board on the progression of the Information Governance agenda and the responsibilities of the Office of Data Protection Officer to provide assurance on the effectiveness of controls for Information Governance, data protection and confidentiality

Key points to note were highlighted:

- There had been a number of operational pressures which had impacted on the Trusts ability to respond in a timely way to information requests.
- Work had commenced on the 2024/25 DSPT however due to the change in requirements there was a probability that the Trust would submit with an "Action Plan" that detailed how the requirements would be met.
- A recall of a number of mobile phones was underway to ensure the operating systems were updated, the Trust's CE+ accreditation would temporarily lapse whilst this work was completed.
- There had been two reportable data breaches during the period, both had been closed.

Item 2025-26(22)

Discussion points:

Any other business Blue Box Items and Close

The Trust Chair closed the meeting at 12.35pm

Date and time of next meeting
Thursday 5 June 2025 9.30am-12.30pm

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

AGENDA ITEM 2025-26 (28b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) action log: 5 June 2025

Key		Key colour code
Total actions on action log	1	
Actions on log **completed** since last Board meeting on 1 April 2025 with a **proposal to close**	1	
Actions due for completion by 5 June 2025 – for update at the meeting	0	
Actions not due for completion before 5 June 2025	0	
Actions outstanding at 5 June 2025**: not having met agreed timescales and/or requirements**	0	

Agenda Item Number	Action Agreed	Lead	Timescale/Deadline	Status
1 April 2025				
2025-26 (6)	**Chief Executive's Report:** terms of reference for Leeds Place Review to be circulated.	Company Secretary	Post-meeting	Circulated by email 1 April 2025 **Propose closure**

Agenda item:	2025-26 (30)

Title of report:	Chief Executive's report

Meeting:	Trust Board Meeting Held In Public
Date:	5 June 2025

Presented by:	Dr Sara Munro (Interim 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 • Business Unit Updates • Education Update

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

2.1 New NHS VSM Pay Framework

The new national VSM Pay Framework was published in mid-May by NHS England and the DHSC. Full details are here: NHS England » Very senior managers (VSM) pay framework
A full briefing on the new framework will be provided to the LCH Nominations & Remuneration Committee in their next meeting. Recent decision-making in relation to VSM pay at LCH aligns with the requirements set out in the new framework.

A regional meeting was held with Fiona Edwards, the new regional director, on the 21 May 2025. Fiona updated all chairs and CEO's across the region about the operating plan, NHS England changes and other relevant topics. It was a helpful session and it is hoped the meeting will be held regularly.

2.2 Financial Update

Towards the end of the planning process in March 2025, the West Yorkshire NHS system was offered an additional recurrent allocation of £40m which was conditional on being able to demonstrate effectively to NHS England that we were taking all reasonable measures to deliver a balanced financial plan across the system and live within our means. Notwithstanding the improvements to financial plans that many organisations were able to make, across the West Yorkshire system at the time there remained a planning gap of £33m that was acknowledged would require collective system effort to deliver. Over recent weeks, Chief Financial Officers/Directors of Finance across the 11 statutory NHS organisations in West Yorkshire have been working together to agree a process for how the system improvement value could be fairly and appropriately distributed across organisations and place, this has resulted in an improvement target of £5.2m (0.3%) being allocated to Leeds place. Discussions regarding how this will be delivered across the 4 statutory organisations remains ongoing.

2.3 West Yorkshire Community Services Update

An independent review by Attain on the community service offer has begun across West Yorkshire. This will provide a valuable insight into the core minimum offer, activity and opportunities to learn across the geography. It is anticipated this will report in the autumn.

3 Quality & Value Programme

3.1 We start the new financial year off the back of the success of the first year of our cost improvement programme, Quality and Value, where we successfully achieved financial balance, saving over £17m. To ensure year 2 can be even stronger we have

undertaken lessons reviews within the programme, and are triangulating this with data from the NHS Staff Survey and recommendations from Internal Audit.

3.2 Year 2 requires us to save at least another £14m, some of which is a legacy CIP from last year that needs to be made recurrent. The programme will include the continued implementation of transformations in some of our larger services, such as the Neighbourhood Teams, and CYPMHS. In addition we will be supporting other clinical services to redesign in a safe way, using our bottom up, quality improvement methodology, that empowers staff to design the solutions. Services in scope include Cardiac, Podiatry, and LMWS.

3.3 There will be a renewed focus on our corporate services, especially as there is a national requirement for us to reduce how much corporate services have grown by since 2018/19. We will be looking for innovative ways to do things differently, such as digital automation, and internal/ external integration.

3.4 Finally, our Making Stuff Better 'innovation pot' has got off to a great start. This initiative encourages staff to pitch for small pots of one off resource to pump prime projects that have a cost benefit. So far over 15 applications have been made, with the majority receiving funding either through the innovation pot or other relevant routes. It's been great to see the energy, and creative ideas from staff on the frontline.

4 Specialist Business Unit Update

4.1 Cardiac Team working with the Homeward Team:
The introduction of heart failure specialists to the Home Ward Frailty, and contribution to their MDT meetings has been welcomed by geriatrician consultants. The specialist nurses have been able to contribute their knowledge, reliable assessments, and vast experience to care planning. The accurate description or account of symptoms of heart failure with the timely recommendation of sensible medical plans has improved patient outcomes. The nurses have good links with the cardiology team and are therefore a useful bridge between the two specialties. They have also provided training and support to the Matrons to upskill their workforce in the management of heart failure, which they've received very positive feedback for.

HHIT Team

4.2 We were invited to present the Intermediate Care model for people experiencing homelessness at both the National Crises Conference and the National Pathway conference as an area of good practice. The Intermediate Care model also won a Quality in Care award for promoting choice and control for the patients we serve.

4.3 The HHIT team has been working with homeless teams in other areas as well as LCH colleagues in Podiatry and LCH Clinical Pathway lead, to develop a Diabetes pathway. This work has been recognised nationally as an area to develop and has been published.

4.4 HHIT were involved with third sector partners and Leeds City Council to successfully interview to being a Making Every Adult Matter (MEAM) City. Collectively we are

committed to co-producing a passport for our patients, to reduce people being retraumatised by telling their story and history to multiple professionals.

5 Queens Nurses invited to Buckingham Palace Garden Party

5.1 Queens Nurses from Leeds attended Buckingham Palace Garden Party to represent the Community Nurses in Leeds who have been awarded that title of Queens Nurse.

5.2 A patient nominated the group of 5 nurses to receive this honour after receiving care from a Queens Nurse from Leeds Community Healthcare as a mark of appreciation for the care they had received.

5.3 The patient initially helped to arrange an afternoon tea at Bowcliffe Hall with the Lord Lieutenant for West Yorkshire, Ed Anderson in 2024 where a small number of Queens Nurses shared their experiences of nursing in a variety of community settings. The group of Queens Nurses' spoke of the challenges of community nursing and shared their passion for the delivery of high-quality patient care.

5.4 Following this, the Lord Lieutenancy office for West Yorkshire nominated them for an invitation to the Buckingham Palace Garden Party.

5.5 On Wednesday 7th May, Gil Marchant Head of Safeguarding/Designated Nurse Safeguarding Children and Adults ICB, Emma Gaunt Clinical Lead - Continence, Urology and Colorectal Service (CUCS) LCH, Beverley Calvert - Clinical Lead Cardiac Service LCH and Liz Grogan Deputy Director for IPC LCH were delighted to be invited by the Lord Lieutenant for West Yorkshire on behalf of His Majesty the King to attend the Buckingham Palace Garden Party, in recognition of them being Queens Nurses and their passion and dedication to community nursing. Liz and Emma had the pleasure of meeting Her Royal Highness Queen Camilla to talk about community care and the role of the Queens Nurse. A few other Queens Nurses from LCH and the ICB are invited to another Garden Party being hosted by His Royal Highness later in May.

'It was such a wonderful experience to be able to visit Buckingham Palace and enjoy the celebrations with lots of people invited from across the country to share the wonderful work of community nursing. There were 26,000 cups of tea served, 20,000 sandwiches and 20,000 cakes for the 8,000 people that attended. The sun shined and we were delighted to be able to meet Queen Camilla.'

Gill Marchant Head of Safeguarding/Designated Nurse Safeguarding Children and Adults ICB, Emma Gaunt Clinical Lead - Continence, Urology and Colorectal Service (CUCS) LCH, Beverley Calvert - Clinical Lead Cardiac Service LCH and Liz Grogan Deputy Director for IPC LCH.

6. Specialist Weight Management Service

6.1 Leeds Specialist Weight Management Service was paused to new referrals from the 15 July 2023 due to significant demand. Service recovery has progressed well, with redesign, additional resource and investment supporting the treatment and discharge of 832 patients in the last 20 months. On 4 September 2023, NICE Technology Appraisal (TA) 875 was published, mandating access to Semaglutide (Wegovy) and on 23 December 2024, NICE TA 1026 was published, mandating access to Tirzepatide (Mounjaro) within Specialist Weight Management Services for the treatment of overweight and obesity. The service following clearing the waiting list, reopened on 10 April 2025 to new referrals.

6.2 The service is currently offering a six-month healthy lifestyle pathway, followed by a medication pathway (if appropriate/required) prescribing most suitable weight loss medication for 18 new patients per month for up to 2 years. Liraglutide, Semaglutide and Tirzepatide are offered to the patients on the medication pathway, depending on clinical need.

6.3 A feasibility study has commenced in collaboration with West Leeds Primary Care Network (PCN) to explore and develop a Primary Care model for delivery of Tirzepatide integrated with the Leeds Specialist Weight Management Service. Investment has also been secured to develop two to three further feasibility studies for Primary Care Models, in different PCN areas.

7 Children's Business Unit Update

Children's Speech and Language Therapy

7.1 The CSLT Patient Information video was instigated following Spring & Summer 2024 student placement projects exploring missed appointments in the service, which

identified a gap in the information available to families, especially in other home languages. In autumn, we gained qualitative feedback from our CSLT admin team as part of our DNA / WNB ("Was not brought") task-finish group. The admin team noted several conversations with families who were unsure why they had been referred, and unsure what to expect from a therapy appointment.

The DNA task finish group agreed that a video could provide an accessible solution and support attendance at SLT appointments. This was filmed in March 2025, and it is currently in editing. It will include versions with voiceovers in the 10 most common non-English languages. Families will be sent the video at point of referral and at confirmation of appointment via an open link on the patient information hub. Referring professionals are encouraged to share this video when discussing a referral to CSLT. This link can also be incorporated into digital appointment letter. We have sought feedback via the Leeds Parent/Carer forum and LCH youth board throughout the process and are tracking ongoing DNA / WNB rates to measure impact.

CBU Children, Young People and Families Networking Event

7.2 On 8 April 2025, CBU planned and hosted a Children, Young People and Families (CYPF) Networking Event to bring together the organisations supporting CYPF across Leeds—including NHS bodies, the Local Authority, and, most importantly, our valued third sector partners.

The event helped to promote the vast number of organisations who working together every day to make a difference to the CYPF in Leeds. The event also highlighted the importance of collaborative working and the power of partnerships. It fostered the sense of community and our shared purpose, reinforcing the commitment of all sectors to work towards a brighter future for children, young people, and families across the city.

Held at St George's Conference Centre in Leeds City Centre, our event showcased the collaborative efforts of our third sector organisations through engaging market stalls, which remained the focal point throughout the day. The event was expertly facilitated by our Youth Board members. We had **13 Market Stalls, 5 guest speakers**, and 3 of our Market Stall Holders gave us an impromptu quick chat via the Youth Board 'Spotlight' at various points in the day.

The 5 guest speakers shared insights into their organisations and highlighted successful partnerships between the NHS and the Third Sector. Sam Prince, Ex Director of Operations for LCH, opened the event with a warm welcome, setting the tone and outlining the day's aims: to raise awareness of the breadth of CYPF services across the city, to share knowledge to improve outcomes for CYPF and to provide networking opportunities among the **110 attendees.**

The atmosphere was lively, with active discussions during the Market Stall breaks and the short "Sound Bite" presentations from our Guest Speakers.

Presentation Highlights

- **Leeds GATE & Chris Lake:** Grace from GATE opened with a heartfelt thank-you for Chris's support of the GATE community, setting a genuine tone for the day. This presentation was able to demonstrate the earnest and important work between organisations that is seen everyday
- **CYPMHS Mental Health Support Team:** Shared the extent of their collaboration with third sector partners.
- **CSLT & Sunshine and Smiles:** Featured a powerful story from a parent and child, who have benefited from services, highlighting the role of SALT LCH in the growth of the Sunshine and Smiles as an organisation. Mum, being one of the founders of Sunshine Smiles has worked very closely with SALT over the years and told us how

LCH/CBU has enabled the ongoing development of the Charity, and how they now are able to employ their own Speech Therapist.

- **0–19 PHINS and Family Action:** School Nurse from PHINS told us the moving story of a young carer, supported by both PHINS and Family Action, who had been able to reclaim their teenage years and overcome some challenges through joint efforts of both organisations, whilst continuing to support the parent
- **Children's Community Nursing Service:** Christine Pearson concluded the presentations by discussing CCNS' work with Candlelighters and St Martin's Hospice to support children with life-limiting conditions.
- The event was overwhelmingly positive, with tangible energy and enthusiasm.
- Attendees praised the day both in person and via follow-up emails.

Emails

Becky Smithson, Family Action *'It was a pleasure to be involved in the event and helpful for me to meet other agencies. It was very informative, and the presentations helped break up the day and share some key messages.'*

Anne Appleby, Barnardo's Nightwatch *'Thank you so much for organising yesterday, we thought it was a great event. We loved chatting with people from other services and hopefully we will be able to come along next time* 😊*'*

Katie Turner, CSLT *' Thank you for hosting the networking event yesterday, I found it really useful, even just to be aware of all the organisations as a starting point for more joint working and signposting. '*

Louise Maciag, Mencap *' It was such a great day, and a brilliant way of bringing people together with a view of working collaboratively. I made some great contacts and left with my head buzzing with ideas! If you have the same event next year please keep us on your invite list, we will absolutely be there!'*

Sharon Underwood, ICAN *'Just wanted to say a huge thank you to yourself and the Team for arranging and facilitating a wonderful uplifting day on Tuesday. The energy in the Room was palpable and attendees seemed to be really enjoying the networking as well as becoming more aware of what was on offer for Children and families in Leeds.'*

Ann Hart, PHAB *'Thank you so much for a wonderful day. I have attended many Market Days for PHAB over the years, but that was the best because of the way it was interactive, and it brought the different groups together. You and your colleagues were also so attentive to me. I am finding 'old age (86) a bit of a challenge, but our PHAB Club is my 'second family' and like to think that we are available for any lonely people with disabilities. Join PHAB and have fun is the Motto...and yes, it does happen.'*

8. Education Update

On 8 May 2025 Leeds Community Healthcare Directors and Education Teams met with NHS England at the 'Senior Leadership Engagement Meeting', LCH had the opportunity to highlight our successes and challenges and talk about best practice going on at the Trust. NHS England provided feedback to directors that it was clear that as a Trust we are passionate about supporting learners and that we facilitate fantastic learning opportunities. We received the results of the National Education Training Survey (NETS) at the meeting, which covers Medical, Nursing and AHP Undergraduate Students, where we are very proud to have ranked as 1st in the Yorkshire and Humber Region based on 'Overall Learner experience'. In the GMC National Training Survey, which just covers Medical Postgraduates (Resident Doctors), LCH ranked a very close 2nd in the Yorkshire and Humber Region, 18th in England and 21st in the UK.

9. Recommendations

The Board is recommended to:

- Note the contents of this report and the work undertaken to drive forward our strategic goals.

Agenda item:	2025-2026 (31i)

Title of report:	2024-25 Year End Trust Priorities Report

Meeting:	Trust Board Meeting Held In Public
Date:	5 June 2025

Presented by:	Andrea Osborne, Executive Director of Finance & Resources Lynsey Ure, Executive Director of Nursing, Allied Health Professionals and Quality					
Prepared by:	Emma Tiernan, Head of Business Claire Gray-Sharpe, Head of Clinical Governance					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	The paper provides a year end update on progress during 2024-25 towards the Trust Priorities. • We will provide proactive and timely care that is person centred by ensuring the right service delivers the right care at the right time by the right practitioner. • To have a well led, supported, inclusive and valued workforce • We will develop a Leeds Community Collaborative in partnership to amplify the community voice and facilitate care closer to home • To ensure that the Quality and Value Programme has the least negative impact on those with the most need and positively impacts where possible • To achieve the 2024/25 Trust's financial efficiency target through delivery of an effective Quality and Value Programme Looking back over the past 12 months we have lots to be proud of, our Q&V programme has been a golden thread through much of our work and a key enabler to delivery of our strategic priorities. Through the programme we have iteratively designed a service led improvement methodology which has received some excellent feedback from staff; the EQIA process has been embedded with a dedicated officer appointed to support their ongoing use and meaningful application to decision making. This has been key to us releasing efficiencies in a safe and sustainable way in 2024/25.

	Following discussion at Committees, it has been agreed that the format of this report will be reviewed for 2025/26 to ensure a greater focus on outcomes and to ensure consistency and alignment with related reports e.g. annual report and papers such as digital strategy, workforce and Q&V.

Previously considered by:	Quality Committee and Business Committee, May 2025 TLT, 28th May 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?	
	No	X	Why not/what future plans are there to include this information?	Equity update included but not specific data

Recommendation(s)	The Board is recommended to note the progress made in 2024/25.

List of Appendices:	None

Trust Priorities: End of Year Report

NHS Leeds Community Healthcare NHS Trust

Strategic Goal: Work with communities to deliver personalised care

Trust Priority: We will provide proactive and timely care that is person centred by ensuring the right service delivers the right care at the right time by the right practitioner

Key Focus Areas

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

Pathways

• Neighbourhood Clinics - the new ICB commissioned LCH Neighbourhood Clinics went live on 1 April. The clinics deliver complex and lower limb wound care in the community which was previously a gap in the service offer across Leeds. This is in line with the Trust's 'Best Place of Care' philosophy.

• Tier 3 Weight Management - NICE guidance was released in December 2024 for Tirzepatide (brand name Mounjaro ®). In addition to introducing this as an option in the core service, we are working with West Leeds PCN to trial a medication pathway as a "proof of concept" for a future service model for the Leeds population. In this model the Tier 3 weight management service will manage the lifestyle offer and the PCN will manage the medication. The trial, started in March, for 20 people from the WLPCN area and is anticipated to last for two years with external evaluation by WYICB. This will help us to increase capacity and to identify the optimum service model as a system across specialist services and primary care to scale up services at pace as new weight loss drugs and pathways are introduced.

• Proactive Support Service - recruitment is underway to launch this new service, in collaboration with ICB and Leeds City Council. The provision of a Proactive Support Service will help reduce the unplanned ending of children's care placements and stabilize children in our system.

Digital

•The Wound Care App will enable remote management of wounds and decrease healing timeframes. The testing highlighted a number of concerns that are currently being reviewed.

• SystmOne Connect was implemented into LSH and shows significant reduction in administration time. This will give patients the ability to communicate with services digitally for activities like self referral, appointments, and prescriptions. This will also make our services more accessible for patients. Plans to implement in other services.

• The Digital Patient Communication Project Team, with 100% Digital have produced a training video. It covers the basics of digital inclusion and a systole template which introduces a digital inclusion screening questionnaire. The screening questions have been co-designed and aim to support conversations with patients and service users to understand any barriers to accessing digital technologies. The template also includes links to relevant support networks. Patient facing staff are encouraged to use the screening questionnaire and to reassess patients regularly.

• The patient "information hub" is progressing. LSH went live in November 24. A survey was undertaken with service users in LSH with the feedback and comments used to inform the design of the new website. Remaining services went live in March 25 and are now further developing the content of their pages to include all patient information leaflets as well as self management pathways. The Reciteme accessibility toolbar is available on all pages so patients can translate content into different languages, fonts, colours etc

Engagement

•Responding to patient focus on the 3Cs (communication, compassion and coordination).

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

•The team have supported services to update information in plain English and accessibility and there is an AIS page on MyLCH. This supports provision of reasonable adjustment where needed.

Forward View - Upcoming Work

In 2025/26, we will aim to reduce the backlog of people waiting for our services in line with 25/26 targets.

Trust Priorities: End of Year Report

Leeds Community Healthcare NHS Trust

Strategic Goal: Enable our workforce to thrive and deliver the best possible care

Trust Priority: To have a well led, supported, inclusive and valued workforce

Key Focus Areas

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

Leadership

- The Organisational Development team developed training modules to support the Quality and Value Programme (Q&V) to equip leaders with the skills to support their services through Q&V.
- The LCH Senior Leadership Team has completed 360 assessments. All have a resulting individual development plan.
- 100% of new starters and middle managers have been offered inclusion training via the LCH Leadership Essentials course.
- Our two newer Staff Networks for Disability, Neurodiversity and Long Term Conditions and LGBTQ+ continue to develop. Our established Race Equality Network is flourishing. Each Network now has an affiliated Executive Director, to support and embed these important forums in the Trust and at the Trust Board.
- 16 staff attended our development programme for a range of identified staff from diverse backgrounds, 'I Thrive We Thrive Programme'. The impact included improved confidence; ability to lead and influence change; career progression, leadership and communication skills. Managers of the participants increased their knowledge of barriers to progression that people from culturally diverse backgrounds experience.

Digital & Technology

- Implementation of a device replacement programme ensuring laptops are replaced at 5 years and mobile phones at 3 years, to ensure staff have fully working devices to enable them to work efficiently.
- New type of laptops will now be provided with better and longer battery life.
- eRostering is fully implemented, enabling systematic skills and capacity planning.
- Hybrid Working is fully embedded. This informs the design and delivery of LCH Estates, Sustainability and Digital strategies.

Retention

- NHS Staff Survey: We achieved a high response rate of 60% through a combination of a dedicated resource to engage staff including use of a communication and engagement plan through sponsorship from the CEO, directors, and general managers.
- A new flexible working approach has been introduced, with some form of flexible working taken up by >50% of LCH staff.
- The overall turnover rate during the year has remained consistently below the 14.5% target, ranging between 9.3% and 10.9%.
- Overall sickness absences during 2024/25, has been trending upwards since the start of the year and continues to be higher than the previous year. Short-term absence levels remained within tolerance throughout the year. Our focus remains on supporting the prevention of and return from long-term sickness absence, where stress/anxiety/depression remains the most prevalent reason for absence.
- WRES overall figures have been improving since April 2024: 14% of the LCH workforce have a Black, Asian & Minority Ethnic background, increasing from 10% in 2021.
- We offer a wide range of physical, mental, and financial wellbeing support including structured and preventative work on psychological health and wellbeing for colleagues e.g. occupational health, Employee Assistance Programme, Staff Development Day for Health and Wellbeing Champions (over 60 people), Mental Health First Aiders (over 70 people), Schwartz Rounds, Critical Incident Staff Support Pathway, which has supported over 130 requests for either group or individuals to be debriefed this year, and wagestream where staff can receive some of their earned wages sooner than pay date.

Forward View - Upcoming Work

Continuation of above work into 2025/26 to ensure we are working towards:

- Quarterly and National Staff Survey results: evidence 5% improvement in staff experience of their leaders.
- Staff Survey results evidence reduction of at least 50% in the gap in discrimination experience of disabled and BAME respondents.
- Long term sickness absence rates return to target levels of <3.5%, with a stretch target of 3%
- Absence due to stress / anxiety / depression is reduced, with overall annual sickness below 5% by 2025
- Staff reporting that LCH takes positive action on HWB rises by 5%
- 18% of the LCH workforce being of a Black, Asian & Minority Ethnic background by 2028

Trust Priorities: End of Year Report

NHS Leeds Community Healthcare NHS Trust

Strategic Goal: Collaborating with partners to enable people to live better lives.

Trust Priority: We will develop a Leeds Community Collaborative in partnership to amplify the community voice and facilitate care closer to home

Key Focus Areas

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

Care Closer to Home

- New model of Enhance rolled out with support targeted at the 5 Neighbourhood areas with the highest levels of deprivation (the percentage of people living in IMD1 and 2): Middleton, Beeston, Armley, Seacroft & Chapeltown. Neighbourhood Teams in these areas will be able to refer to Enhance for support with enabling attendance at Clinics and Health Hubs. Delivery Partners can provide more intensive support at home for these patients. Enhance funds a Self-Management Health Hub in 4 Neighbourhood Team areas: Beeston, Armley, Seacroft & Chapeltown.

Community Collaborative

- Work with partners to develop a Community Collaborative has not progressed due to key national policy developments:

- The requirement for ICBs to establish Provider Collaboratives. West Yorkshire ICB has requested that 'Provider Reviews' are undertaken at 'Place' level to determine Provider Collaborative arrangements, to complete by September 2025.
- The requirement for ICBs, local authorities and health and care providers to progress development of a Neighbourhood Health model in 2025/26.

Discussions are underway within and across health care partners to agree our collective ambition and approach. Further guidance is expected in the 10 Year Health Plan which is due to be published in June.

- Community Dental: The incumbent providers across West Yorkshire (Locala, Mid Yorks NHS Trust, Bradford District Care Trust & LCH), have been working together as a collaborative for 15 months, supported by the ICB, to understand, improve and integrate care across the West Yorkshire Region. In October the ICB adopted a most suitable provider approach to re-procure the service at a regional level (Yorkshire & Humber) from 1st April 2025. We were part of a West Yorkshire collaborative bid, with Bradford District Care Trust acting as the coordinating provider and LCH remaining responsible for the Community Dental Service in Leeds. We are delighted to announce we won the tender and will be mobilising from 1st April 2025.

Engagement

- We are working with the Leeds Parent Carer Forum to support their voice being heard in service developments/redesigns.
- LCH has two Patient Safety Partners who are not employed by the trust and work as critical friends and patient advocates. They provide support and feedback with a patient safety lens for their workstreams which include Quality Walks, review of our literature, and attendance at Quality Committee.

Forward View - Upcoming Work

Support the development of the foundations of the community element of the neighbourhood health model by April 2026

Mobilisation of new WY Community Dental collaborative.

To strengthen our commitment to patient engagement, the Patient Experience and Engagement role will be restructured into two dedicated roles, one focused on patient experience and the other on engagement. In addition a new Engagement Clinical Governance role will be introduced to provide vital support across the trust. This structure will enable the Trust to maintain a focus on meaningful engagement, ensure alignment with our strategic priorities, and embed patient engagement at the forefront of service development and improvement.

Trust Priorities: End of Year Report

Leeds Community Healthcare NHS Trust

Strategic Goal: To embed equity in all that we do.

Trust Priority: To ensure that the Quality and Value Programme has the least negative impact on those with the most need and positively impacts where possible

Key Focus Areas

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

Data

- LCH equity data on PIP is now structured into access, experience and outcomes to support improved access to the data.
- Additional PowerBI reporting has been developed to support the Access LCH campaign, providing trust wide and service specific data on equity in waiting times for people in the most deprived communities (IMD1). The data is currently being reviewed to identify the causes of difference in missed first appointments for people living in IMD1 compared to the rest of the population that is contributing to inequity in the reduction of waiting lists.
- System-wide workshops on equity and missed appointments were held in April and July 2024, followed by an internal workshop with the Health Equity Leadership Group in July 2024. Mapping of the causes and possible solutions to missed appointments were developed, along with a suite of resources on MyLCH (December 2024). Trust-wide coordinated action to address missed appointments started in February 2025, as part of the Access LCH initiative, with admin phone calls to people who had missed appointments. There have been insufficient data points since this process started to identify any impact.
- Heartt App: Improvements in equity data collection and utilisation has been foundational work to support future use of HEARTT. This includes engagement with Leeds Office of Data Analytics and data from Access LCH to direct focus of HEARTT pilot and roll out in 2025.

Engagement

- Our equity work is part of LCH's response ('you said...we did) to what patients, carers and communities who are at most risk inequity have told us are barriers to their access, experience and outcomes. This has been summarised by Healthwatch and the Leeds Person Centred Care Expert Advisory Group as "the 3 Cs": communication; compassion and coordination.
- Communication: LCH and partners were part of the NHSE's pilot of their Accessible Information Standard self-assessment framework. The new Information Hub has an accessibility tool and our range of Easy Read leaflets now includes end-of-life care. These leaflets have been developed with people with Learning Disabilities.
- Compassion: cultural competence is one of the improvement actions in our new Racial Equity plan and in our Equality Delivery System (EDS) plan. We have delivered training to 23 leaders supporting them to engage their services in the Cultural Conversations programme to improve inclusive patient care and team working, also responding to staff network experience.

EQIA - updated

- EQIAs have been embedded as a vital part of the Quality and Value programme, with processes and governance structures established for this. 52 EQIAs have been heard at an initial panel meeting. An EQIA officer has been appointed to support their ongoing use and meaningful application to decision making.
- We recognise service changes LCH makes have equity implications on patients and partners across the system. We are exploring how, for significant changes, we can use EQIAs to convene a conversation with our partners about system implications and mitigating actions. As a starting point, our Medical Director convened a partners forum to discuss implications of changes to our musculoskeletal services.

Forward View - Upcoming Work

- The Equity team will continue to work to address inequity in missed appointments and waiting lists and the aim of reducing missed appointments for people in IMD1 (currently 10.8%) to be in line with IMD2-10 (6.8%). This would improve access to services and contribute to improved health outcomes for people in our most deprived areas, saving over 8,000 missed appointments each year and reducing the overall missed appointment rate.
- The 'About Me' template is planned to be developed and implemented this year. This will be essential for collecting key information about patients on demographic data, reasonable adjustments and communication needs. Strengthening the quality of this data available will enable us to meet patient needs as well as having greater ability to analyse our data by key equity variables to inform action.
- LCH is working with partners in the Leeds Healthcare Inequalities Oversight Group to develop a Health Equity Index which will provide a simple, standardised way to measure equity within the health and care system. It will be applied to a range of performance and quality indicators to measure progress made on health equity and provide actionable insights. This will complement existing internal work to develop a measurement framework and equity dashboard.
- Regarding EQIA, at the City Wide Adults and Health scrutiny panel on Health Inequalities held in November 2024, it was notable that LCH are much further along with the consistent use of EQIA than other health partners. However, the issue was raised, of how we can better understand the collective and cumulative impact of decisions we are making across health and care on populations. We will need to work with partners to address this in a more logical, consistent and systematic way going forwards.

Trust Priorities: End of Year Report

Leeds Community Healthcare NHS Trust

Strategic Goal: Use our resources wisely and efficiently both in the short and longer term

Trust Priority: To achieve the 2024/25 Trust's financial efficiency target through delivery of an effective Quality and Value Programme

Key Focus Areas

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

Service Redesign

- Looking back over the past 12 months we have lots to be proud of in relation to our achievement of the £15.8m savings required for our Quality and Value Programme.
- We have iteratively designed a service led improvement methodology which has received some excellent feedback from staff.
- We have restructured the Workforce Directorate; Business, Change, and Development Service; Quality Improvement; and Business Intelligence. These teams now have more effective and efficient structures in place.
- We introduced a robust approach to vacancy control, which means we have been able to approve most vacancies coming through our Quality and Value Panel.
- We have developed a procurement workplan to oversee efficiencies within contracts – this includes savings of nearly £900k per year by signing up to a new mobile data contract.

IT, Digital and Estates Transformation

- See tab 1 for digital update.
- Estates workstream achieved all £1m of its target through the sale of underutilised sites at Otley and Horsforth, rationalisation of space at sites including
St Mary's and St George's, closure of Killingbeck due to rising costs with services supported to move elsewhere. We also moved out of our training room at Shine and into a much more cost-effective option at Onward House.

Business Development

- We retained our service at Wetherby Young Offenders Institute and Adel Beck Secure Children's Home, which now in includes the addition of Aldine House Secure Children's Home.
- We secured the extension of our contracts within our Community Beds service, and within our Healthcare in Police Custody service.
- We safely demobilised our Liaison and Diversion Service in Hull and Humberside.

Forward View - Upcoming Work

Transform our services through year 2 of quality and value, for more effective service delivery that ensures equitable access and financial balance. Clinical services that are in scope of a redesign include: Therapy, Community Matrons, Pharmacy Technicians, Healthcase Management, LMWS, Podiatry, Cardiac, Respiratory, Diabetes, Stroke, Dental, ICAN, Children's SLT, Children's Audiology. The corporate services in scope include Admin Services, Finance, and QPD. We will also continue workstreams that implement digital innovations; that develop our business; and which rationalise our estates usage.

Under the business development workstream in 2025/26, we will be exploring income generation opportunities as well working in partnership with Leeds City Council and the Leeds GP Confederation to respond to the new Community Care beds tender when it is released.

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (32)

Title of report:	People Headlines and Strategy Update

Meeting:	Trust Board Held In Public
Date:	5 June 2025

Presented by:	Laura Smith / Jenny Allen, Director of People					
Prepared by:	Laura Smith / Jenny Allen, Director of People Ann Hobson, Transformation Lead					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	This paper provides Trust Board with information on key headlines linked to the LCH People Directorate portfolio. Produced 4 times per year, it is reviewed and discussed at People Culture Committee prior to coming to Trust Board. The paper also provides an update on the progress made against LCH Workforce Strategy (2021-2026) outcome measures at the end of Q4 of 2024/25; and overall position against the Strategy's outcome measures to date.

Previously considered by:	N/A

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

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	X	Why not/what future plans are there to include this information?	Paper is workforce-focused. It includes EDI data and considerations

Recommendation(s)	It is recommended that the Trust Board:

	• Notes the Workforce Headlines presented in this report • Notes the progress achieved in pursuit of the target measures set out in the current LCH Workforce Strategy. • Notes that the People & Culture Committee will now receive this report prior to its appearance at Board.

List of Appendices:	Appendix 1: Workforce Strategy Progress Dashboard Appendix 2: Workforce Strategy underpinning SPC charts

People Strategy Update & Headlines

1. Introduction

This report, previously regularly provided to the Business Committee as well as to Trust Board, was presented to the new LCH People & Culture Committee on 21 May 2025, for the first time.

It provides a current snapshot of People & Culture headlines, priorities and progress; and details of current standing against the objectives set out in the LCH Workforce Strategy 2021-26.

Highlighted in this month's report are:

- People & Culture Priorities for 2025/26
- Preparation for an LCH Mutually Agreed Resignation Scheme
- Staff Networks

The Business Committee requested increased brevity in this report in its February 2025 meeting, which this paper seeks to deliver.

2. People & Culture Headlines

2.1 People & Culture Priorities for 2025/26

This year's context, with the expectation of structural changes for the NHS nationally and regionally, and consideration locally of how Leeds can best deliver for its communities, is informing our People Directorate planning and priorities for 2025 / 26.

Whereas in recent years the Directorate has focused on delivering workforce growth; a primary focus this year is to ensure LCH has the skills, information and support it needs, to deliver redesigned services in an environment of change and partnership.

The table below sets out a brief summary of the updated focus the Directorate is considering against each of the 7 pillars of the current LCH Workforce Strategy.

Strategy Pillar	Previous focus (Oct 2021-March 2025)	Proposed focus (2025- 2026)
Organisation Design	Establish approaches to WF planning, eRostering, hybrid working (achieved)	Deliver expert support to organisational change
Resourcing	Grow workforce & increase retention (achieved)	Specify and deliver efficiencies in resourcing processes
Foundations	Develop service specs & KPIs (not fully achieved)	Transform the People Directorate's services to deliver greater efficiency and improved customer experience
Leadership	Improve overall quality of leadership (achieved)	Develop managerial capability aligned with organisational priorities
Wellbeing	Reduce sickness absence (not fully achieved) Improved engagement (achieved)	Analyse available intelligence to guide targeted interventions
Inclusion	Improve representation, reduce disparity of experience (achieved*)	Promote and embed inclusion and belonging
System Partner	Deliver collaboration and cross-organisation working (achieved)	Connect with partners where it enables achievement of LCH and system priorities

The People Directorate delivered its own service redesign and Quality & Value Programme efficiencies during the second half of 2024/25. This puts the Directorate in a strong position to now focus on supporting the rest of LCH, while it also works to implement the ongoing transformation of its own service offer and continue to improve efficiency into its ways of working.

2.2 MARS Scheme

In March 2025, NHS England formally approved LCH's request to run a Mutually Agreed Resignation (MARS) Scheme during 2025/26.

The request to NHS England followed internal approvals via the Nominations & Remuneration Committee, Business Committee and Trust Board; as well as formal partnership engagement with the Trust's Joint Negotiating and Consultation Forum (JNCF).

Plans are in place to deliver the Scheme during Q2. It is expected to deliver up to 35 WTE mutually agreed departures. A final timetable is scheduled to be approved by the Trust Leadership Team in advance of Trust Board on 5 June 2025.

2.3 Staff Networks

Each of LCH's 3 Staff Networks is now supported by a Board Director and a People Consultant, and has access to dedicated administrative support.

This level of support aims to enable greater visibility, connection, development and impact for the Networks.

2025/26 has brought leadership changes for some of LCH's staff networks, including the departure of the LGBTQIA+ Network's Chair and the standing down of the Disability, Neurodiversity & Long Term Conditions Network Chair and Vice Chair. The LGBTQIA+ Network is being ably led by its Vice Chair, and succession plans are under development with both Networks.

National Staff Networks Day (14 May 2025) saw the Networks come together at an event at White Rose Park, to celebrate and reflect on their progress and influence.

The People & Culture Committee's focus on both Inclusion and Engagement will see Network Chairs joining regularly joining Committee meetings to directly participate in and influence discussions. The inaugural meeting of the People & Culture Committee will welcome the Chair of LCH's Race Equality Network to the discussion.

3 Workforce Strategy Delivery Progress – Quarter 4 2024/25

The dashboard at ***Appendix 1*** shows at-a-glance RAG-rated progress against the measures set out in the Workforce Strategy 2021-26. ***Appendix 2*** provides a dashboard with key metrics evidencing the trajectory of progress.

The RAG rating key is as follows:

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

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

3. Conclusion

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

4. Recommendations:

It is recommended that the Trust Board:

- Notes the Workforce Headlines presented in this report
- Notes the progress achieved in pursuit of the target measures set out in the current LCH Workforce Strategy.
- Notes that the People & Culture Committee will now receive this report prior to its appearance at Board.
  .

Laura Smith / Jenny Allen and Ann Hobson
Director of Workforce and Transformation Lead
14 May 2025, updated 21 May 2025

Appendix 1:

Leeds Community Healthcare NHS Trust

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

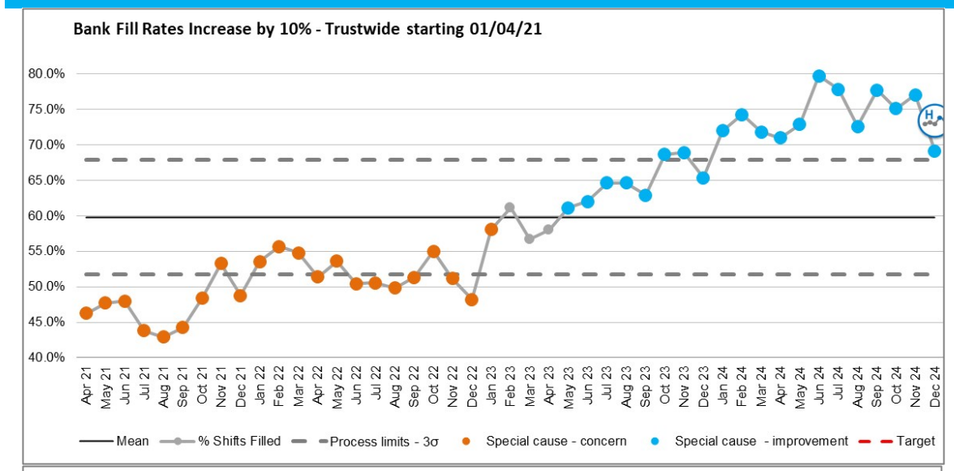
Theme	Measure	Rag Status	Theme	Measure	Rag Status
Resourcing	Bank Fill Rates increase by 10% and active bank capacity increases by 20%	Completed	Organisational Design	Resourcing plans are in place for each Business Unit and refreshed annually. Primarily undertaken at service level and linked to Q&V programme, in addition to annual organisational planning round	Completed
	Turnover is below 13%, with stretch target of 11%	Completed		The overall LCH Workforce Plan reflects system partnership approaches to specific pathways, careers or roles see above	Completed
	Vacancy fill rates achieve 90%, with more applicants for hard-to-recruit roles than in 2020/21. Filling of International recruits. Some recent successful filling of consultant vacancies. Focus for 2025/26 is on smaller number of essential vacancies, to reduce overall workforce size	Superseded		e-Rostering is fully implemented, enabling systematic skills and capacity planning by services	Completed
	Range of advertising and marketing options is increased, with regular targeted campaigns for high priority roles / services. Increased range introduced and now dialling back in 2025/26 in response to changed organisational need & priorities	Completed		Hybrid Working is fully embedded, supporting and informing the design and delivery of LCH approaches to Estates, Sustainability and Digital	Completed
	Recruitment Service offer is clearly specified, with associated KPIs regularly monitored and achieved	In progress		A new LCH approach to Flexible Working is developed and introduced, with some form of flexible working taken up by >50% of LCH staff	Completed
Leadership	Quarterly and National Staff Survey results evidence overall improvement of at least 5 percentage points in staff experience of their leaders, with areas implementing Leadership Development action plans seeing specific improvement in scores	On target	Inclusion	14.5% of the LCH workforce have a Black, Asian & Minority Ethnic background, increasing from 10% in 2021 and working towards 18% by 2028	On target
	New managers have attended an LCH Leadership Essentials module, or provided evidence of recent equivalent training with a previous employer LEAD Programme	Superseded		LCH talent management programme cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career	Completed
	Executive Team performance in Committee and Board settings reviewed by external audit partner, informing Well Led action planning and individual development plans.	Completed		Staff Survey results evidence reduction of at least 50% in the gap in discrimination experience of disabled and BAME respondents, with aspirations towards complete closure of the gap. Whilst the overall trend for BME staff has shown a narrowing of the disparity gap, for staff with a disability, the disparity gap remains (Based on WRES and WDES staff survey results 2019-2024)	Improving
	LCH talent management programme cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career. 2025/26 focus on targeting existing development offers	Completed		100% of new starters and middle managers have been offered training in LCH's approach to inclusion via the LCH Leadership Essentials course. Now focused on LEAD programme, and Skills Boosters, targeted to services going through organisational change; and 25/26 focus additionally on where areas of need are identified and New Manager Induction	Superseded

Appendix 1:

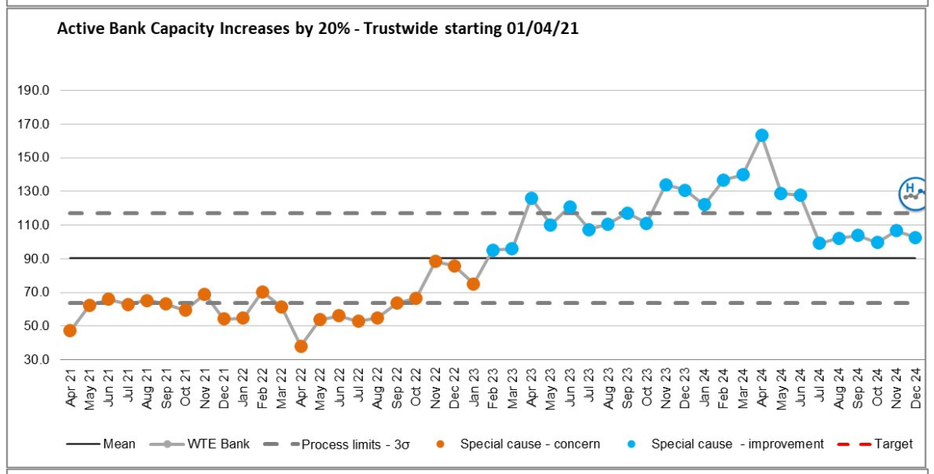
Wellbeing	Our “lead indicators” from the Staff Survey around staff engagement, motivation, and support from line managers, improve year on year between the 2021 and 2024 Staff Surveys. 2024 engagement scores dipped back to 2022 levels, but other scores maintained	**On track**	**System Partner**	A minimum of 4 recruitment or training exercises per year, on average, are carried out collaboratively with ICP or ICS partners	**On track**
	Absence due to stress / anxiety / depression is reduced, with overall annual sickness below 5% by 2025. Sickness back to 2021 levels of 6.5%, some way off 5%	**Improving**		The GP Confederation has a full suite of pay, terms & conditions protocols	**On track**
	Long term sickness absence rates return to target levels of <3.5%, with a stretch target of 3%	**On track**		LCH staff in multiple services are working beyond LCH’s organisational boundaries in support of LCH and system goals	**Completed**
	Staff reporting that LCH takes positive action on HWB rises by 5%	**Improving**		LCH staff join ICP and ICS colleagues in undertaking collaborative and system leadership training opportunities	**Completed**
	Health & wellbeing conversations are embedded as a regular part of appraisal and employee / leader conversations, supported by LCH leadership training	**Completed**			
Foundations	Service specification with KPIs is in place for Resourcing, Workforce Information and HR	**In progress**	**Foundations**	Core KPIs including “time to recruit;” “average length of formal ER case” are met and within benchmarked norms	**In progress**
	A co-produced Organisational Training & Development offer and approach is in place, in partnership with QPD	**Completed**			

Appendix 2: Workforce Strategy Dashboard: performance charts against quantitative outcome measures

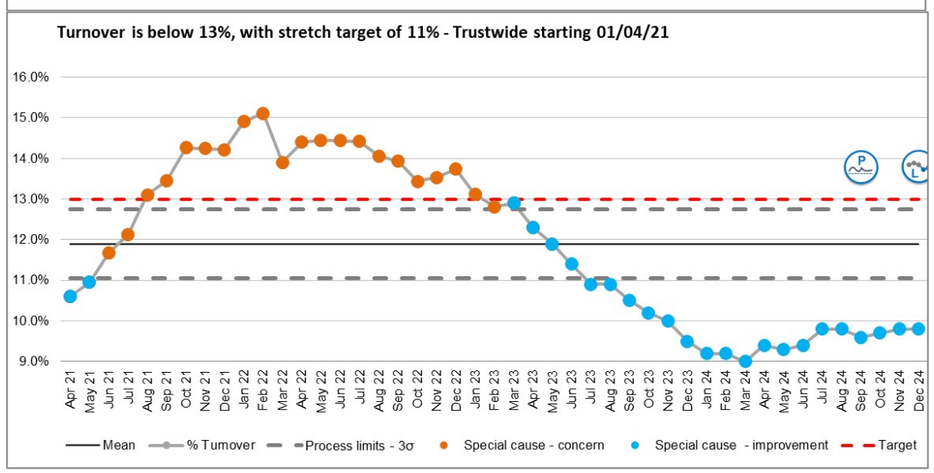
Resourcing



Increased 52% on average YTD in comparison to Apr 21-Mar 22



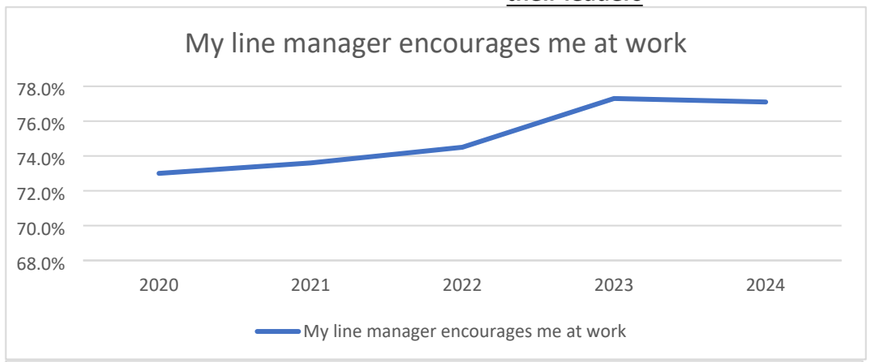
Increased 87.4 on average YTD in comparison to Apr 21-Mar 22



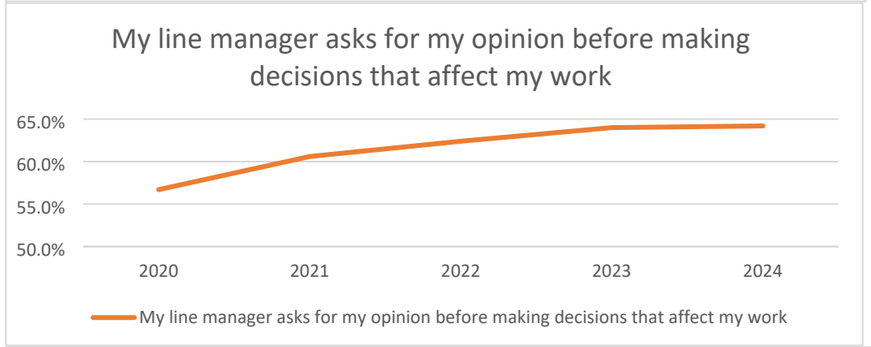
Decreased 4.6% since Apr 22

Leadership

Staff Survey results evidence overall improvement of at least 5 percentage points in staff experience of their leaders

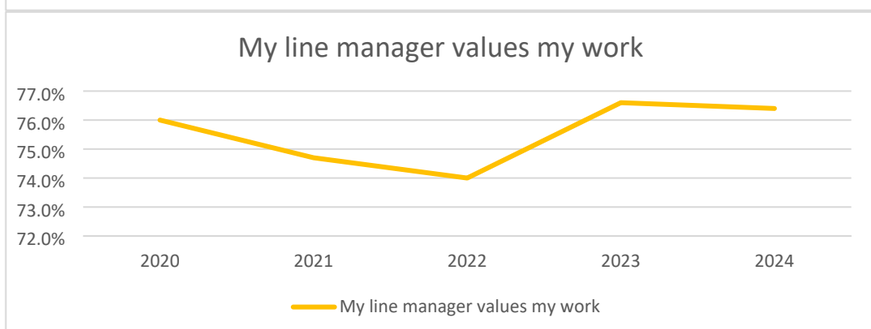


Increased 4.1% since 2020



Increased 7.5% since 2020

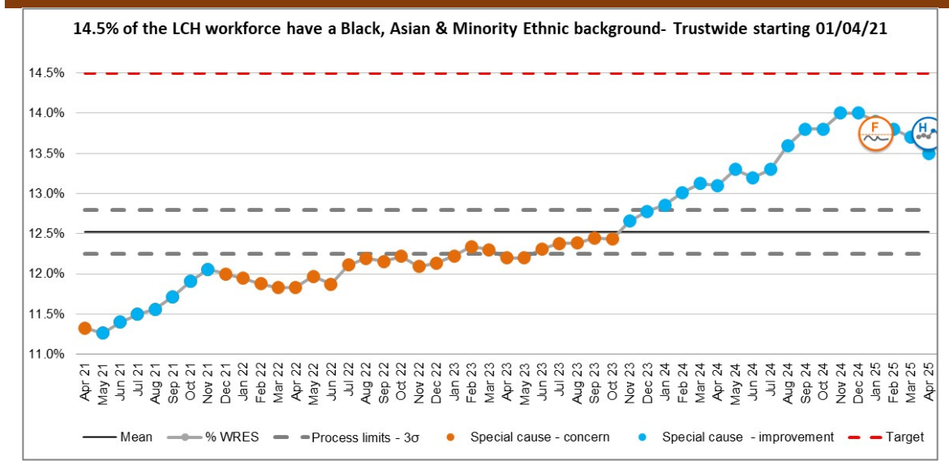
Increased 4.2% since 2020



Increased 0.4% since 2020

Appendix 2: Workforce Strategy Dashboard: performance charts against quantitative outcome measures

Inclusion



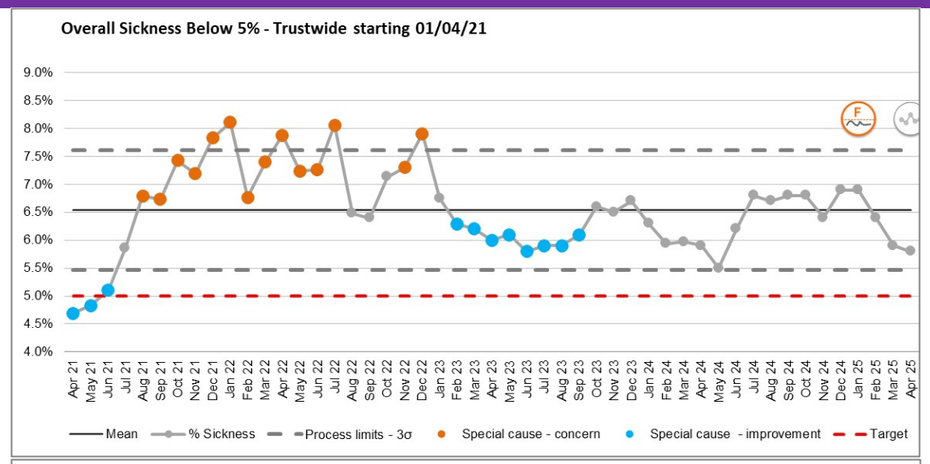
Increased 2.7% since Apr 21

Staff Survey results evidence reduction of at least 50% in the gap in discrimination experience of disabled and BAME respondents

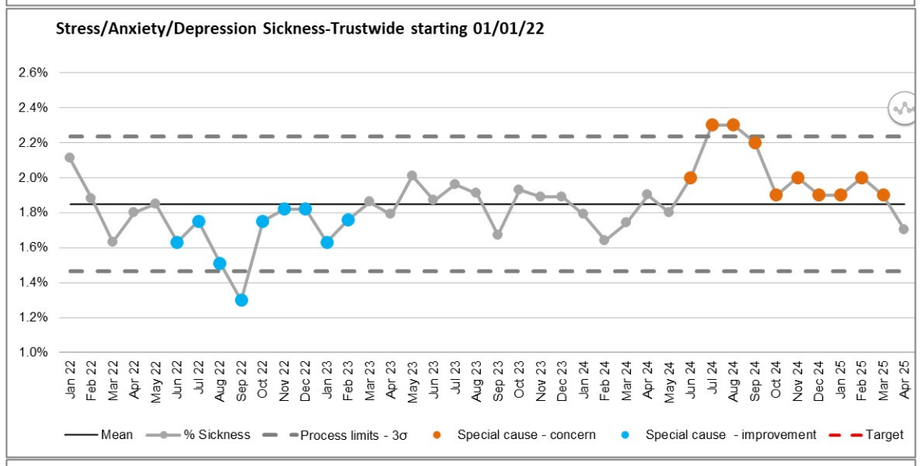
Decreased 11% since 2020

Decreased 4% since 2020

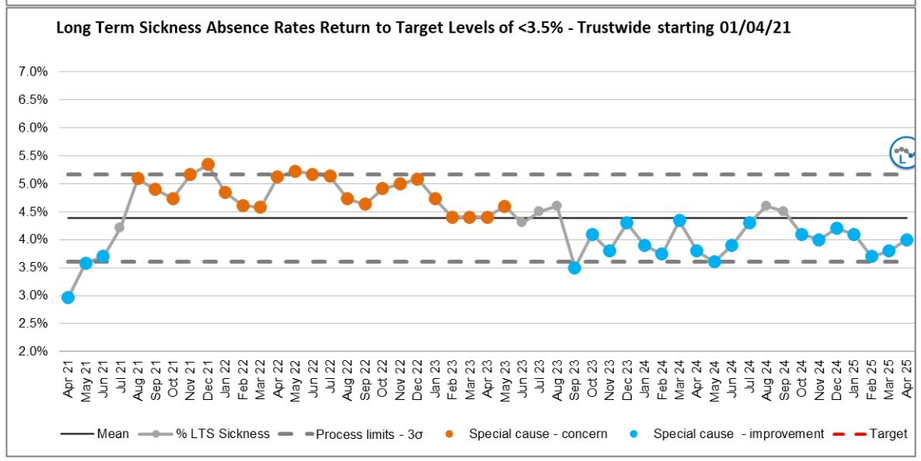
Wellbeing



Decreased 0.2% since Apr 22



Increased average 0.3% since Apr 22



Trending as a decrease in LTS since Aug 23

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	**Report to:**	Trust Board 5th June 2025
Date of Meeting:	27th May 2025	**Date of next meeting:**	24th June 2025

Introduction

Quorate meeting with a full agenda and good debate on key topics in relation to Quality Assurance in LCH. A spotlight agenda item was presented by Chris Garside AHP Practice Education Facilitator on Innovations in placement for student dietitians at LCHT. Showing good quality practice and opportunity for student retention into workforce.

Alert	Action
N/A	

Advise

- QAIG key issues for escalation were noted. A question on the style of paper and how we can make this more robust for future committees. This will be reviewed in the next Quality Committee and QAIG Joint workshop 24th June 2025
- Clinical Audit Plan 25/26 – We reviewed 2025/26 the clinical audit plan to ensure it reflected clinical and safety priorities organisationally. The Plan was approved.
- End of year Trust priority report was reviewed and approved by Quality Committee for final sign off 5 June 2025.
- Quality Account 24/25 – A review took place as part of committee meeting. It was agreed to make further amendments based on collective comments and the sign off will take place as part of the End of Year Sign off meeting on 25th June 2025.
- Performance Brief – This was a review for data in April 2025. All elements were discussed in Safe, Caring, Effective and Responsive.
- Quality & Value Programme – A review of the Q4 position for the 24/25 programme and plans for 25/26

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Assurance

- Safeguarding Internal Audit Sudden Unexpected Infant Death – Committee were pleased to see an excellent level of assurance from the internal audit and thanked the team for their hard work

Risks Discussed and New Risks Identified

Committee Escalation and Assurance Report

- The Risk Register report was presented, showing movement in clinical and operational risks scoring 8 and above. There was a discussion around the Trusts newaly formed Risk Management Group and how we improve our trustwide reporting. We continue to have 2 x Extreme risks scored 15 and above.

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	**Risk score (current)**	**Overall level of assurance provided that the strategic risk is being managed (or not)**	**Additional comments**
Risk 1 Failure to deliver quality of care and improvements: If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm.	16 (extreme)	Reasonable	N/A
Risk 2 Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage.	16 (extreme)	Reasonable	N/A
Risk 3 Failure to implement the digital strategy. If the Trust fails to implement the agreed digital strategy, then, services could be inefficient, software may be vulnerable, and the impact will be delays in caring for patients and less than optimum quality of care.	12 (high)	Reasonable	N/A
Risk 4 Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation, and adverse media attention**.**	9 (high)	Reasonable	N/A
Risk 9 Failure to prevent harm and reduce inequalities experienced by our patients. If the trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently causing harm, delivering unfair	12 (high)	Reasonable	N/A

Committee Escalation and Assurance Report

care and exacerbating inequalities in health outcomes within some cohorts of patients.			

Author:	Lynsey Yeomans/Helen Thomson
Role:	Executive Director of Nursing and AHPS/Committee Chair
Date:	27/05/2025

Agenda item:	2024-25 (34i)

Title of report:	Quarter 4: Mortality Report

Meeting:	Trust Board Meeting Held In Public
Date:	5 June 2025

Presented by:	Executive Medical Director					
Prepared by:	Geraint Jones (CCIO)					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	

Executive Summary:	**Adult and Child Mortality Summary** Adult deaths (735 in Q4) are within normal variation. A data reporting issue incorrectly classified 69 incidents as "fatal" when only 9 were actual attributed deaths. This has been corrected through data cleansing, with policy alignment and training improvements underway. Learning disability mortality remains stable at ~2 deaths monthly. Child mortality has stabilised at 2.6 (within 0.4 of mean), reversing the previous upward trend. Communication gaps were identified between services about foetal abnormalities, and safety concerns about "Next to me" cribs have been escalated nationally.

Previously considered by:	Quality Committee/QAIG

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?	Equity analysis shows higher mortality in services serving vulnerable populations and areas of high deprivation, reflecting

				broader social determinants of health.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	• Note the contents of the Trust Q4 mortality report. • Approve the action plan for mortality reporting. • Endorse city wide approach to equity analysis for mortality data. • Support request to prioritise Mortality data and reporting review within Business Intelligence.

List of Appendices:	

Mortality Report Q4 2024/25

Adults Deaths

Total Adult Deaths: The total number of adult deaths reported in Q4 was 735, this figure is within normal variation.

An incident in Police Custody has resulted in a Regulation 28 Learning From Deaths report being issued. Key learning was in relation to improvement of joined up working and responses to the unresponsive patient between both LCH healthcare staff and Police force.

Mortality Reporting

*What***:** A change to the way in which data is recorded and reported nationally using the LFPSE framework on datix is giving a false impression of LCH in relation to the number of incidents resulting in a fatal outcome. The appearance of LCH being an outlier in the region, with 69 fatal incidents recorded, has been investigated and is a result of how the incidents on deaths are reported within Datix following the move to the LFPSE framework. Clinical, Quality, Clinical Governance and Information leads met to identify cause for the issue and agree objectives and actions for resolution. The investigation has shown that the actual number of attributed deaths is 9 in 2024/25. Short- and long-term objectives were set to resolve the current issue and mitigate further for the future.

So What: All incidents reported as fatal in 2024/25 have been bulk rejected to clear and reset the LFPSE data. The incidents have been reviewed and reclassified with appropriate LFPSE outcomes based on severity of harm cased by the incident. All reported incidents have already been subject to the appropriate Patient Safety Incident review procedures to confirm cause of death and level of harm.
The elevated figure was due to staff reporting the outcome of incidents as “fatal” meaning LCH caused the death rather than the severity of the harm caused to the patient before they died. Reporting the outcome of the incident as “fatal” has resulted in a higher incidence of cause of death being attributed to LCH care or delay in care. The over reporting therefore makes LCH appear as an outlier in mortality in comparison to place and peers.
The over reporting is a result of a change made by NHS England to how LFPSE data is collated not an LCH change, although the resolution requires a change in the LCH incident reporting process. The way mortality and incidents are first reported on Datix with an outcome of death is the cause of the over reporting. Reclassifying the outcome to the appropriate level of harm cause by the incident has corrected the issue. The review and reclassification has resulted in a reduction in the number of “fatal” incidents to 9, which is the known fatal incidents following rapid review and appropriate case reviews. This figure aligns to our peer levels of “fatal” incidents.

Now What: Corrective measures have been agreed and actioned to ensure the data for the LFPSE dashboard is correct to mitigate the immediate risk of any reputational damage and ensure the correct data is available. Improvement plans have been agreed for sustainable improvements in reporting to maintain patient safety and organisational reputation and optimise opportunities for learning from deaths.

Immediate actions:

- Rejection, review and correction of previously reported fatal incident data – complete.

- Process to reject and review newly reported fatal incidents to confirm correct level of harm – complete.
- Communication to staff completing mortality reviews and patient safety reviews regarding corrective measures. Message on datix and update on published mortality policy. – complete

Sustainable improvement actions:

- Update reporting deaths process to ensure incidents where a patient has died is reported correctly. Align process across Trust where possible to reduce variation – in progress.
- Algin mortality and patient safety review policies – in progress
- Mortality policy update to include updated reporting deaths process, format being reviewed for easier readability – in progress.
- Review datix for better alignment with LFPSE and improve ease of reporting – in progress.
- Update training to ensure new process and policies embedded in practice – to be started.

People with Learning Disabilities

The mortality rate for people with learning disabilities remains stable at approximately 2 deaths per month, from 2019, with only 1 individual with learning disabilities dying this quarter. All LD deaths are undergoing level 2 mortality reviews as standard; no incidents were identified this quarter.

LeDeR Reviews: LCH attendance at the LeDeR review meetings has paused due to long term absence of the LD Lead.

Child Deaths

Total Deaths: Child deaths have stabilised this quarter, returning to within 0.4 of the mean (2.6) and reversing the previous upward trend. All deaths have undergone Trust Rapid Review, with one review pending. A communication gap has been identified where LTHT midwifery services are not consistently sharing foetal abnormality information with 0-19 PHINS, prompting a new incident reporting process.

The publication of a Regulation 28 Prevention of Future Deaths report, following a death in another organisation, was taken as a learning opportunity prompting immediate communication and alerts to staff and families to minimise future harm. Concerns about the rise of "Next to me" cribs after a twin death is being escalated to the National Team.

A backlog of 29 reviews (down from 36) is being addressed, prioritising CDOP-ready cases. Gaps in Clinical Lead role for CBU and Paediatrician coverage of child death reviews have been delaying some actions; interim coverage is arranged for upcoming meetings. Limited paediatrician coverage remains on the risk register, though currently sufficient for notifications.

Equity

While disproportionate mortality among Black children was noted this quarter, the Chair of Child Mortality Review Group has recommended that equity data analysis at Trust level is of limited benefit due to small numbers. A whole-Leeds approach would be more impactful, with clear communication of city-wide learning and understanding of its applicability within our Trust.

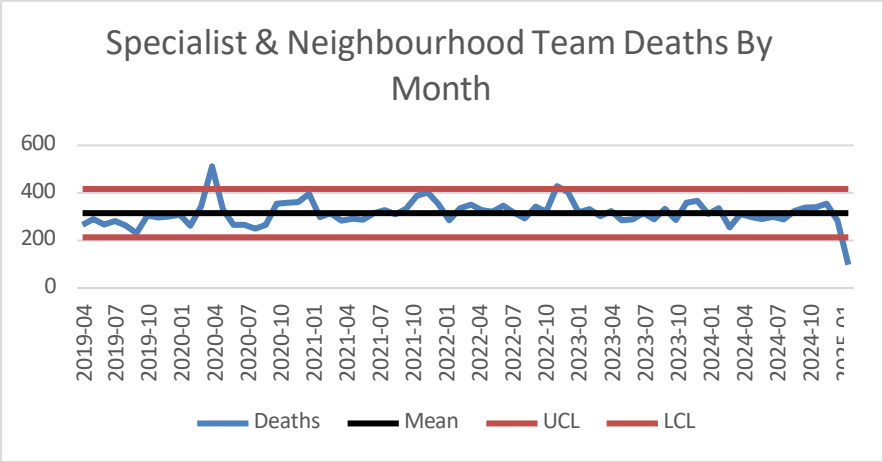
No new ethnicity trends were identified for preferred place of death.

Higher reporting of deaths for people aged 75 and below were concentrated in specific services: Homeless Health Inclusion Team (100%), TB services (76%), Leeds Mental Wellbeing (84%), and Specialist Weight Management Services (82%). Neighbourhood teams with elevated reporting included Beeston (36%) and Chapeltown (34%), with all other teams/services below 20%.
Deaths in areas of highest deprivation (Decile 1&2) were most prevalent (>50%) in TB service, Homeless Health Inclusion Team, Leeds Mental Wellbeing Service, and the Armley, Beeston, and Chapeltown Neighbourhood Teams. These patterns align with Leeds demographics, reflecting areas of increased deprivation or high-risk populations.
Ongoing work continues with Business Intelligence to review and analyse ethnicity data more comprehensively across services for multiple purposes including mortality reviews. The “About me” work to visualise relevant flags and demographics including ethnicity, learning disabilities and reasonable adjustments kicked off in April 2025. Combined with the Business Intelligence updates to the mortality data and visualisation will improve reliability of the available date for surveillance and improvement.

Recommendations
Board is recommended to:
1. Note the contents of the Trust Q4 mortality report.
2. Approve the action plan for mortality reporting.
3. Endorse city wide approach to equity analysis for mortality data.
4. Support request to prioritise Mortality data and reporting review within Business Intelligence.

Key Opportunities Risks and Successes Adult Mortality Report flash report, Q[4] 24/25

Quantitative Data:

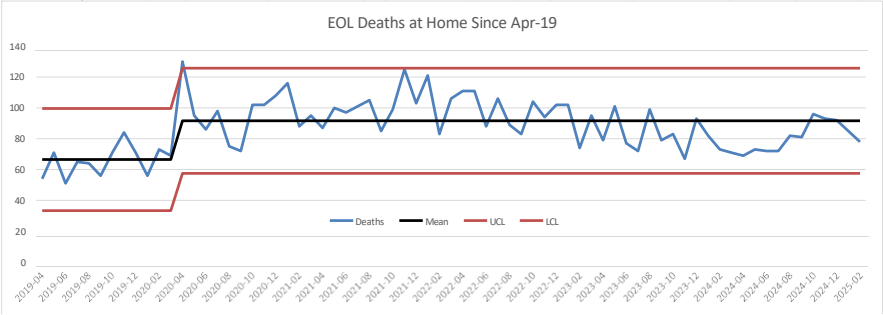


NT Level 1 Assessments Completed

Month	YES	NO	Grand Total	% Completed
2024-01	132	189	321	41%
2024-02	124	142	266	47%
2024-03	128	179	307	42%
2024-04	105	118	223	47%
2024-05	123	156	279	44%
2024-06	115	144	259	44%
2024-07	100	164	264	38%
2024-08	115	143	258	45%
2024-09	110	142	252	44%
2024-10	146	139	285	51%
2024-11	173	125	298	58%
2024-12	166	126	292	57%
2025-01	179	134	313	57%
2025-02	124	114	238	52%
2025-03	18	70	88	20%
Grand Total	**10649**	**9225**	**19874**	**53%**

Specialist Level 1 Assessments Completed (Includes those completed by NTs)

Month	YES	NO	Grand Total	% Completed
2024-01	48	87	135	36%
2024-02	43	83	126	34%
2024-03	46	77	123	37%
2024-04	31	59	90	34%
2024-05	32	61	93	34%
2024-06	29	72	101	29%
2024-07	29	70	99	29%
2024-08	42	79	121	35%
2024-09	39	56	95	41%
2024-10	32	75	107	30%
2024-11	42	68	110	38%
2024-12	37	76	113	33%
2025-01	54	74	128	42%
2025-02	34	74	108	31%
2025-03	6	27	33	18%
Grand Total	**3439**	**4962**	**8401**	**40%**



For inclusion within the bereaved carers survey *** Data for this report is from 1st January - March 18th due to timescales required for submission***.

There were a Total of 735 Adult Deaths in Quarter 4 2024/25. Adult deaths are tracking within normal variation levels for reporting, Individual reporting for Team/services for SBU and ABU shows all teams are within usual variation with no outliers.

Trends A Health Needs assessment has recently been completed across West Yorkshire ICB network which identified significant increases in deprivation levels within all cities however, Leeds was identified as the highest. Leeds Palliative Care Network are in early discussions regarding their renewed priority areas for inclusion within the bereaved carers survey which will focus on Deprivation, Learning Disability and Ethnicity .

Learning Disability

There has been 1 person with a learning disability (LD) who died in Q4 open to LCH. This case was not referred for a Rapid Review which is being investigated and due to staff absence, we do not have a formal update this quarter for Learning disability.

Preferred place of Death: The numbers of patients dying at home continue to move towards pre pandemic levels. Understanding the factors for different population groups and how they may impact on end of life care is being increasingly explored within the network. This will be considered for LCH reporting for Q1 25/26. (PIP report) PPD achieved for patients included on EPaCCS: March year to date figures .

1st choice 75.8%

1st or 2nd choice 80.3%

Ethnicity data: There were no new ethnicity trends identified for preferred place of death. We will review 24/25 ethnicity data in Q1 25/26 as this is supplied annually from BI. Higher reporting teams for deaths for people aged 75 and below were noted to be Homeless Health inclusion **Team** 100%, **Tb** 76% , **Leeds Mental Wellbeing** 84% **and specialist weight management services** 82% and **Beeston** (36%) and **Chapeltown** (34%) **Neighborhood Teams**. All other neighborhood Teams /services are below 20%. The demographic of the city dictates that these are all areas of either increased deprivation or high-risk populations.

Percentage of deaths in Decile 1&2 outliers (above 50%): TB service, HHIT, LMWS, Armley, Beeston and Chapeltown (All three NT's to be expected).

Ongoing work continues with BI to review ethnicity data.

Expected/Unexpected deaths.

SBU (All Services except Podiatry, MSK & Gynae) = 83 Expected and 10 unexpected deaths, 176 were not recorded.

ABU = 285 Expected and 34 Unexpected deaths 3209 were not recorded.

SBU: Open Serious and Internal Concise Investigation Status: 1: LMWS PCMH: 99238: Moderate harm reported in May: PSII led by LYPFT as main provider. Timescales are overdue due to LYPFT capacity, investigation ongoing and remains overdue DoN aware.

ABU: One open Patient Safety Incident investigation open for Beeston NT within Q4 24/25. Unexpected death in care home for a patient we were providing insulin administration for. Any learning to be reported in Q1 25/26.

Inquests: Regulation 28 received from an inquest involving Police Custody 86232, this is ongoing, and further updates will be given.

Theme noted in relation to deaths related to wound infections. HTA completed to review the wound infection framework with plans to update this and work remains ongoing.

Increase in inquests noted this year trust wide. Will continue to be monitored.

Mortality questionnaires: Current BI data indicates that the completed 1&2's are low; See risk section

Level 1: NT=53% and SBU 40%

Level 2: NT= 52% and SBU 51%

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

Key Opportunities Risks and Successes Adult Mortality Report flash report, Q[4] 24/25

Opportunities/Successes (Making Stuff Better/Celebrations)

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

Opportunity/Success

Business units Clinical Leads are now tracking all actions derived from mortality surveillance meetings and Inquest feedback. Mortality presentation slides updates to reflect Action ID's and actions needed to be taken forward. This provides clear assurance evidence for relevant action and improvements. One example is the creation of renewed guidance for palliative care bed transfers to reduce overreliance on the palliative care ambulance service which has been circulated citywide.

Inquest learning is now a standing item on the mortality surveillance meeting agenda with Sarah Yeomans attending to provide feedback on learning and actions required.

BAF 1	BAF 2	BAF 3	BAF 4

Opportunity/Success

Due to retirement, we have an opportunity to review the function and role of the medics within the mortality process and consider further the role of primary care to create the most impact on assurance.

BAF 1	BAF 2	BAF 3	BAF 4

Opportunity/Success

Review of the mortality policy is underway in order to have a clear process for reporting deaths as a result of an incident. This should improve accuracy of data from datix.

BAF 1	BAF 2	BAF 3	BAF 4

Risks/issues

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

RISK

Long term absence of LD Lead Nurse.
There is a risk of a Gap in specialist knowledge and expertise within the Trust. Potential delays in subject matter expert review of incidents and delays in obtaining feedback from mortality and Leder reviews for patients with a learning disability.

Mitigation

Request from QAIG for any potential specialist support from other agencies e.g. LTHT/ICB/LYPFT.

*BAF 1	BAF 2	BAF 3	BAF 4

RISK

There are potential inaccuracies within the available Mortality data sources. Specifically, the completion of mortality 1&2 review templates and unexpected deaths. There is a risk we could be making decisions based on partial or misinformation.

Mitigation

In Q1 25/26 We require support from QAIG to secure dedicated time from the Business Intelligence Team to support the Business units and Quality Leads to review and cross reference data sources to ensure robust and accurate data is being provided throughout the system.

BAF 1	BAF 2	BAF 3	BAF 4

RISK

Mitigation

BAF 1	BAF 2	BAF 3	BAF 4

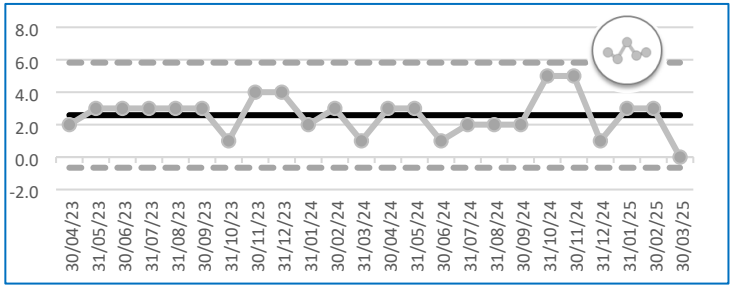
S1 Systems, processes & practices to keep people safe	*S4 Medicines management*	*S5 Track record on safety*	*S6 lessons learned & improvements made*	*E1 Standards, legislation & evidence-based practice*	*E2 Outcomes of care & treatment*	*E3 Staff skills, knowledge & experience*	*R4 Listening & responding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

Key Opportunities Risks and Successes Adult Mortality Report flash report, Q[4] 24/25

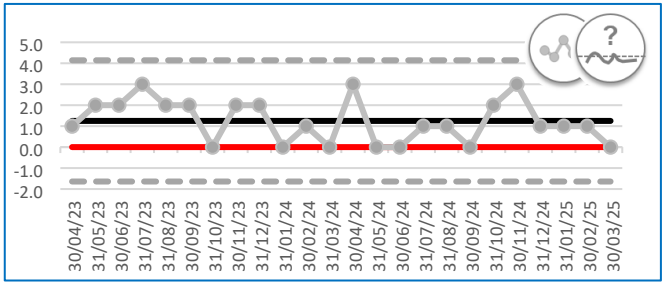
BOARD ASSURANCE FRAMEWORK (BAF) – QUALITY COMMITTEE RISKS		
Risk 1 Failure to deliver quality of care and improvements: If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm. **Quality Committee (Exec Director of Nursing and AHPs)**	**Risk 2** Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage. **Quality Committee and Business Committee (Exec Director of Operations)**	**Risk 3** Failure to invest in digital solutions. If the Trust fails to invest in improving core technology and in new digital solutions, then resource may not be utilised effectively, services could be inefficient, software may be vulnerable and the impact will be delays in caring for patients and less than optimum quality of care. **Quality, Business and Audit Committees (Exec Director of Finance and Resources, Exec Medical Director)**
Risk 4 Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation and adverse media attention. **Quality and Business Committees, and Trust Board. (Senior Management Team)**	**Intentionally Blank**	**Intentionally Blank.**

Key Opportunities Risks and Successes – Child Deaths Q4 2024/2025

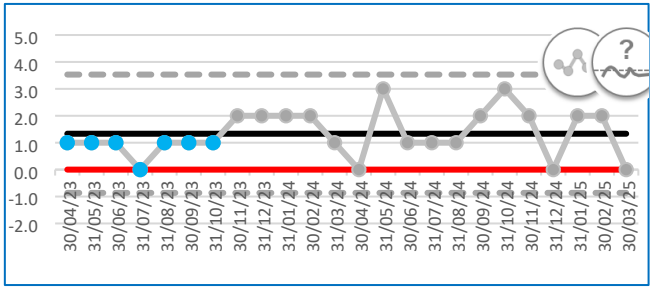
All Child Deaths

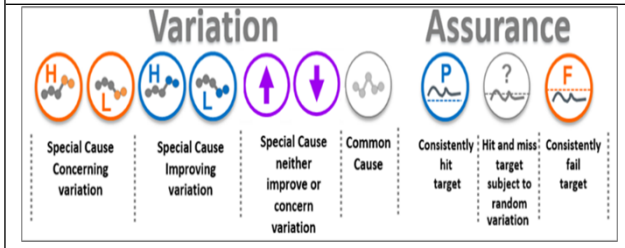


Unexpected Child Deaths

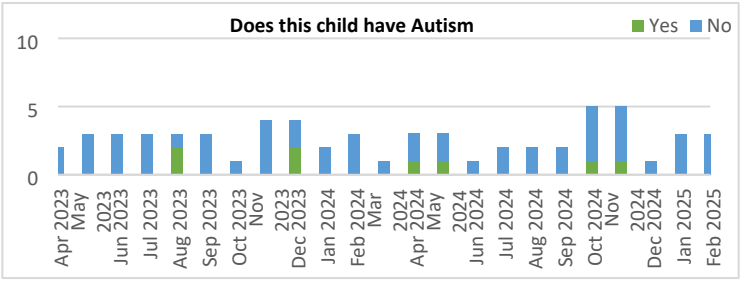


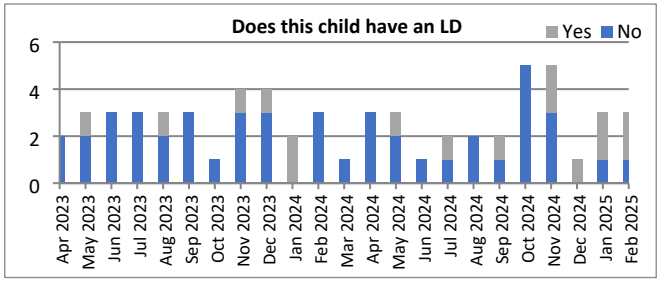
Expected Child Deaths





The deaths have returned to within 0.4 of the mean (Mean = 2.6), therefore have not continued to show an upward trend as reported last quarter. All deaths have been subject to the Trust Rapid Review process, with one outstanding for the quarter, this death is subject to the internal rapid review process and will be discussed at panel. There is some early learning noted; whereby midwifery (LTHT) are not sharing relevant information about suspected fetal abnormality. Informed the Chair of the Child Death meeting and CDOP as this was a feature in two recent deaths brought to the Trust Child Death meeting. The Quality Lead for CBU has requested all incidents where LTHT do not advise 0-19 PHINS of an abnormality to be incident reported to ensure the relevant data is collected to support work moving forward as this is impacted on the 0-19 offer. The information is scrutinised at the LCH Child Death meeting and Citywide, Child Death Overview Panel.

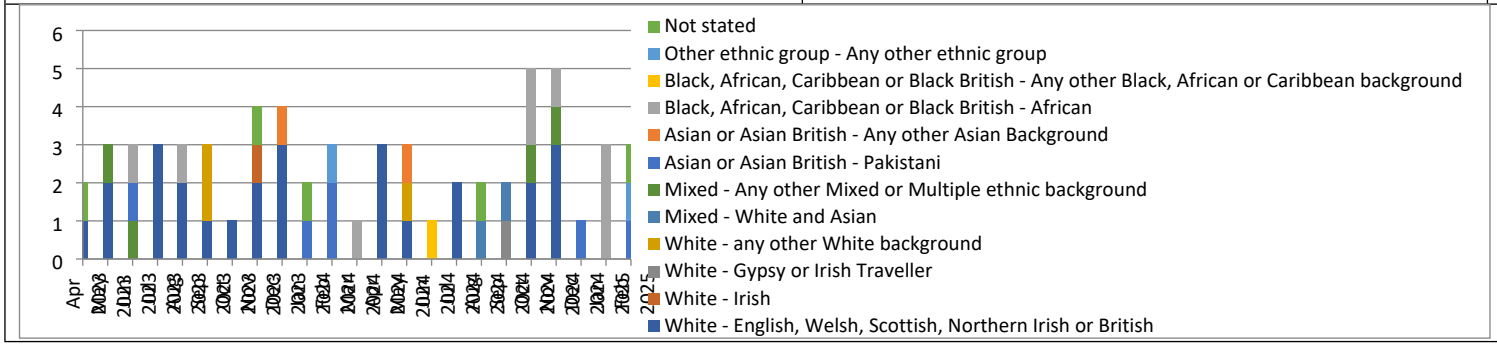




This information needs to be considered in relation to

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

Therefore, it is limited in its usability.



Ethnicity

The ethnicity of the children who have died has been reviewed, it is evident this quarter that there is a disproportionate number of children with their ethnicity recorded as black. Although the last quarter report acknowledges this is discussed Leeds wide at CDOP, and was not going to be included, this will be continued to be monitored.

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

Key Opportunities Risks and Successes – Child Deaths Q4 2024/2025

Opportunities/Successes (Making Stuff Better/Celebrations)

Opportunity/Success – to prevent future deaths

A Regulation 28 Prevention of Future Deaths report has been published following the death of a baby whilst in a sling and breastfeeding.

Alert sent to 0-19 PHINS for immediate action. Information shared with practitioners and via the 0-19 Facebook page for families.

BAF 1	BAF 2	BAF 3	BAF 4 √

Opportunity/Success - to prevent future deaths

There has been a reported child death of a twin sharing a Next to me crib (there were other known risk factors involved in the case). These types of cots are on the rise, there was concern shared at the child death meeting regarding the use of these.

To escalate the concern to the National Team.

BAF 1 √	BAF 2	BAF 3	BAF 4

Opportunity/Success

BAF 1	BAF 2	BAF 3	BAF 4

Opportunity/Success

BAF 1	BAF 2	BAF 3	BAF 4

Risks/issues

RISK
There are currently twenty-nine child deaths to review, this has decreased from last quarter (36). CDOP have advised they are now awaiting LCH cases for discussion, this was previously unknown, we have been reviewing the deaths in date order.

Mitigation
Continue to review between 6 and 8 cases every 2 months, we will now prioritise the deaths which CDOP are ready to review, with 8 cases requiring more urgent review. We have agreed to bring forward the next child death meeting to support with this work

*BAF 1 √	BAF 2	BAF 3	BAF 4

RISK
There is a current gap in the Clinical Lead role for CBU and Clinical Lead role for ICAN Paediatricians, this is resulting in lack of progression for some key actions which require senior oversight.

Mitigation
Escalated to the General Manager for CBU and Head of Service for ICAN and Children's Community Nursing, agreed for the Head of Service for ICAN and CCN to cover May 25 meeting.

BAF 1	BAF 2 √	BAF 3	BAF 4

RISK
Risk remains of limited number of Paediatricians covering the Service, the service has Paediatricians who can cover notifications. This is on the risk register ID 1121. (Improving situation to remain until closed on the risk register. **No change from last quarter.**

Mitigation
The service has Paediatricians who can cover notifications.
There have been no reported incidents in relation to this.

BAF 1 √	BAF 2	BAF 3 √	BAF 4

Additional or supporting information (optional)

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

Agenda item:	2025-26 (34iv)

Title of report:	Mortality and Learning From Deaths Annual Report 2024/25

Meeting:	Trust Board Meeting Held In Public
Date:	5 June 2025

Presented by:	Ruth Burnett, Medical Director					
Prepared by:	Geraint Jones, CCIO					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	This report provides assurance that the Trust has robust mortality review processes in place during 2024/25. Adult mortality remained within expected ranges, with 80% of patients dying in their preferred place of death. Learning disability mortality was stable, with improved identification processes implemented. Child mortality showed normal variation with increased cases in Q3 but now stabilised. Key focus areas included improving ethnicity recording, addressing equity gaps together with Leeds Palliative Care Network in preferred place of death achievement, and enhancing communication between services. The Trust has updated its Mortality Review Policy, aligned with Medical Examiner processes and "Making Data Count" principles. Recommendations focus on sustaining improvements, addressing equity gaps and optimising data collection and presentation.

Previously considered by:	Quality Committee

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

Is Health Equity Data included in the report (for patient care	Yes	✓	What does it tell us?	**Equity Summary:** Analysis of 2024/25 mortality data revealed a decline in preferred place of death achievement for

and/or workforce)?				certain ethnicities earlier in the year. This is from small numbers in the data set and is being investigated as may be related to a temporary reduction in a IPU beds. Higher mortality rates continue to be observed in areas of highest deprivation (Decile 1&2), particularly in TB services, Homeless Health Inclusion Team, and specific Neighbourhood Teams.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	1. Approve this report as assurance regarding Trust mortality processes during 2024/25 2. Support the ongoing implementation of the revised Mortality Review Policy 3. Endorse the focus on improving ethnicity recording and addressing equity gaps in achieving preferred place of death 4. Note the progress made in aligning mortality reporting with the NHS "Making Data Count" strategy 5. Support the ongoing work to implement the "About Me" workflow to improve data quality

List of Appendices:	

Annual Mortality Assurance Report 2024/25

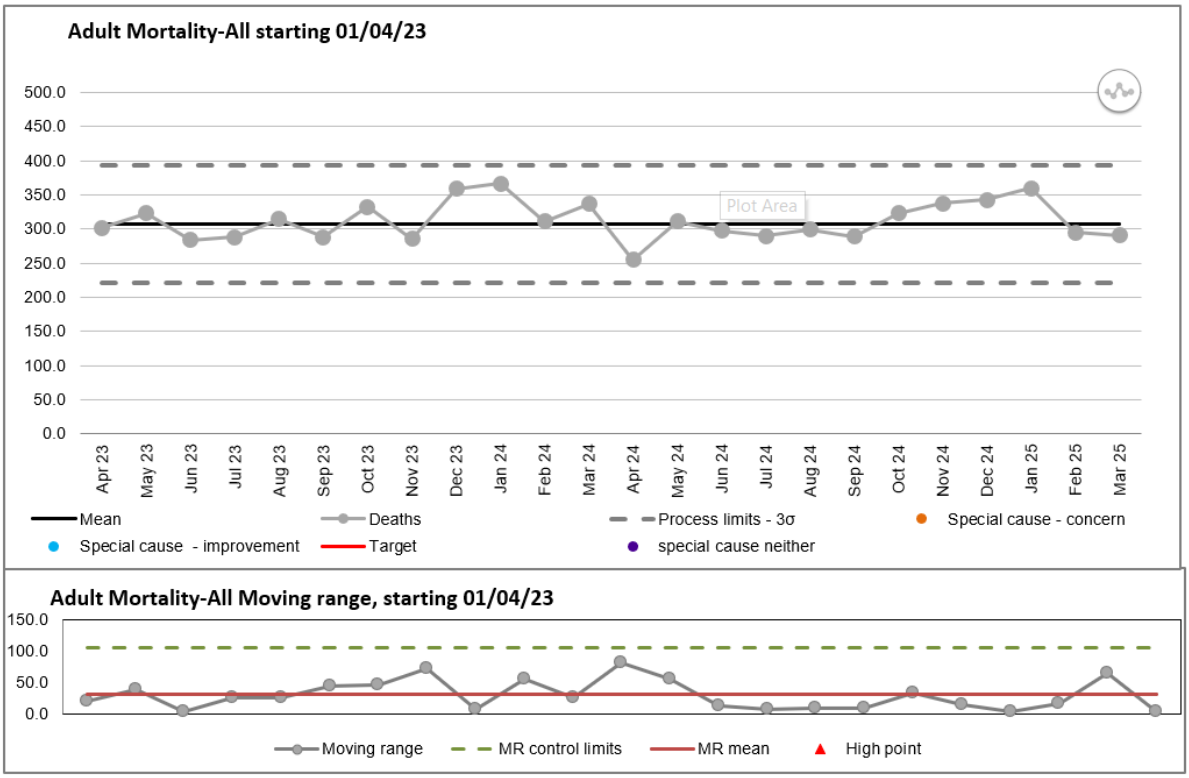
1. Introduction

This report provides an overview of mortality data and assurance processes within the Trust during the 2024/25 financial year. Building on quarterly reports presented to the Quality Assurance & Improvement Group (QAIG) and Quality Committee throughout the year, this annual report aims to demonstrate how the Trust effectively reviews, learns from, and improves care following patient deaths. The mortality reporting framework has been updated during this period to align with changes in the Medical Examiner process and the NHS "Making Data Count" strategy, with increased emphasis on Statistical Process Control (SPC) charts for data visualisation and analysis.

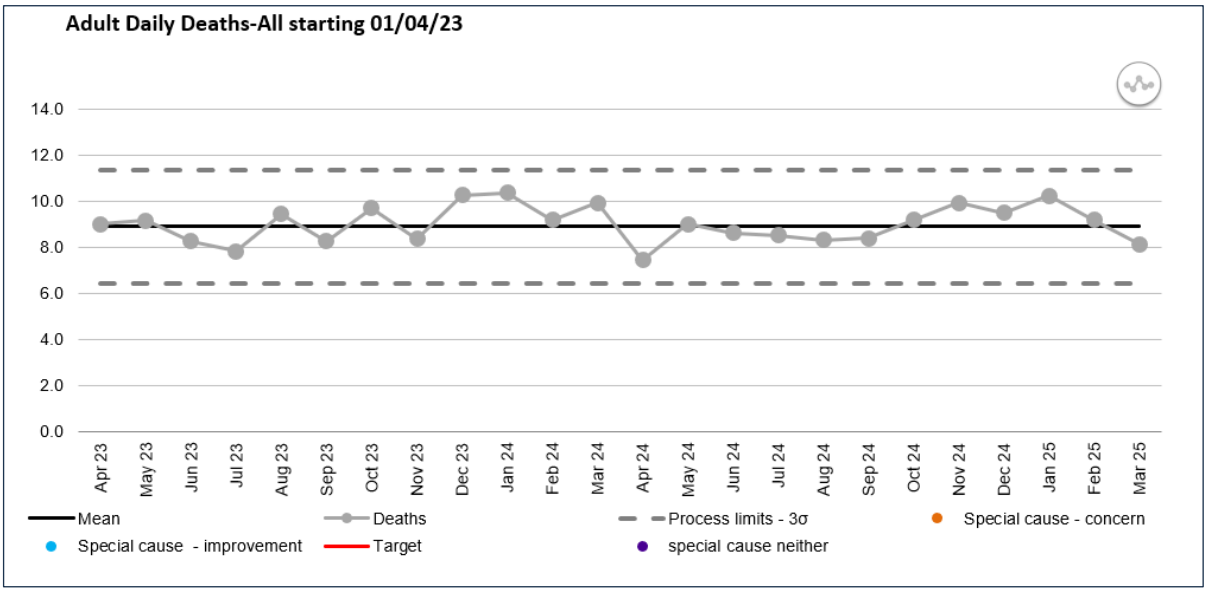
2. Current Position

Adult Mortality

Overall adult mortality across 2024/25 showed normal variation within control limits. Some seasonal variation noted in line with national data. The final quarter (Q4) reported 735 deaths, consistent with expected patterns.



Mortality data continues to be monitored across neighbourhoods and services to identify local patterns and emerging trends, enabling early detection of any areas of concern. There is a clearly agreed process within the Adult Business Unit to follow in the event of the upper control total being breached, or a cluster of deaths occurring in a particular neighbourhood, in a younger than expected age group or in any of the bed bases. For the 2024/25 period, the daily death rate by neighbourhood remains within control limits and no trends noted. All neighbourhoods and specialist teams are operating within expected control limits, with no outliers identified.



Throughout the year, approximately 80% of patients died in their preferred place of death (PPD), a figure that has remained relatively stable since 2022.

Developments in adult mortality review include:

- Implementation of a revised mortality review process aligning with the Medical Examiner process
- Enhanced training to support the achievement of the 75% target for completion of Level 1 assessments
- Identification of data quality issues in expected/unexpected death classification.

Learning Disability Mortality

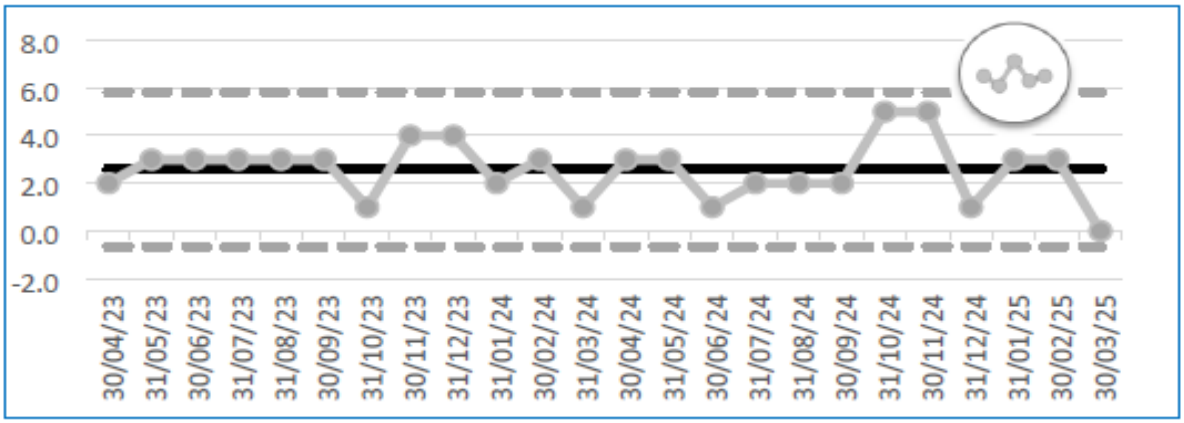
The mortality rate for people with learning disabilities has remained stable at approximately 2 deaths per month since 2019. A 50% increase in learning disability deaths was noted in Q1, however subsequent investigation identified this as improved identification rather than increased mortality. All deaths of people with learning disabilities are now subject to Level 2 mortality reviews as standard practice.

Developments in learning disability mortality review include:

- Introduction of a dashboard on Datix to provide data for children with registered disability and autism
- Inclusion of the Learning Disability Lead within the review process
- Identification of potential equity gaps in achieving preferred place of death

Child Mortality

Child mortality data showed normal variation throughout most of the year, with an increase in Q3 (36 cases) followed by stabilization in Q4 returning to within 0.4 of the mean (2.6).



Communication gaps between services were identified as a recurring theme, with specific focus on information sharing between acute trusts and community services.

Key challenges in this area include:

- Capacity issues for timely review of child deaths
- Limited paediatrician coverage (Risk ID 1121)
- Backlog of reviews being addressed through regular review meetings

Mortality Reporting Process Improvements

Significant improvements to mortality reporting were implemented during 2024/25:

- An updated Mortality Review Policy aligned with audit recommendations
- Transition to the LFPSE framework, with identification and correction of data quality issues
- Enhanced data visualisation using SPC charts
- Improved data collection processes for ethnicity recording

3. Impact

Quality
The review of mortality data has identified several quality improvement opportunities:

- Communication gaps between services, particularly regarding child deaths and changes in patient status
- The need for improved recording of expected/unexpected deaths
- Refinement of processes for timely mortality reviews

Actions taken to address these include updated policies, additional training, and process improvements. The Trust has responded appropriately to Regulation 28 Prevention of Future Deaths reports, implementing learning and improvements to services.

Risk and Assurance
The mortality review process provides assurance that deaths are appropriately reviewed, and learning is identified.

Risks identified include:

- Limited paediatrician capacity for child death reviews
- Data quality issues affecting the accuracy of mortality reporting
- Communication gaps between services

These risks are being actively managed through process improvements, additional training, and ongoing monitoring.

Equity
Analysis of mortality data has identified potential equity gaps:

- Decline in PPD achievement for Asian and Black patients noted in Q3 data has improved in Q4 and will continue to be monitored. Likely due to temporary reduction in IPU beds combined with data quality issues which are being addressed.
- Higher mortality in areas of highest deprivation (Decile 1&2)
- Challenges in ethnicity recording, with data missing for a significant number of adult deaths and 25% of child deaths

Learning from the frailty fellowship is being integrated into End of Life and Palliative care case management to address these disparities. We are working closely with Leeds Palliative Care Network to optimise equity especially in terms of data collection, analysis and identifying potential improvements. LCH chairs the LPCN EDI group and is currently looking at experience with three focus areas: LD, deprivation and ethnicity. The group is currently scoping what data is already available.

4. Next Steps

The Trust will continue to strengthen mortality review processes through:

1. Implementation of the updated Mortality Review Policy.

2. Introduction of an "About Me" workflow visualisation within SystmOne in 2025/26 to improve ethnicity, Learning Disabilities, communication needs and reasonable adjustments data recording.
3. Ongoing work with Business Intelligence to optimise data quality, analysis and visualisation.
4. Continued focus on achieving equity in preferred place of death
5. Sustainable improvement actions to ensure accurate incident reporting and classification
6. Close alliance with the LPCN and alignment with West Yorkshire Palliative and End of Life Care Holistic Needs Assessment.

5. Recommendations

The Board is recommended to:

1. Receive this annual report as assurance regarding Trust mortality processes during 2024/25
2. Support the ongoing implementation of the revised Mortality Review Policy
3. Endorse the focus on improving ethnicity recording and addressing equity gaps in achieving preferred place of death
4. Note the progress made in aligning mortality reporting with the NHS "Making Data Count" strategy
5. Support the ongoing work to implement the "About Me" workflow to improve data quality

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 5 June 2025
Date of Meeting:	30 April 2025	**Date of next meeting:**	28 May 2025

Introduction

Quorate meeting for key items which needed sign off. Full discussion on key topics – good challenging conversations with constructive feedback provided on papers requiring comment. This Committee included a scheduled Information Technology workshop which focussed on the progress of the team.

Alert	Action
No Alerts	

Advise

- The Committee was advised that the Internal Audit on Recruitment for pre-employment checks received significant assurance. The Committee discussed the key findings and actions to mitigate the risk, including any cyber/fraud related issues.
- The Committee received a verbal update on MindMate SPA service and progress with Northpoint. The business case drafting is underway. The Committee was advised that the digital requirements were being reviewed with AireLogic. The Committee sought assurance on value for money (such as evidence of seeking potential digital solutions from a range of providers) and the overall risk/reward of the business case.
- The Committee reviewed the proposal for the disposal of land at Burmantofts Health Centre. The Committee confirmed that it was supportive of the land sale i.e. option 4 and recommended that it go to Board for approval.
- The Committee received a verbal update on the Neighbourhood model. It was noted that West Yorkshire (WY) have commissioned 'Attain' to review where we are across WY with LCH leading by example on programmes like Home First, where LCH have concentrated on admission avoidance to hospital with good demonstrable success to date. Also, good discussions noted with primary care.

Assurance

- Q&V – The Committee welcomed the Q&V results for the end of year and thanked all teams involved in their efforts in the first year of the programme, with a surplus of £1.9M exceeding planned position by £0.9M. The Committee also noted the pressure and the ongoing risk to achieve recurrent savings and congratulated the CIVAS team in their recurrent savings achievements for the last fiscal. The Committee noted the £500k stretch target, to add to the recurrent corporate savings of £2.4M for 2025/6. The Committee discussed the impact of the transformation on staff and well-being and **noted to flag this for discussion to the People and Culture Committee.** The Committee discussed lessons learnt and requested to see a report once finalised.

Committee Escalation and Assurance Report

- The Committee welcomed the Digital, Data and Technology strategy report update, and acknowledged the progress of the digital strategy and transformation in the last year e.g. embedding equity with Leeds Sexual Health service for the Trust 'information hub which is a website which can be accessed 24x7 e.g. patients requesting medications. The Committee asked for the next update to include plan priorities and timescales.
- The Committee received the EPRR annual report and improvement plan, it discussed how comprehensive it was and congratulated the team. The Committee discussed the role of cyber security given the current external landscape, and was assured further work is being undertaken in this area.
- The Committee discussed the financial report. It congratulated the team and wider team on this fantastic effort for the year end results. The Committee does recognise the risks particularly in recurrent benefits as we progress in the new fiscal. The Committee discussed plans around CAMHS, including out of area placements. The committee was assured with the deep dive on partnership assurance and PwC action plan.
- Waiting lists – all services doing a one-page business case to come to the committee on reducing the waiting list backlog. The Committee was assured of current plans, with a focus on missed appointments.
- The Committee noted the progress made by the Information Technology team, presented as part of the IT workshop - including achievements e.g. MDE and Cyber Plus. Plans were discussed with Committee asks for: i) assurance to be provided on timescales, ii) further detail requested for assurance on cloud and network infrastructure. iii)The Committee asked for a deep dive on cyber to be brought forward.
- The Committee agreed that it had received reasonable assurance against all relevant strategic risks.

Risks Discussed and New Risks Identified

- No new risks identified or discussed.

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	Risk score (current)	Overall level of assurance provided that the strategic risk is being managed (or not)	Additional comments
Risk 2 Failure to manage demand for services: If the Trust fails to manage demand in service recovery and in new services and maintain equity of provision then the impact will be potential harm to patients, additional pressure on staff, financial consequences and reputational damage	16 (extreme)	Reasonable	

Committee Escalation and Assurance Report

Risk 3 Failure to invest in digital solutions. If the Trust fails to implement the agreed digital strategy, then, services could be inefficient, software may be vulnerable, and the impact will be delays in caring for patients and less than optimum quality of care.	12 (high)	Reasonable	
Risk 4 Failure to be compliant with legislation and regulatory requirements: If the Trust is not compliant with legislation and regulatory requirements then safety may be compromised, the Trust may experience regulatory intervention, litigation and adverse media attention.	9 (high)	Reasonable	
Risk 5 Failure to deliver financial sustainability: There is a risk that the Trust will not be financially sustainable which will jeopardise delivery of all our strategic goals and priorities.	16 (high)	Reasonable	
Risk 6 Failure to have sufficient resource to transformation programmes: If there is insufficient resource across the Trust to deliver the Trust's priorities and targeted major change programmes and their associated projects then it will fail to effectively transform services and the positive impact on quality and financial benefit may not be realised.	9 (high)	Reasonable	The issue of maintaining the wellbeing of staff with a 'healthy' transformation culture was raised and to flag into the new People and Culture committee for monitoring.
Risk 7 Failure to maintain business continuity (including response to cyber security): If the Trust does not have suitable and sufficient staff capacity, capability and leadership capacity and expertise, within an engaged and inclusive workforce then the impact will be a reduction in quality of care and staff wellbeing and a possible misalignment with the objectives of the Q&V programme.	12 (high)	Reasonable	
Risk 8 Failure to have suitable and sufficient staff resource (including leadership): If the Trust does not have suitable and sufficient staff capacity, capability and leadership capacity and expertise, then the impact will be a reduction in quality of care and staff wellbeing and a net cost to the Trust through increased agency spend.	12 (high)	Reasonable	

Committee Escalation and Assurance Report

Author:	Lynne Mellor
Role:	Committee Chair
Date:	12 May 2025

Committee Escalation and Assurance Report

Name of Committee:	Audit Committee	**Report to:**	Trust Board 5th June 2025
Date of Meeting:	15th April 2025	**Date of next meeting:**	15th July 2025

Introduction

Quorate meeting with a full agenda and good debate on key topics – good challenging conversations, particularly around internal audit outcomes, with constructive feedback provided on papers requiring comment.

Alert	Action
• N/A	

Advise

- External Audit – advised that the value for money work had commenced, no risks or areas of significant weakness identified to date. Committee accepted that the fees were increasing due to the time, experience and expertise required to perform the audit. The Audit Strategy Memorandum was noted.
- Annual Report progress update – assurance provided that this was on track. First draft of the Annual Governance Statement was well-received. Those Charged With Governance (TCWG) statements were approved.
- Performance Brief Development Plan – Committee was advised that quotations were being sought for an external review of performance, its reporting arrangements and format of the report.
- Draft Head of Internal Audit Opinion – expected to be significant assurance pending four final audits currently in draft form awaiting management responses.
- Request from Committee for all fieldwork to be completed by end of Jan 2026 to allow time for all reports to be finalised by the end of March 2026.

Assurance

- Committee received and noted the Tenders and Quotations waiver report, and Losses and Special Payments report.
- The Security Management Report was noted, with assurance given that effective security management structures and processes were in place in the Trust. A reducing trend in security incidents was highlighted, and consideration was being given to the use of body-worn CCTV.
- Two final Internal Audit reports received – both significant assurance: Recruitment: Pre–employment checks, and Board Assurance Framework and Risk Management Framework. Four further reports issued in draft form and awaiting management responses. On track to fully deliver the plan.
- Cyber Security six monthly update received and noted.

Committee Escalation and Assurance Report

- Audit Committee Annual Report, Review of Performance and Terms of Reference (ToR) - all reviewed and approved. ToR to be approved at next Board in June. Committee also considered the annual reports from the Board sub-committees and agreed each provided assurance they were conducting their business in accordance with their ToR and within the scheme of delegation.
- Board Assurance Framework – processes noted for the review of the 24/25 BAF and the plan for 25/26.

Risks Discussed and New Risks Identified

- N/A

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

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

Author:	Helen Robinson/Khalil Rehman
Role:	Company Secretary/Committee Chair
Date:	17/3/2025

Agenda item:	2024-25 (37)

Title of report:	Charitable Funds Update Report

Meeting:	Trust Board meeting Held In Public Board
Date:	5 June 2025

Presented by:	Executive Director of Nursing and Allied Healthcare					
Prepared by:	Charitable Funds Officer					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	This paper presents the rationale for establishing a regular six-monthly reporting cycle to the Board from the Charitable Funds Committee. Historically, the Committee has submitted assurance reports on an ad hoc basis. However, due to the increasing volume, complexity, and strategic importance of charitable activity, it is proposed that charitable funds become a standing item on the Board agenda twice annually.

Previously considered by:	Charitable funds committee

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

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

Recommendation(s)	1. **Note** the increasing scale and strategic importance of the Charity's work. 2. **Approve** the proposal to include Charitable Funds as a standing item on the Board agenda on a six-monthly basis.

	3. **Support** the development and launch of a dedicated social media presence to enhance visibility and engagement. 4. **Endorse** the continued exploration of new fundraising opportunities, with appropriate risk oversight by the Charitable Funds Committee and Steering Group. 5. **Recognise** the contribution of staff and volunteers to the Charity's success and the positive impact on Trust services and the wider community.

List of Appendices:	N/A

1 Introduction

The Charitable Funds Committee is responsible for overseeing the management and use of charitable funds in accordance with the organisation's charitable objectives and regulatory requirements. In recent years, there has been a notable increase in:

- The number and scale of charitable projects.
- External donations and fundraising initiatives.
- Strategic alignment of charitable activities with organisational priorities.

This growth has highlighted the need for enhanced visibility and governance at Board level.

2 Current position/main body of the report

The Charity continues to grow in both scale and impact, with increasing recognition across the city. Our presence is becoming more visible to supporters, partners, and the wider community, which is reflected in the growing engagement with our fundraising initiatives.

Fundraising Activities

- **Leeds 10k Event (15th June 2025)**:
  We are participating in the Leeds 10k for the first time as a charity, with 14 runners registered, of which 12 are staff members. So far, the total funds raised amount to £1,038. Please refer to the attached email from the staff members who are running for further details.
- **LCH Front of House Initiatives**:
  The Front of House team continues to support fundraising efforts through various activities such as raffles, football cards, and the tuck shop. These initiatives have been consistently successful within the organization.
- **LCH Giving Voice Choir**:
  The most recent donation from the choir was £716.28. Their ongoing support is greatly appreciated.

Upcoming Fundraising Events

- **September 2025**: Yorkshire 3 Peaks Challenge.
- **October 2025**: Restart Heart Day - CPR-ATHON.
- **Charity Golf Day**: Discussions are underway with a local golf club to host this event.

Grants

- **Hannah House Grant from Rothwell Freemasons**:
  A grant of £20,400 has been received to upgrade the current sensory room at Hannah House.
- **Hannah House Grant from Rothwell Lions**:
  Ongoing discussions regarding the allocation of funds (exact amount to be confirmed).

- **Expression of Interest (EOI) to NHSCT**:
  An EOI has been submitted for £150,000 to deliver online groups for children and young people who are on the CYPMHS waiting list.
- **Workforce Wellbeing Grant**:
  We are in talks with ICB and other local trusts to submit a joint EOI for the workforce wellbeing grant recently launched by NHSCT.

Legacy

- We have received an interim payment of £12,000 from the sale of a house left to the charity in a will.

Corporate Fundraising

- Corporate fundraising has proven challenging, mainly due to the charity's limited presence on social media. Companies often expect substantial visibility for their support. I would appreciate any suggestions or introductions to local businesses that may be willing to partner with us.

3 Impact

Impact of Fundraising Activities on Service Projects

The funds generated through our fundraising activities are having a tangible and positive impact on the services and projects we support. These contributions are enabling us to enhance service delivery, support innovation, and reach more individuals in need. Below are recent examples of how the funds are being utilised:

TB Service – Bus Cards for Service Users

We have allocated funds to the TB service to provide bus cards to service users who face financial barriers when attending essential appointments. This initiative aims to reduce missed appointments and improve access to healthcare, ensuring that individuals can maintain a healthy lifestyle. Many of these service users experience social isolation and feel unheard, and the bus cards offer a practical solution that facilitates both accesses to care and relationship-building. By providing these cards, staff have an opportunity to engage with service users, fostering trust and enabling them to develop and sustain positive relationships.

HHIT – Gardening Project for Service Users in LS19

The HHIT team has successfully applied for and received funding for a gardening project for service users staying at [facility name] in LS19. This initiative originated from a simple conversation between the team and the service users, where it became clear that a group had developed a keen interest in gardening and wanted to grow vegetables. The funding has been used to purchase gardening equipment, providing the service users with an opportunity to engage in physical activity and access green space. Research shows that exposure to nature and green environments can significantly improve mental health, and this project will contribute to both the physical and emotional wellbeing of participants.

OT Services – Conference Funding

Our Occupational Therapy (OT) services have been awarded funds to organize a conference later this year, bringing together colleagues from across the city and various trusts to share knowledge and best practices. This event will provide a platform for professionals to learn from one another, exchange ideas, and explore new ways of working, ultimately enhancing the quality of service we provide to our users.

4 Quality

The commitment from staff who have taken part—and continue to take part—in fundraising for our Charity is truly commendable. Their dedication reflects the values of our organisation, and their efforts are deeply appreciated.

It is important to note that not all charitable work involves a direct financial ask. Some of the most impactful contributions have come from projects that promote the incredible work of our frontline staff and enhance the Trust's reputation. These initiatives have had a positive effect on staff morale and public perception.

However, there are challenges. For example, while public engagement activities such as the recent stall at Trinity Shopping Centre are valuable, they require adequate support to ensure safety and effectiveness. Attending such events alone is not feasible, and additional volunteer or staff support would enable more of these outreach efforts to take place.

Despite these challenges, the Charity continues to grow from strength to strength, driven by hard work, passion, and a shared commitment to making a difference for the people of Leeds.

5 Resources

To further support our growth and visibility, it is recommended that the Charity establish its own presence on social media platforms. Discussions with other NHS charities have highlighted that a significant proportion of their support and donations come through social media engagement.

A dedicated social media presence would allow us to:

- Share stories of impact and success.
- Promote fundraising events and campaigns.
- Engage with supporters in real time.
- Reach new audiences and build community support.

This would require minimal investment but could yield substantial returns in terms of awareness and income generation.

6 Risk and Assurance

As the Charity explores new and larger fundraising activities, it is recognised that these come with inherent risks—particularly financial commitments required to initiate events or campaigns.

With the oversight of the Charitable Funds Committee and the support of the Charity Steering Group, we are confident in our ability to identify, assess, and manage

these risks appropriately. At present, there are no corporate risks that require escalation to the Board.

We remain committed to responsible stewardship and will continue to monitor and report on risk as our activities evolve.

7 Equity

In line with our commitment to inclusivity and fairness, the following considerations were made:

- Access and Representation: Fundraising and charitable activities are designed to be inclusive and accessible to all staff, patients, and community members, regardless of background.
- Community Engagement: Efforts are being made to reach diverse communities across Leeds, ensuring that the benefits of charitable projects are equitably distributed.
- Staff Participation: Opportunities to engage in fundraising are open to all staff, and we continue to explore ways to support participation from underrepresented groups.
- Digital Inclusion: As we move toward launching a social media presence, we will ensure content is accessible and representative of the diverse communities we serve.

No negative impacts on protected or diverse groups have been identified at this stage. Ongoing monitoring will be conducted to ensure equity remains a core consideration in all charitable activities.

8 Next steps – ‘What's Next’

The Charity is at an exciting point in its development, and the following next steps are proposed:

- Launch a Social Media Platform: Establish a dedicated presence to share updates, celebrate successes, and engage with supporters more effectively.
- Expand Outreach: Continue to build relationships across the city, raising awareness of the Charity’s work and the incredible efforts of our staff.
- Strengthen Volunteer Support: Explore ways to increase volunteer involvement to support public engagement activities safely and sustainably.
- Develop a Communications Plan: Create a strategy to ensure consistent messaging and visibility across all platforms and events.
-

Through continued dedication and collaboration, the Charity will build on its momentum and further enhance its impact on the Trust and the people of Leeds**.**

5 Recommendations

The **Board** is recommended to:

6. **Note** the increasing scale and strategic importance of the Charity’s work.
7. **Approve** the proposal to include Charitable Funds as a standing item on the Board agenda on a six-monthly basis.

8. **Support** the development and launch of a dedicated social media presence to enhance visibility and engagement.
9. **Endorse** the continued exploration of new fundraising opportunities, with appropriate risk oversight by the Charitable Funds Committee and Steering Group.
10. **Recognise** the contribution of staff and volunteers to the Charity's success and the positive impact on Trust services and the wider community.

Jodie Collins
Charitable Funds Officer

Lynsey Ure
Executive Director of Nursing and AHPS

20th May 2025

Agenda item:	2025-26 (38i)

Title of report:	Performance Report

Meeting:	Trust Board Held In Public
Date:	5 June 2025

Presented by:	Andrea Osborne, Director of Finance					
Prepared by:	Victoria Douglas-McTurk, Head of BI and Performance, Adam Glass, Performance Manager					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	This report highlights key areas of performance; including areas that are performing well, areas where improvement work is underway, and early warning of deteriorating performance. Performance is split across six Domains, and a summary of overall performance and improvement initiatives is given for each domain, followed by a focused update into specific indicators that meet criteria for inclusion in the narrative section of this report.

Previously considered by:	Senior Leadership Team Quality Committee Business Committee

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

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes	X	What does it tell us?	There is a widening gap between patients in IMD1 vs IMD 2-10 for how long people wait before care starts
	No		Why not/what future plans are there to	

			include this information?	

Recommendation(s)	- To seek any further assurances required - To direct any further improvement work

List of Appendices:	Appendix 1 – Summary of Indicators Appendix 2 – Indicator Movements

Leeds Community Healthcare NHS Trust

LCH Performance Brief

April 2025

Introduction

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

Performance is measured across six domains, using indicators selected by the Board at the start of the financial year:

- Safe - By safe, we mean people are protected from abuse and avoidable harm
- Caring - By caring, we mean staff involving and treating people with compassion, kindness, dignity, and respect
- Responsive - By responsive, we mean services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice, and continuity of care
- Effective - By effective, we mean that care, treatment, and support received by people achieve good outcomes and helps people maintain quality of life and is based on the best available evidence
- Well-led - By well-led, we mean leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture
- Finance – Finances are well managed

Performance Summary

The overall picture of performance in the organisation shown by the measures in this report has not changed significantly since the last report. The number of measures exceeding their target has remained the same although this month none are showing deterioration which indicates each is stable and expected to continue to exceed targets.

There are the same number of improving measures as last reported. Good progress continues to be made in the Trust' appraisal rate and training compliance. The focus on reaching the 90% target for these continues. Each operational business unit is achieving more than 85%.

We have achieved the 99% target for DM01 in on Children's Audiology Service in April for the first time since before the pandemic. This is the result of focussed effort by the service including setting and monitoring an activity plan, weekend clinics and improvements to the referral pathway. More detail is available in the narrative

More measures are reported as deteriorating in comparison to the last report. Key measures that fall into this category are BME staff proportion and 18-week RTT and non-RTT equity measures. Narrative is provided on each of these.

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

Table 1a – Summary of SPC Indicator Performance and Assurance

	Passing	Inconsistent	Failing	No Target
Improving	NHS Talking Therapies 6 weeks treatment target Patient Ethnicity Recording	Diagnostic 6-week target (DM01) DQMI - IAPT Positive Patient Feedback	Appraisal Rate Patient Safety Training Training Compliance	Agency Percentage Agency Spend (£k) DQMI - CSDS
No Change	NHS Talking Therapies 18 week treatment target UCR 2hour Performance	Duty of Candour Leavers within 12 months Sickness Absence Starters and Leaver Net Movement	Eating Disorders 4-week Routine Target	CAMHS Accessing Treatment DM01 Equity LMWS Access ND Waiting times (over 5s) NHS Talking Therapies Screening within 2 weeks NT Contacts NT Productivity NT Staff funding utilised NT Vacancies, Sickness & Maternity WTE Number of complaints RTT 52 week equity
Deteriorating	Staff Turnover		18-week waiting list target (non-RTT) 18-week waiting list target (RTT) 52 week waiting times (RTT) 65 week waiting times (RTT) 78 week waiting times (RTT) BME Staff Proportion DQMI - MHSDS	Non-RTT 18 week equity NT Referrals RTT 18 week equity

Table 1b – Non-SPC Indicator Summary

Categorisation of Non-SPC Indicators

No Concern	Concern
cDiff Infections	CAS Alerts Outstanding
Deteriorating Patient Incidents	Eating Disorders 1-week Urgent Target
E.Coli Infections	Overdue PSII Actions
Fall Incidents	
Meatal Tear Incidents	
MRSA Infections	
MSA Breaches	
NCAPOP Audits	
Never Events	
NICE implemented from 2019	
NICE implemented from 2020	
NT Clinical Triage Incidents	
Number of PSIIs	
Presure Ulcers Incidents	
Priority 2 Audits	
RIDDOR incidents	
Total Audits completed	

Table 2 – Indicator movements since previous report

Indicator	Previous Report	This Report	Narrative
Number of PSIIs	Concern	No Concern	Although not showing in the data charts, the narrative highlights seven cases that had incorrect classifications
Overdue PSII Actions	No Concern	Concern	There are 6 overdue PSII Actions in April, and a further 3 were reported in March
Patient Ethnicity Recording	Passing, No significant change	Passing, Improving	Performance has improved, and remains above the target
RTT 18-week equity & Non-RTT 18-week equity	No Assurance icon, No significant change	No Assurance icon, Deteriorating	A pattern of growing difference is emerging between patients in IMD1 vs IMD2-10. Patients in IMD 1 are becoming increasingly more likely to wait more than 18 weeks for both RTT and Non-RTT services
NT Contacts	No Assurance icon, Improving	No Assurance icon, No Change	Following a one-off reduction in March, activity levels have returned to within normal patterns
NT Referrals	No Assurance Icon, No significant change	No Assurance Icon, Deteriorating	A statistically significant pattern has emerged, with 7 consecutive months where referrals have been higher than the mean
CAMHS Accessing Treatment	n/a	No Assurance Icon, No significant change	This indicator is measured on a Financial Year-to-date timeframe. Having crossed into a new financial year, this indicator has reset to zero. Although the data chart suggests a sharp decline in numbers, there is no cause for concern

Indicator	Previous Report	This Report	Narrative
Talking Therapies 18-week target	Passing, Improving	Passing, No significant change	Following recent improvements, good performance continues at a consistent level.
Sickness	Inconsistent, Deteriorating	Inconsistent, No significant change	Performance has actually improved to below the target level, but remains inconsistent as the target continues to sit within the control limits. This highlights that performance could see further failures of the target without being the result of any process change. However, performance within the reporting period sits at good level below the target, following a recent period of high sickness.
BME Staff Proportion	Failing, No significant change	Failing, Deteriorating	A statistically significant change is now occurring, with 5 consecutive months of decline in a row leading to deteriorating performance.
Staff Turnover	Passing, No significant change	Passing, Deteriorating	There have been two months of higher than usual turnover, with both March and April appearing above the upper control limit.
Agency Percentage	No Assurance Icon, No significant change	No Assurance Icon, Improving	There has been a longer-term reduction in this indicator, as agency usage declines.

Safe

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

Summary

The Trust has successfully supported fifteen Learning Response Leads to complete training delivered by the Health Services Safety Investigation Body (HSSIB) in a systems approach to investigating. This will further strengthen the trust's management of Patient Safety Incidents in line with the Patient Safety Incident Response Framework. They will continue to be supported by the six Patient Safety Specialists to ensure that a systems approach and humans factors thinking is applied to incident investigations.

The Central Alert System (CAS) Notification for the medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls remains overdue. Monthly strategy meetings continue to review the outstanding actions and the progress against each of these across the three clinical business units. This is co-ordinated by the Medical Device Safety Officer as the subject matter expert who is responsible for collating the updated position which is then uploaded by the Patient Safety Team to the Medicines and Healthcare products Regulatory Agency (MHRA). The Adult Business Unit are monitoring reporting numbers of staff trained, numbers on caseload to be re assessed using new risk template and numbers of new patients assessed via the monthly performance report.

Indicator Updates

This section gives updates on specific indicators that meet criteria in the Safe Domain.

Compliance in Level 1 and 2 Safety Training

What is the trend that we see?

There is a slight month on month improvement, however this has not reached the target of 95%

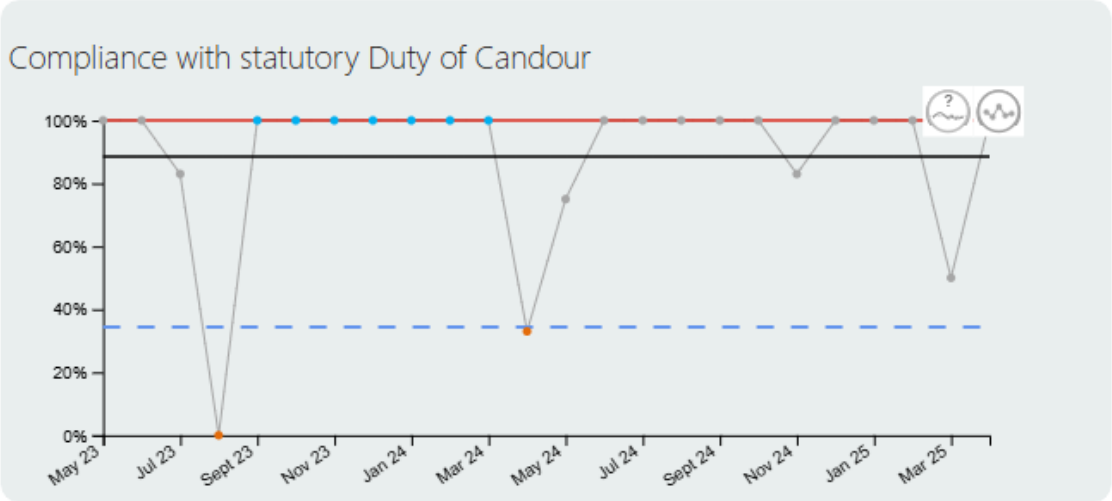
What is being done about it?

Individual Team compliance with this training is available on the Performance Information Portal (PIP) and should be formalised for review alongside other Statutory and Mandatory Training with compliance reported as part of the individual team performance meetings. Managers within the service will then ensure that time is protected for staff in their teams to complete this.

When do we expect to see improvement?

We would expect to see an improvement when the process of monitoring the compliance with this training is included within individual team performance processes.

Compliance with statutory Duty of Candour



What is the trend that we see?

There was one DoC response not dealt with as timely as was possible. Due to the complexity of the situation, there were several discussions about the most appropriate clinician to contact the family, this had already been delayed due to an ongoing police investigation. There was, however, an opportunity to resolve the discussions sooner to support timely Duty of Candour once LCH were permitted to make contact.

What is being done about it?

This was an anomaly due to the specific circumstances outlined above.

When do we expect to see improvement?

N/A see above.

Number of Patient Safety Incident Investigations (PSII)

What is the trend that we see?

Although not showing in current data sets, there have been eight declared Patient Safety Incident Investigations in April. Seven of these were historic incidents which had previously been reviewed and actions underway, however these should have been declared as fatalities as per the National patient safety requirements "*Death thought more likely than not to be due to problems in care*". The remaining PSII was managed as per process.

What is being done about it?

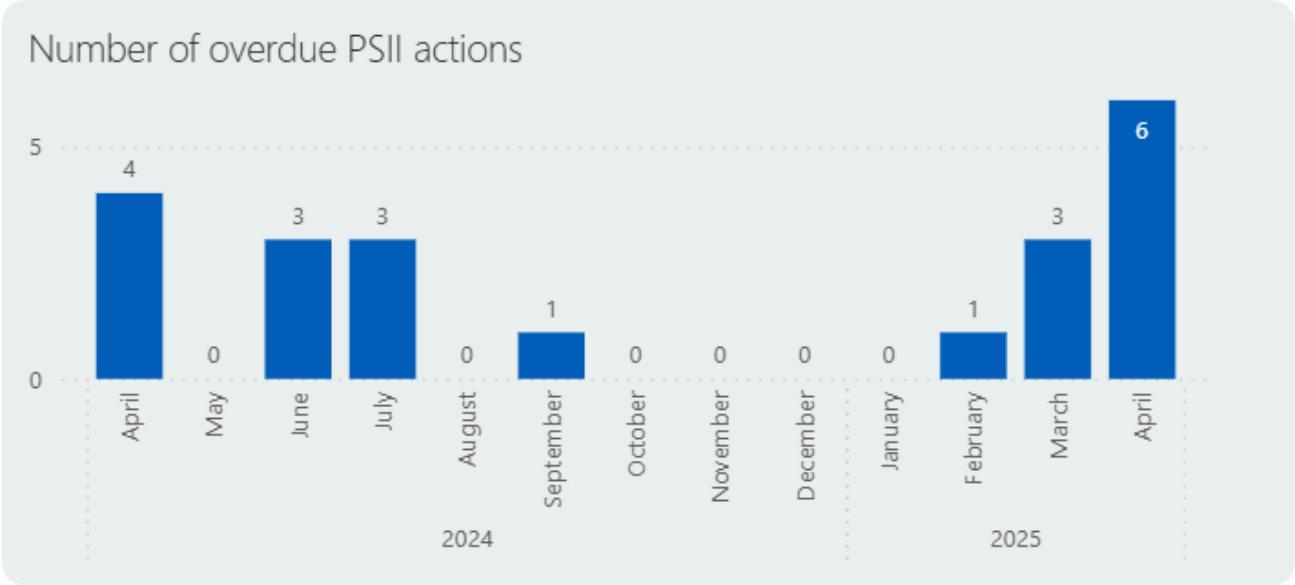
The April PSIIs will be subject to a full Patient Safety Incident Investigation in line with the Patient Safety Incident Response Plan to identify system learning and improvement. Learning will be shared via the six-monthly Patient Safety Report.

We will correctly report all future incidents where death is thought more likely than not due to LCH care.

When do we expect to see improvement?

Learning will be identified through the PSII investigations and SMART actions agreed and progressed. Learning themes will also be shared via the six-monthly Patient Safety Report.

Number of overdue PSII actions



What is the trend that we see?

There are six overdue PSII Actions, three are linked to IPC, two are dependent on the ratification of The Management of the Deteriorating Patient Policy, this has been written and is awaiting ratification. The remaining three are within ABU.

What is being done about it?

Once ratified the policy will be launched. Work has already commenced by the Sepsis Nurse to deliver bespoke face to face training with Neighbourhood Teams around the identification of soft signs using a tool, called RESTORE2, which is embedded into the policy with an escalation route when concerned or NEWS2 over certain parameters. There is also an ongoing deteriorating patient questionnaire pilot at Pudsey NT commenced in April, lasting 8 weeks.

The essential visit guidance is complete for one outstanding action this needs to go through a PDSA cycle to look at useability, once complete and any issues resolved this will be rolled out to the remaining NHT. Deputy Director of Nursing aware of the delay.

A further action will be completed by 16/05/2025

The remaining action has been discussed and escalated to ABU senior leadership team, a request for an extension will be submitted for this.

When do we expect to see improvement?

All outstanding actions will be complete by the end of June 25.

Caring

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

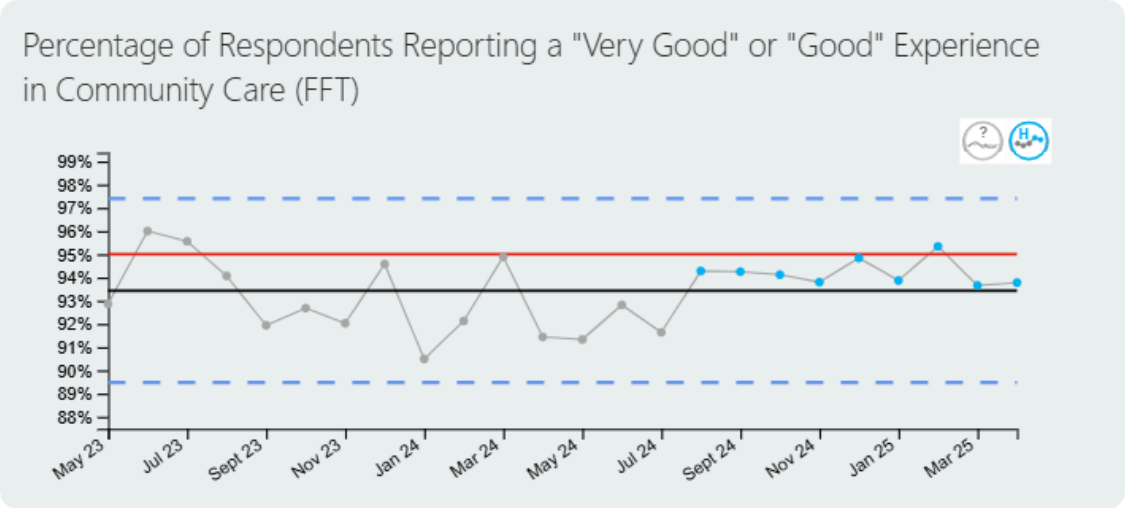
The organisation aims to uphold a strong commitment to caring by ensuring staff engage with individuals compassionately and respectfully. Staff are expected to treat people with kindness, uphold their dignity, and involve them in decisions about their care. While there are examples of positive interactions and a culture that values empathy, there are also areas of concern.

Recent Friends and Family Test (FFT) results indicate that a lower-than-expected percentage of patients and service users would recommend the service and allow we are above average, we have only met our target once in the reporting period. We are reviewing this on a regular basis, and we are committed to ensuring quality of care is not impacted.

Indicator Updates

This section gives updates on specific indicators that meet criteria in the Caring Domain.

% of Respondents reporting a “Very Good” or “Good” experience in Community Care (FFT)



What is the trend that we see?

Following a period of fluctuation, there has been a continued pattern of above average performance. However, the target has only been achieved once during that period. The data has not yet reached the target but continues a pattern of above average performance.

What is being done about it?

While there is currently no engagement officer in post to oversee this data, we have now progressed to actively recruiting the engagement posts to support monitoring and providing feedback on these findings.

When do we expect to see improvement?

We anticipate that the engagement posts will be appointed by late May to early June. Once these roles are in place, they will support the monitoring and analysis of FFT data, allowing for a more informed insight.

Effective

By effective, we mean that care, treatment, and support received by people achieve good outcomes and helps people maintain quality of life and is based on the best available evidence.

Summary

Work to improve the measures available within the Effective domain continues. Current methods for collecting and reporting on patient defined goals are being examined with the aim of identifying the best method for collation and standardising processes across the organisation. Additionally, a review of the suggested measures for the effectiveness domain has been completed. This has clarified which measures are currently in place and can be reported on in the short term, and which will need further development. Changes to the measures reported in the Performance Brief will be considered as part of the review of performance reporting planned in the coming months.

Clinical audit

The Trust audit program continues to reflect increased pressures on services and the Clinical Effectiveness Team, with an increased number of audits reported as postponed or abandoned this quarter. Technical issues with data flow have prevented submissions to two of the national audits the Trust is participating in for 24.25 and work is underway with Clinical Systems, Business Intelligence and the national teams to rectify this. Work is underway to review the national audits for 25.26, establish which are of relevance to the Trust and ensure our systems and processes will enable submission.

NICE

Compliance with the Trust rolling program for NICE review and implementation continues, with regular risk assessment of any compliance that falls outwith the agreed two year standard for implementation.

Equity

Work is underway with the Leeds Health Inequalities Oversight Group to develop an embed an equity index that can be utilised on datasets of priority, and will be introduced to Performance Brief reporting once agreed and established.

In the last quarter increasing differences in waiting times have been noted across both consultant-led and non-consultant pathways. This was also noted in evaluation of the Access LCH initiative to reduce waiting list sizes, namely that there had been an 8% reduction in IMD2-10, but 5% in IMD1. Analysis suggests this is due to increased rates of DNA and CNA rates, rather than a difference in rates of invitation to appointments and work is underway in Quarter 1 to establish how the Access LCH initiative and DNA policy can be adjusted to negate this trend.

Indicator Updates

This section gives updates on specific indicators that meet criteria in the Effective Domain.

Audit & Effectiveness

What is the trend that we see?

176 audits have been registered to date for the 2024-25 Annual Audit Plan. This is an increase of 10 since Quarter 3. However, 31 audits have either been postponed or abandoned, bringing the total number down to 145. As services add audits to the Annual Audit Plan throughout the year, the total number of audits registered increases, which will affect the data reported each quarter.

Local Audits

Breakdown across the organisation of audits registered to date is:

Business Unit	Registered	Completed	Uncompleted	Postponed	Abandoned
Adult Business Unit	16	9	6	1	0
Children's Business Unit	73	41	15	1	16
Specialist Business Unit	80	35	32	2	11
Corporate Services	7	5	2	0	0

National Audits:

LCHT currently participate in 5 national audits and submit data to 3 of these.

Business Unit	Audit
SBU	National Diabetes Footcare Audit (NDFA)
CBU	National Epilepsy 12 Audit
SBU	National Respiratory Audit Programme (NRAP).
SBU	Sentinel Stroke Audit Programme (SNAPP)
SBU	National Audit of Cardiac Rehabilitation (NACR)

Data submission for 2 audits (NACR and SSNAP), has been limited due to changes in data set requirements and resulting issues with data collection and reporting.

What is being done about it?

- A new annual audit plan (AAP) has been launched for 2025-26 to improve reporting to Clinical Effectiveness Team (CET).
- Drop-in sessions have been delivered throughout Quarter 4 to support completion of AAP.
- Quarterly drop-in sessions to be offered to support ongoing engagement with audit completion and updates to CET.
- Escalation to Clinical Leads and Medical Director regarding inability to submit data to 2 national audits.
- Liaison with services involved in audit, Clinical Systems and Business Intelligence to request updates and timeframes for completion.
- Awaiting SSNAP audit to have a community upload function to support data upload.
- Monthly review of National Audits by Clinical Effectiveness and Compliance Manager including updates from services via the Business Unit Clinical Lead
- There are 9 national audits that CET are reviewing with services to ascertain relevance to LCHT.

When do we expect to see improvement?

It is likely that we will not see an improvement for local clinical audits until 2025-2026 when the new annual audit plan is being utilised and training sessions completed.

There should be an improvement in reporting on national audits by the end of Quarter One 2025-2026. Timeframes for completion from Clinical Systems is June and then will require Business Intelligence (BI) input. We would expect to see an improvement in Quarter Two, but this will depend on capacity in Clinical Systems and BI teams for both audits and for SSNAP to have implemented the community upload function.

NICE

What is the trend that we see?

There are 20 open guidance currently in the organisation with assessment pending or action plans in place.

Three Guidance are currently out of the two-year timescale to implementation set out in the PL326 Policy for the Dissemination, Implementation and Monitoring of NICE Guidance. One guidance has become overdue during this reporting period. One guidance will potentially become overdue in the next reporting period. One overdue guidance has been closed. These are:

- NG197 Shared Decision Making
- NG212 Mental Wellbeing at Work
- NG218 Vaccine Uptake in the General Population
- NG236 Stroke rehabilitation in adults (becomes overdue in quarter 3).

All guidance has been risk assessed as low or minor risk. Seven guidance were reopened in 2024-2025 to check for compliance against service redesign and developments.

Compliance Statement:

Year issued	Number Open
2021-2022	2
2022-2023	1
2023-2024	3
2024-2025	14

What is being done about it?

All guidance has been risk assessed as low or minor risk. Actions to achieve full concordance with NICE guidance have been escalated to Business Unit Clinical and Quality Leads.

Seven guidance were reopened in 2024-2025 to check for compliance against service redesign and developments.

When do we expect to see improvement?

The number of open NICE Guidance fluctuates depending on new guidance issued. Improvement should be seen by the end of Quarter 1 in the number that are open.

What is being done about it?

Work to contact patients who missed appointments was started during the Access LCH initiative, with targeted signposting and adjustments put in place dependent on the cause of the missed appointment. Work is ongoing to identify how this can be continued and opportunities being identified for proactive support to patients at greatest risk of missing appointments.

A review of missed appointment policy is also underway, and a Trustwide workshop to understand current processes was held in May 2025 to inform further actions

When do we expect to see improvement?

Detailed action plans relating to missed appointments will be drawn up during Q1, and the review of policy will also be completed in this timeframe.

Responsive

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

Summary

Although patients continue to wait long times to access treatment in some of our services, further improvements have been made during this period. These include within Tissue Viability, Podiatry, Children's Occupational Therapy and Children's Audiology.

The total number of people waiting for care to start is continuing to decrease towards more sustainable levels. A total of 27,448 people were waiting for care to start at the end of February 2025, compared to 30,091 at the start of the calendar year. This represents a reduction of 9% over a period of 4 months. The total number of patients waiting more than 52 weeks continues to decrease, standing at 4,139 at the end of April 2025 to a high of 5,709 in August 2024, and 5,428 at the end of December 2024.

Our Children's Audiology Service met the target for 99% of patients seen within 6-weeks, achieving 100% in April 2024.

Key areas of risk are highlighted in this report, including services with the greatest concerns relating to 52-week waiting times.

Access LCH Programme

The Access LCH Programme came to a formal close in April 2024, with more than 1000 additional first appointments undertaken during the campaign.

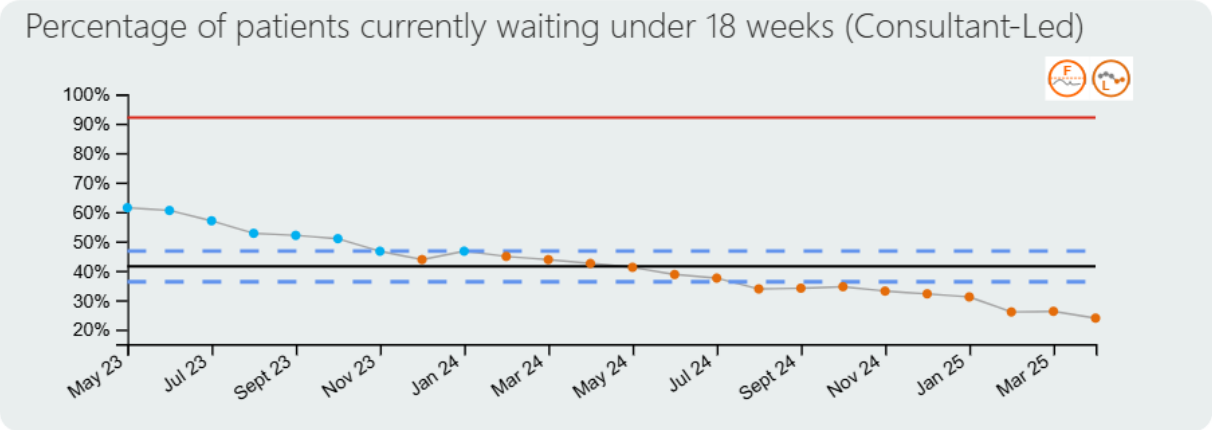
A review in April highlighted the strengths and challenges of the campaign and took forward learning for the new financial year. The Steering Group for the campaign has now been merged with the Patient Access Meeting, to consolidate the governance and oversight of responsiveness performance.

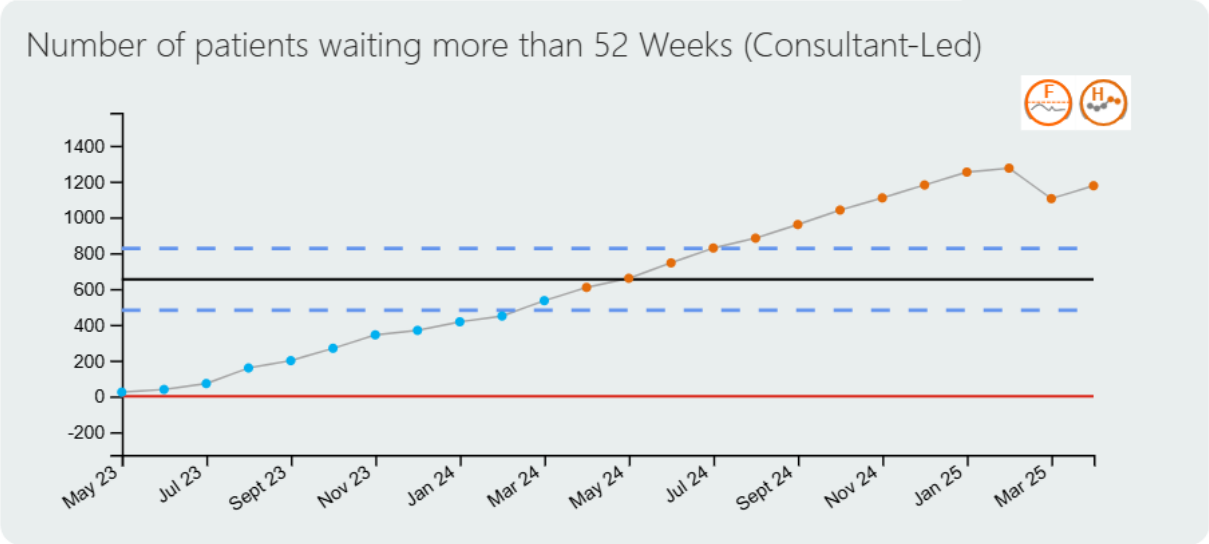
Further updates are given below on other key indicators for responsiveness.

Indicator Updates

This section gives updates on specific indicators that meet criteria in the Responsive Domain.

RTT (Referral to Treatment) Waiting Time Standards





What is the trend that we see?

Performance continues its decline in the percentage of patients waiting less than 18 weeks, however there are early signs of improvement for people waiting more than 52 weeks. The same pattern of improvements can also be seen in the 65-week and 78-week indicators within Appendix 1.

The key services affecting this performance are ICAN Paediatric Clinics (primarily PND) where demand for pre-school neurodevelopmental (autism) diagnosis outstrips available capacity. At the end of April 2025, there were 2,138 people waiting on the PND waiting list, 1,219 (57%) of which were over 52 weeks.

In Community Gynaecology waiting times are long due to the length of wait that people experience under LTHT care prior to transfer to LCH care. The overall size of the Community Gynaecology waiting list has reduced in recent months (418 at the end of December 2024 to 124 at the end of April 2025) however at the end of April there were 100 people who have waiting more than 52 weeks on the list, which represents 81% of the waiting list.

What is being done about it?

For ICAN Clinics, the primary driver of the demand continues to be for Paediatric Neuro-Developmental (PND) assessments in under 5s. The service is currently in the process of piloting a needs led offer, to run alongside the assessment and diagnosis pathway. This will provide first-line support to all families that are referred, regardless of whether they meet the criteria for diagnosis.

The pathway for diagnosis is also being redesigned to focus on assessments being conducted and led by Paediatricians, supported by effective information gathering from other disciplines and leveraging capacity in other CBU services. The proposed pathways have been modelled to help understand the capacity required to meet current and future demand, and this will be used to inform a business case requesting permanent ICB investment in the new model.

In the short term, additional clinics are now being offered by locum staff, which include diagnostic assessments being completed during the first appointment. The service has also outsourced assessments for children approaching their fifth birthday (to preclude them joining a further waiting when they transition to the over 5s service)

Two primary actions are being progressed within Community Gynaecology. Firstly, we have reached agreement with LTHT that they will now be responsible for all RTT breaches for patients on this pathway. This means that this service will be removed from this indicator during this financial year. Ongoing performance monitoring will take place through the alternative non-RTT 18 week measures that apply to other services. This will allow the Trust to maintain the ability to measure responsiveness for this service, but we will no longer be held to account nationally for breaches of RTT consultant led standards.

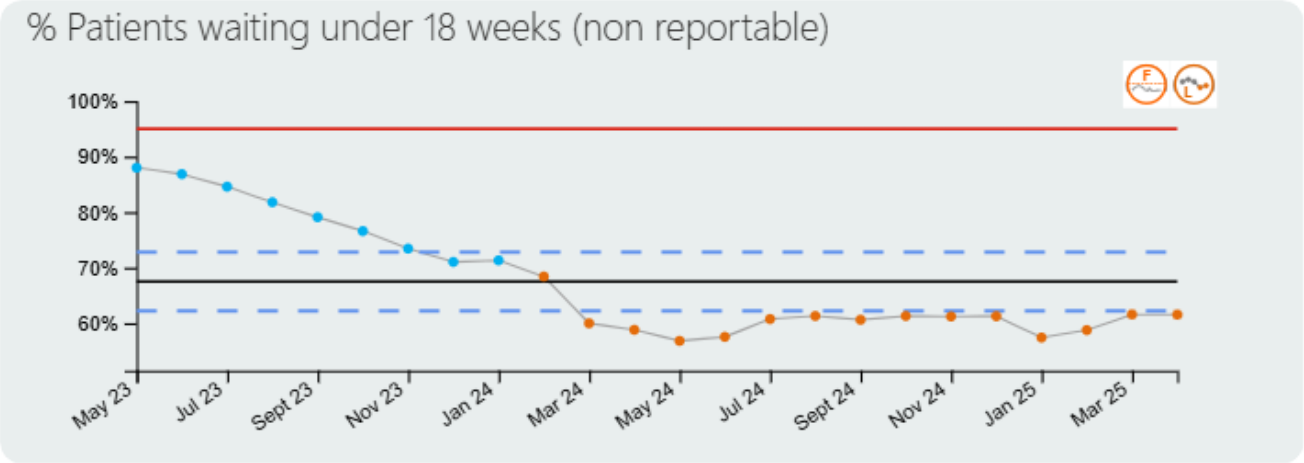
Secondly, the service continues to improve its local responsiveness, and we have seen a reduction in the overall size of the waiting list due to introducing additional clinics. The service has arranged appointments to see 92% of the people currently waiting more than 52 weeks during May and June, and we project that there may be as few as 10 people waiting this long by the end of June 2025.

When do we expect to see improvement?

As mentioned above, ICAN are piloting the needs led offer and offering this to 250 young people who are currently on the waiting list. Letters for these patients will be sent to them in April and the responses to these will be reviewed in May.

Improvements in Community Gynaecology will no longer be visible as part of this indicator, but will be reported through other indicators. Improvements are already visible in local response times, as described above.

% of patients waiting under 18 weeks (non reportable)



What is the trend that we see?

Performance has continued to hold steady but remains significantly below the target of 95%. This, however, does hide some areas of good improvement and recovery for some services.

For example, Children's Audiology currently holds a waiting list of only 115 patients, compared to 1,072 at the end of April 2024. The Tissue Viability Service has successfully reduced the number of patients waiting from 119 at the start of May 2024 to 58 and the end of April 2025. Children's Occupational Therapy also continue to improve, achieving a 51% reduction in the number of people waiting over the last 12 months.

The total number of patients now waiting more than 65 weeks has reduced throughout March and April, falling to 2,268 at the end of April 2025 from 3,052 at the end of February. At the time of writing, 72% of these were children awaiting ND assessments in both our Pre-School and School Age assessment teams. Of all the patients waiting more than 18 weeks within the Trust, 28% are children or young people waiting for a neurodevelopmental assessment, such as autism. A total of 2,662 children are waiting on these lists, but this doesn't include further children waiting to be accepted for the school-aged assessment waiting list within MindMate SPA. There has been some reduction in the number of school-age children waiting within CAMHS; the overall waiting list size stands at 875 at the end of April 2025 versus 1,305 at the start of January 2025.

What is being done about it?

This update focuses on updates in neurodevelopmental assessment services, Podiatry, Community Dental and Adult Speech and Swallowing Service.

School Age and Pre-School Autism Assessments

Within the school-age service reductions are being driven by discharges of families who have taken up a right-to-choose offer, and so no longer need to wait for an assessment. Further work continues within the CAMHS Quality & Value project to redesign the proposed service offer, which would lead to a reduction in referrals meeting criteria for assessment.

Our Pre-school Service has successfully out-sourced 517 patients which will be assessed by the end of June 2025. There are now no children waiting over 18-weeks waiting to start an autism assessment. However, there are still 1,364 patients waiting over 18-weeks on the paediatrician waiting list with suspected autism. Further work

continues to remap the autism pathway which will see a needs-led approach implemented and a reduction of children referred through to the Complex Communication Assessment team for advanced autism assessment.

Podiatry

Some reductions are now visible in the number of people waiting for care to start. This has primarily been driven through the long-term transformation work the service has been focussed on delivering. Communication has been made directly with approximately 1000 patients to confirm if they still require support from the service, and over 450 have requested to be discharged to date. 450 additional appointments have been created through the re-design work, a small number of which have been created through the Access LCH campaign.

This work has led to the number of people waiting for care reducing from 6,922 in January 2025 to reach 5,861 by the end of April.

Dental

Waiting Times for Community Dental remain a national and regional problem, and these challenges are replicated in LCH. The service is currently recruiting, and has new starters joining in coming weeks, but there continues a longer-term risk to our ability to reduce the number of people waiting, and to ensure that patients aren't waiting excessively. The service is currently developing plans to utilise targeted non recurrent monies received through the new WY CDS contract from 1st April to reduce waiting lists over a three- year period. This will need to delivered being mindful of maintaining balance in reducing waiting times for routine assessment against delivery of targets to deliver full courses of treatment.

At the end of April 2025, a total of 2,818 people were awaiting routine assessments within the service, of which 1,263 have waited longer than 52 weeks.

Adult SLT

The service has used funding available from Access LCH to hire locum staff and set clear expectations of the number of patients per week that these colleagues will provide appointments to. Issues during on-boarding processes slowed down achievement of these goals, and so the service did not see all patients waiting more than 52 weeks by the end of March. A long-term gap is evident between capacity and demand, where referrals have been rising steadily over the last two years and there are outstanding issues to address in terms of access criteria to the service in relation to rapid access care. The service is scoping options for a future service model to inform a business case.

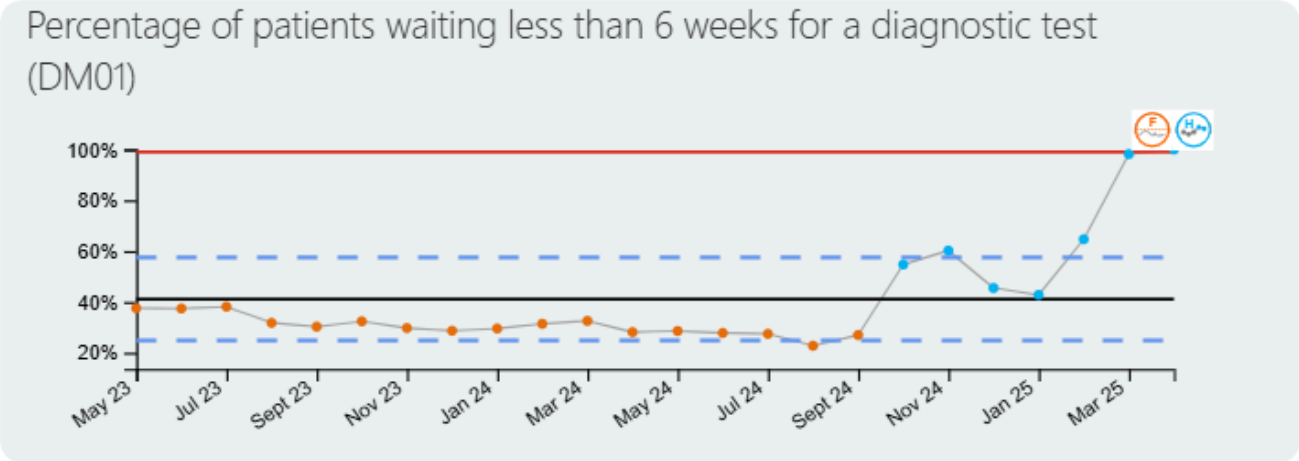
Significant work has been completed to date as part of Quality and Value to define a new offer of clinic treatment pathways, and implementation work continues. The service has considered deploying opt-in approaches, following Equity Impact Assessments, this was considered unsuitable for the patients referred, many of whom are struggling with communication needs.

The service currently has 902 people waiting, which has reduced from 1,042 in February. A total of 113 people have waited more than 52 weeks.

When do we expect to see improvement?

It is unlikely that full recovery of this target will be achieved during the next financial year, given the number of people awaiting ND assessments, however it is likely that the plans described above will begin to show impact during Q1 and 2.

% of patients waiting less than 6 weeks for a diagnostic test (DM01)



What is the trend that we see?

Performance continues to improve in recent months, following waiting list review work. The total number of people waiting has now fallen to 115 at the end of April, from 508 at the end of December. Performance against the 6-week Diagnostic Standard has also climbed to 100% by the end of April. *(Note: the icon on the graph above has been incorrectly calculated. The icon suggests that the service has failed to meet the target in the most recent month, but they have in fact passed the target. The technical reasons for this display format are being investigated but could not be resolved in time for this report.)*

What is being done about it?

The service has a clear plan of activity that is being monitored during Patient Access Meetings and the Access LCH programme.

The service has also offered further appointments to patients waiting more than 4 weeks, to further reduce waiting times. The service has conducted weekend clinics with additional monies available via Access LCH, which have been popular with families, but these are not currently planned to continue.

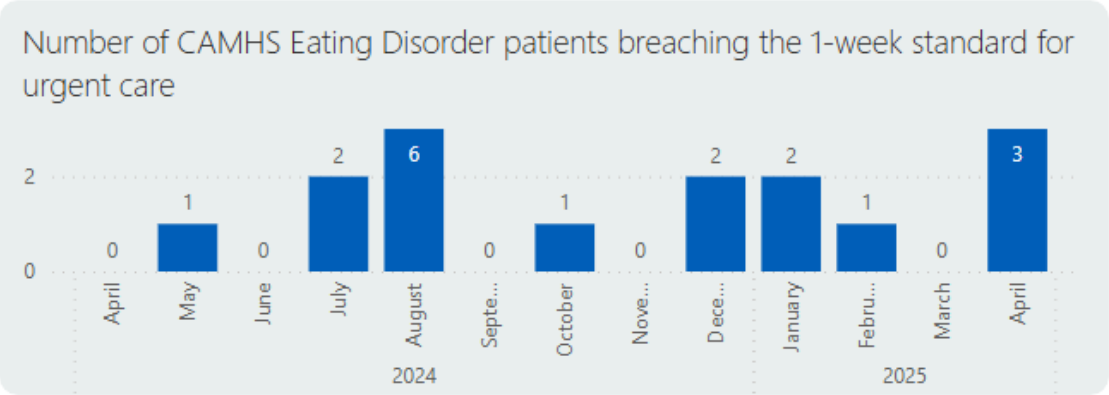
The service has also completed work with other CBU services to change protocols that led to automatic referrals being placed even when no hearing or speech concerns were present. This should lead to a safeguarding of the service's performance over the medium to long term.

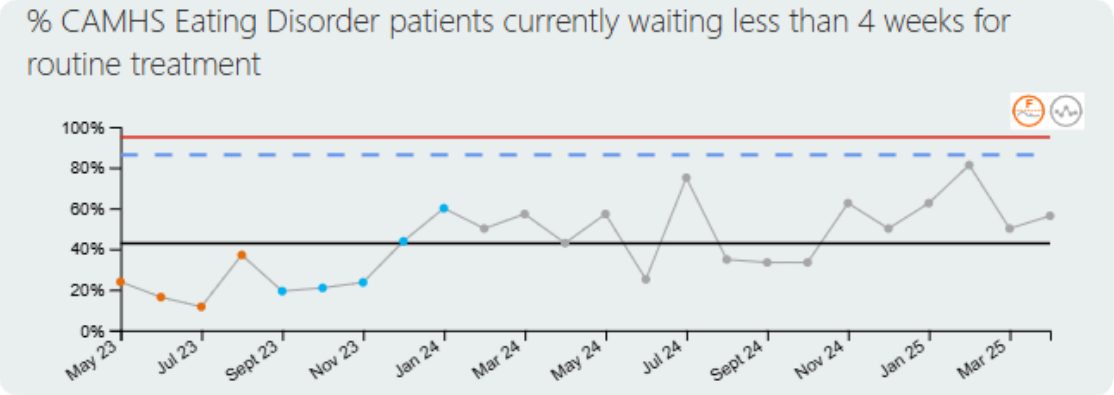
Projections for May 2025 indicate that there will be some breaches of the 6-week Diagnostic Standard in the month. The waiting list data indicates that 5 patients are booked in to be seen in May who will have waited 6+ weeks, and a further 10 who do not have appointments booked and are at risk of breaching the 6 week target.

When do we expect to see improvement?

Having reduced the overall number of waiters and met the 6-week Diagnostic Standard target in April-25, the service is in a much better position to achieve wait time targets in future months.

CAMHS Eating Disorder Waiting Time Standards





What is the trend that we see?

Performance against both the urgent and routine targets continues to be below target, and this is being driven by demand that outstrips capacity. The service is currently commissioned to support 100 cases per year but has received an average of 140 referrals per year since 2022. At the time of writing 17 patients were waiting.

The service recorded 3 breaches of the 1-week urgent standard during April 2025.

What is being done about it?

The service is rebalancing the number of assessment appointments compared to treatment appointments, which will lead to improvements in starting new cases, but may lead to reductions in the frequency of treatment appointments for patients already on the caseload. Routine patients may have assessment appointments rescheduled if required for urgent cases.

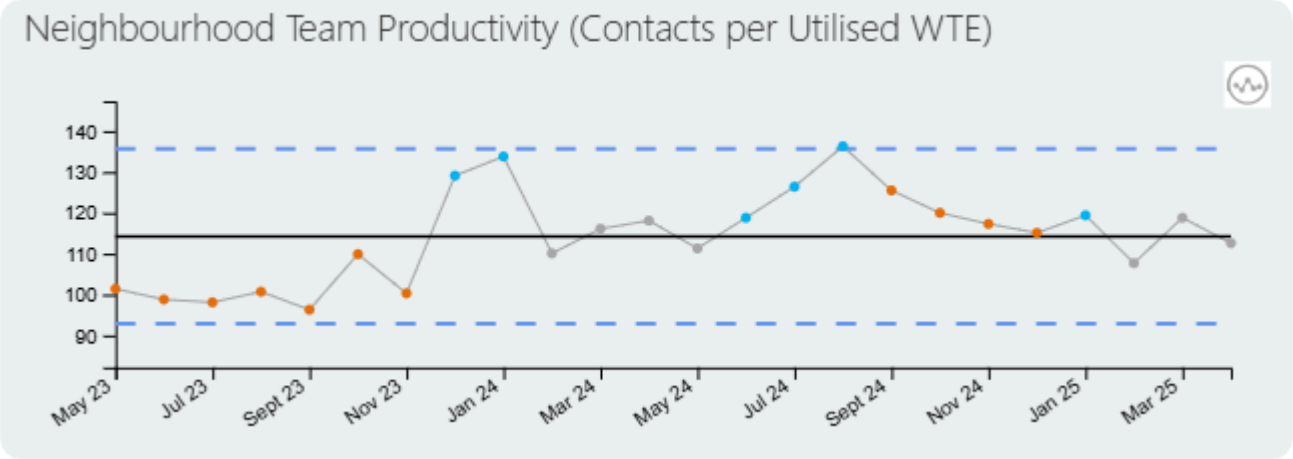
The service is conducted a deep-dive data review to present to ICB commissioners in March 2025, following which options for future arrangements will be considered, but there is no current commitment from commissioners to increase funding for this service.

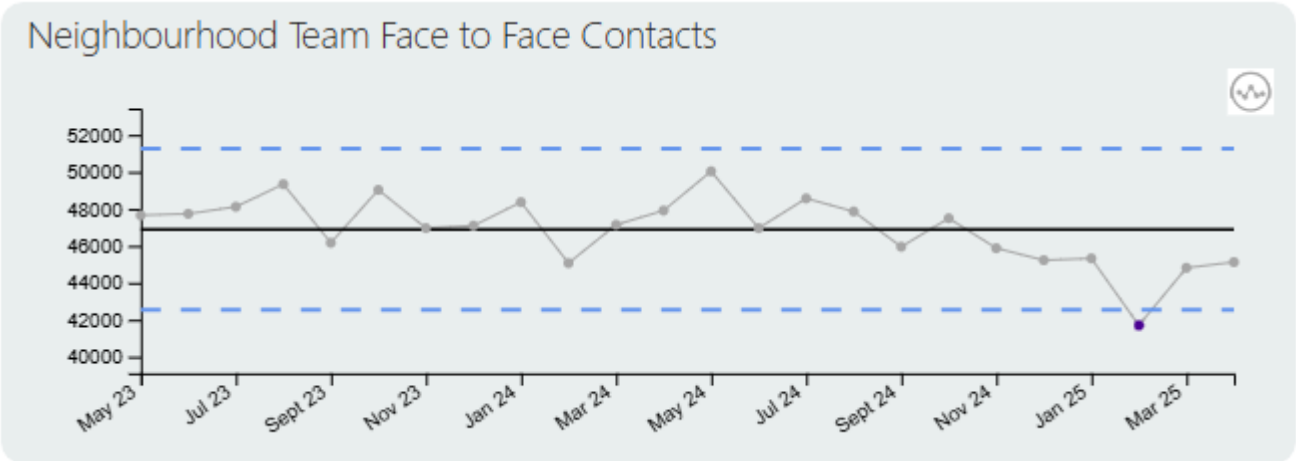
Some work is also being conducted to understand the current demand patterns for ARFID support. ARFID is a non-commissioned service offer for patients with eating disorders, and the service continues to receive referrals for this support. The deep dive has been asked to present some data to commissioners on the volume of this currently unmet demand.

When do we expect to see improvement?

We are not expecting to see any long-term improvement to this indicator during this financial year.

Neighbourhood Team productivity





What is the trend that we see?

The declines in productivity previously reported have begun to stabilise, returning to a stable position the closely follows average performance. The number of contacts completed by the teams also returned to usual levels of variation following a one-off reduction in February below the lower control.

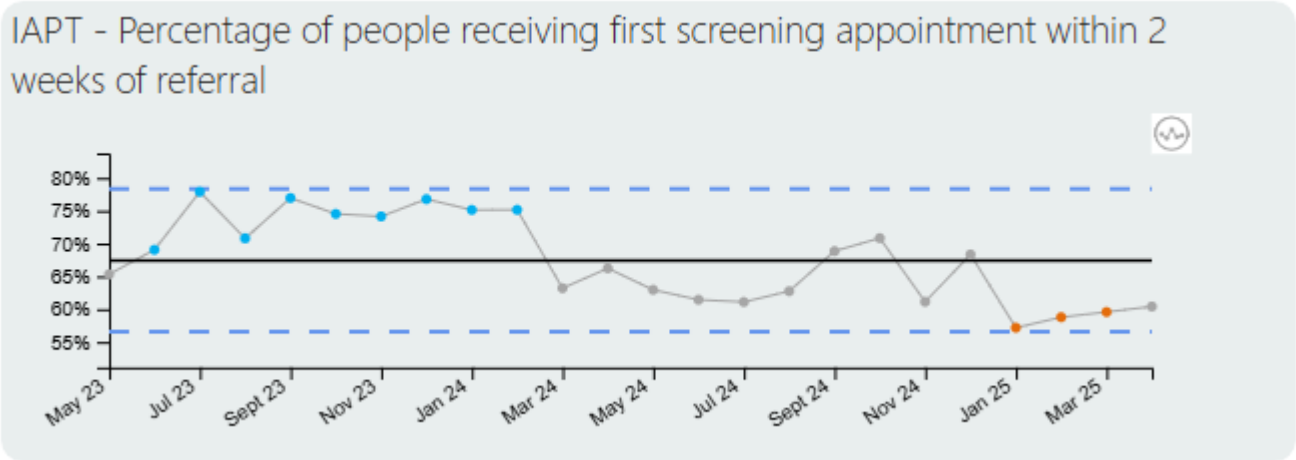
What is being done about it?

ABU Leadership team are aware of this situation and continue to monitor. Work is underway to investigate root causes, and particularly to understand the impact of recent changes to therapy activity recording within SystmOne, which may well be the primary cause of this pattern. Action plans will be developed if this cause is ruled out following these investigations.

When do we expect to see improvement?

These numbers are being investigated and will be reported back to the ABU Leadership team for further consideration.

LMWS



What is the trend that we see?

Performance against this measure has begun to show early warning signs of statistically significant variation, with three out of four data points in Q4 and April showing as close to the Lower Control Limit. However, there are early signs of improvement since January.

What is being done about it?

Performance will be monitored, and action plans put in place should the current improvements not be sustained.

When do we expect to see improvement?

For monitoring

Well-Led

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

Summary

Well Led measures are within tolerance, with continued improvement seen in appraisal rates and statutory and mandatory training rates.

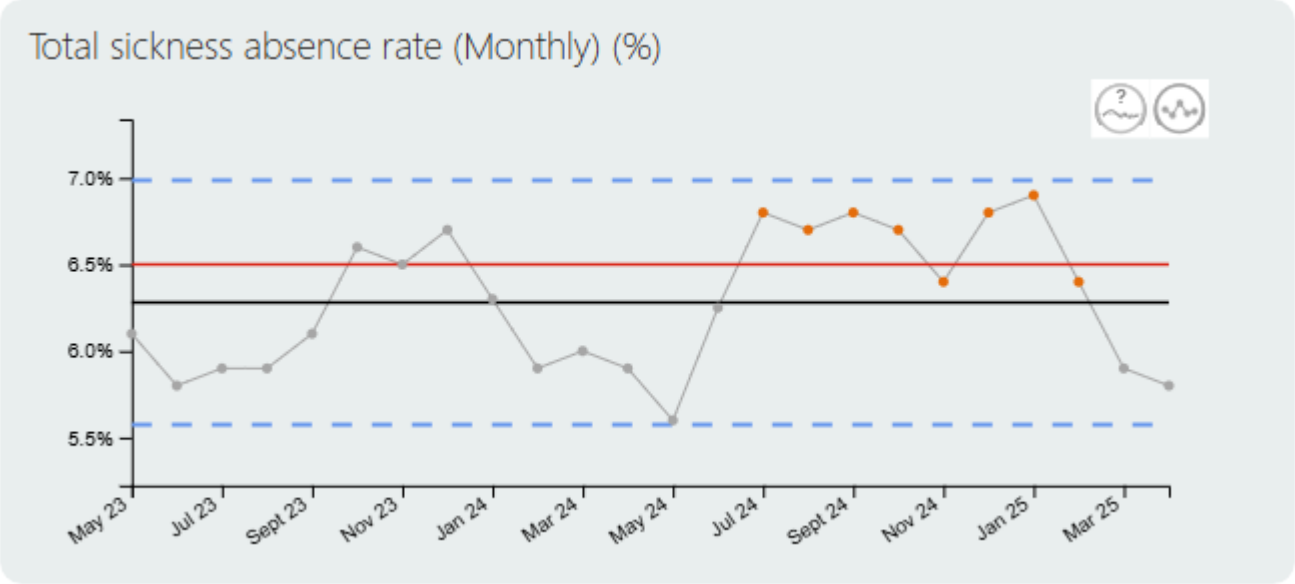
Sickness absence has seen a reduction which, whilst welcome, aligns with seasonal fluctuations.

A decline in BME representation figures is of concern. A potential system issue has been identified which may be a contributing factor; and work is underway to understand this further. The Trust's approved ED&I Action Plan remains in place.

Indicator Updates

This section gives updates on specific indicators that meet criteria in the Well-Led Domain.

Total sickness absence rate (monthly %)



What is the trend that we see?

Sickness absence lies within the control limits at 5.8% overall, achieving target. We have not seen a significant change however a positive decline in short term sickness across all Business Units, each Business Unit is below target which could be down to seasonal trends.

We've also seen a consistent decline in long term sickness since January following similar trends to this time last year.

Of particular concern is sickness absence in the Nights Service in Adults Business Unit which is currently running at 21.4%.

What is being done about it

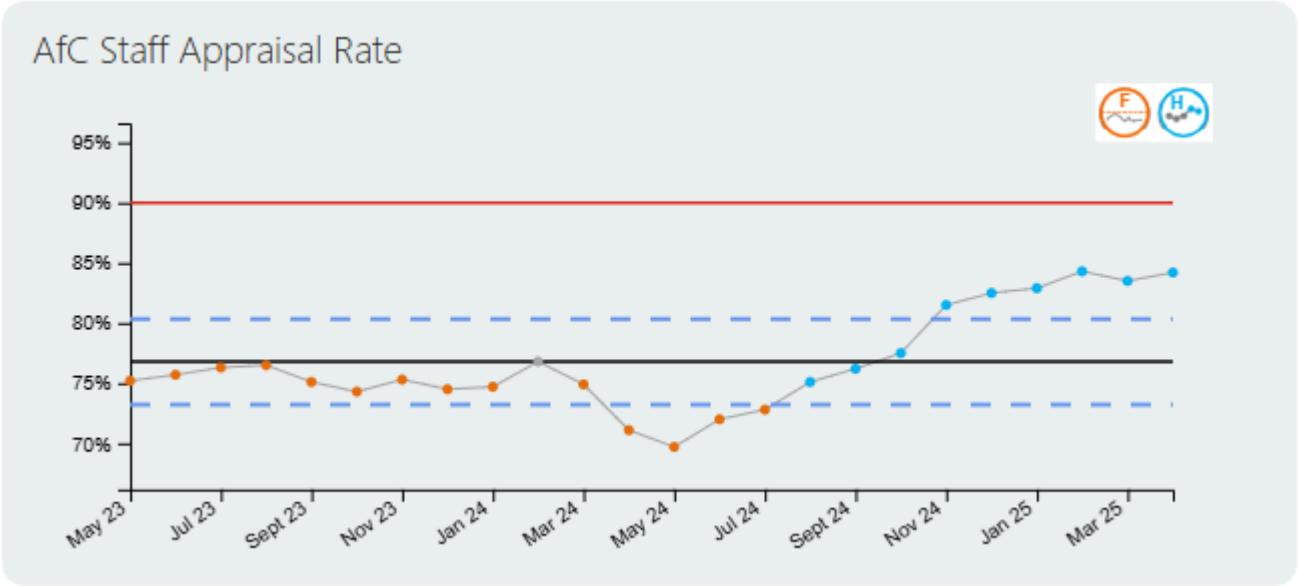
The People Directorate have initiated a specific piece of work in this area to understand the underlying causes, once determined, interventions led by the Adult Business Unit with support will be implemented

When do we expect to see improvement?

This metric is not changing significantly; the variation is what we would expect to see and a positive decline in overall absence rates is expected to continue as we enter the summer season.

We anticipate improvement to the sickness rates in the Adults Night Service within 3 months of starting the interventions.

AfC Staff appraisal rate



What is the trend that we see?

A steady and gradual improvement towards the target since August 2024, resulting in the highest compliance rate since 2021. The last six months performance has been above the mean.

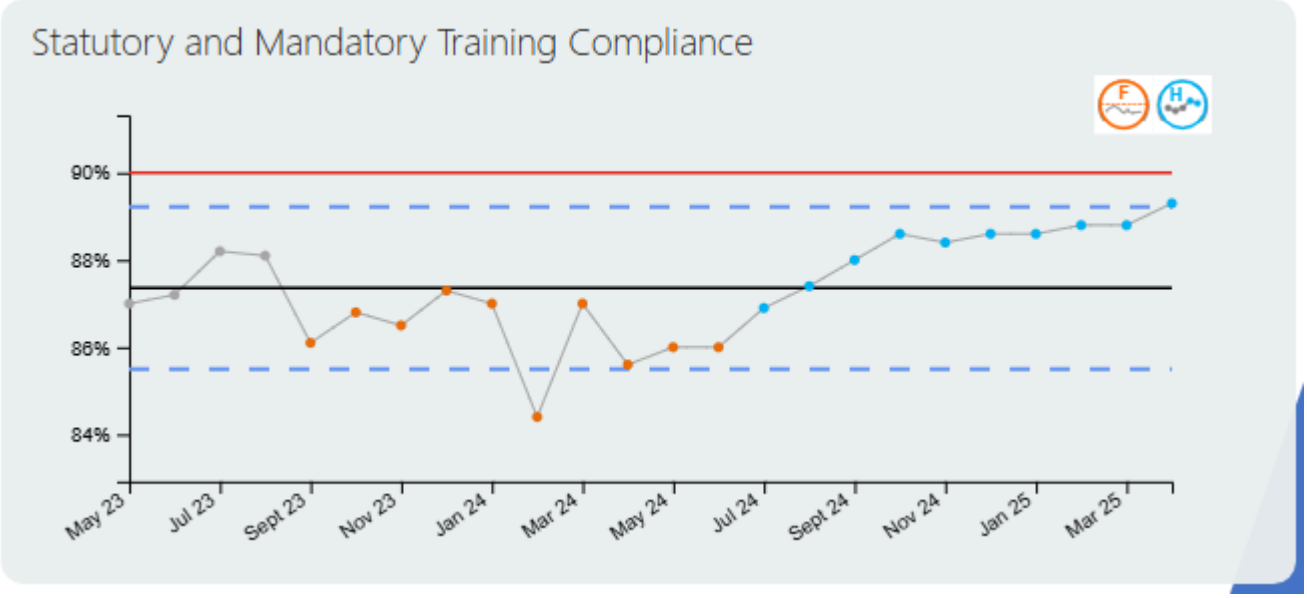
What is being done about it

The ABU and SBU teams have been set challenges and targets as part of the trust's performance panel, with ongoing monitoring at the BU level. A recent appraisal audit has identified several actions to be implemented over the next few months to improve the reporting of appraisal compliance. Several of the planned audit actions aim to ensure more accurate reporting.

When do we expect to see improvement?

We expect to see continued improvement through 2025/26.

Statutory and mandatory training compliance



What is the trend that we see?

Performance has shown a steady improvement towards the target since June 2024. The 90% target continues to appear difficult to achieve and the trajectory of improvement has slowed.

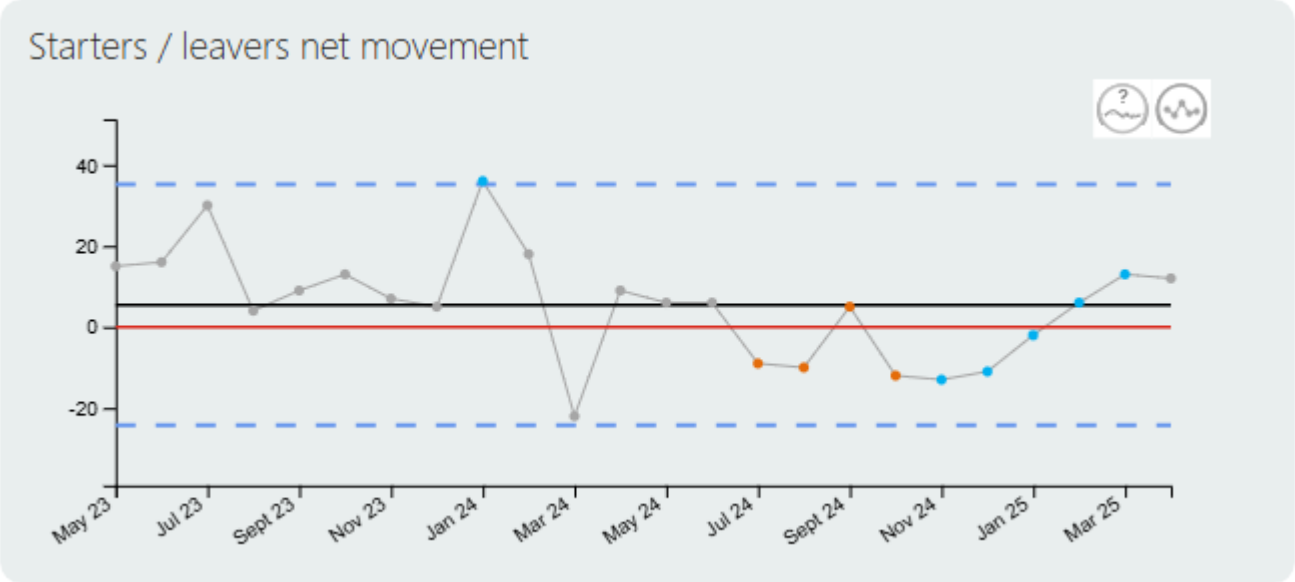
What is being done about it

Performance monitoring is currently conducted at the BU level through the performance panel. Additionally, a new multi-disciplinary group, Mandatory Learning Oversight Group (MLOG), has been established as part of the People and Culture Committee to enhance oversight. The first meeting is scheduled for 4/06/25.

When do we expect to see improvement?

In the short term, significant improvement is not expected, as reflected in the trends observed over the past eight months. However, there is potential for progress through MLOG, particularly with the implementation of themed reviews. This is likely to materialise in Q4 of 2025.

Starters/leavers net movement



What is the trend that we see?

While for most of the reporting period the performance has remained inconsistent, LCH is currently seeing more starters than leavers. Variation remains within control limits

What is being done about it?

The weekly Quality & Value panel considers all vacancy requests to ensure that any vacancies approved for recruitment meet essential criteria. This will continue to be monitored as we start Year 2 of the Quality and Value programme

When do we expect to see improvement?

Revisit metric during Q2 of 25/26.

Reduce the number of staff leaving the organisation within 12 months

What is the trend that we see?

Following a period of instability, the inconsistent pattern continues from April 2024 however this has shown an increase to above the target however remains within tolerance.

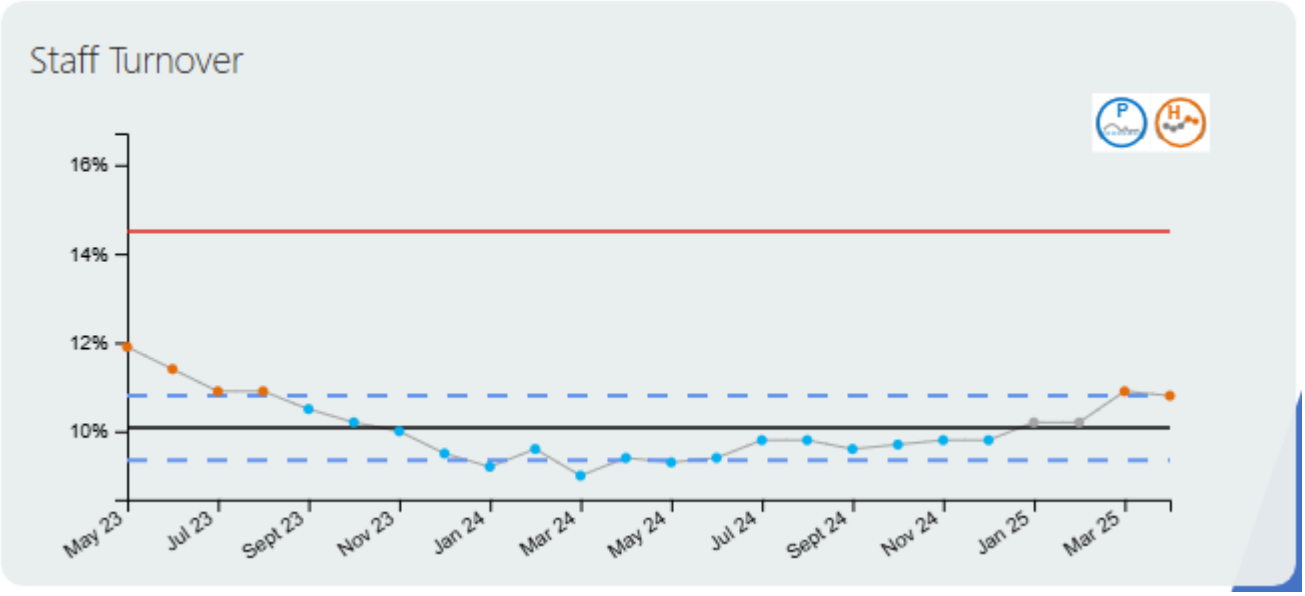
What is being done about it?

There are no immediate concerns to report.

When do we expect to see improvement?

Performance against this metric is expected to remain within tolerance

Staff Turnover



What is the trend that we see?

Staff turnover has remained low and consistently achieved the target. Recent months have shown an increase in turnover above the upper control limits, but this is not threatening achievement of the target.

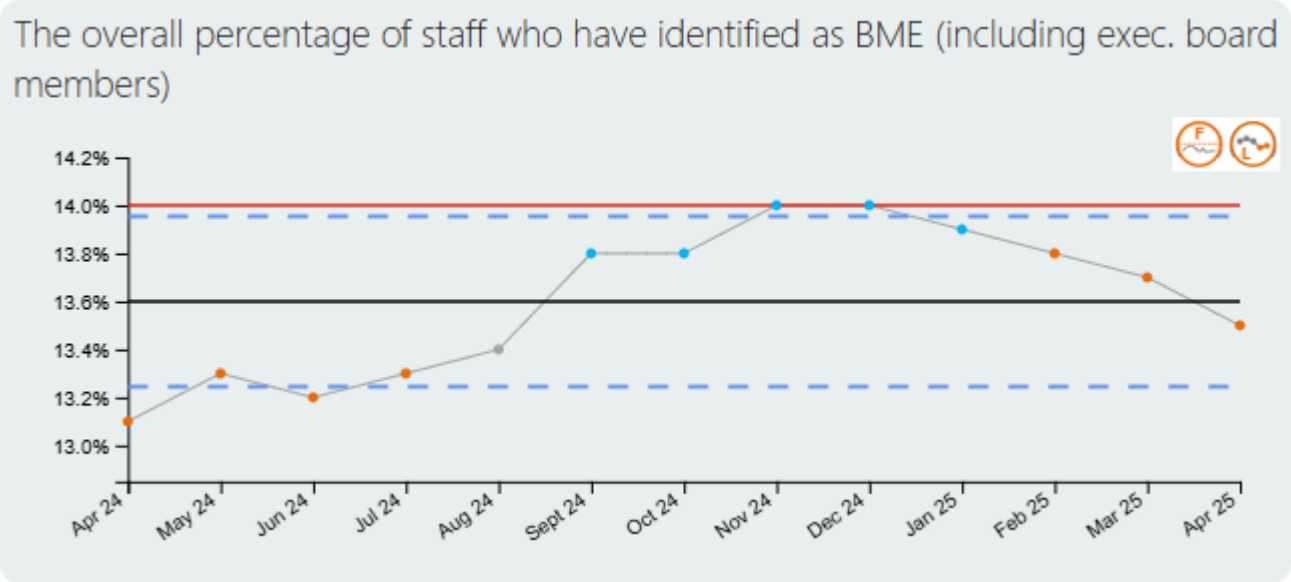
What is being done about it?

To continue to monitor

When do we expect to see improvement?

To continue to monitor

Percentage of staff who have identified as BME (inc. exec. Board members)



What is the trend that we see?

Since achieving target position, there has been a decline in the percentage of the LCH workforce recorded in the Electronic Staff Record as BME. There appears to be some correlation between the start of this decline and the implementation of a new system at LCH which receives new starter details.

What is being done about it?

Investigation is underway to establish whether there is a causal link; and to address any system issues identified. The Trust's existing ED&I Action plan remains in place.

When do we expect to see improvement?

By the end of Q1 we expect to have established any causal link and identified actions to address.

Finance

Summary

Prior Year	Key Financial Indicators	YTD Plan	YTD Actuals	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Varianc
(1,943)	Adjusted (Surplus)/Deficit	-	-	-	-	-	-
50,908	Closing Cash Balance	47,408	49,587	(2,179)	43,426	43,426	0
(7,628)	Capital Expenditure (CDEL)	(5,054)	0	(5,054)	(9,711)	(9,711)	0
	Quality & Value Programme						
9,130	Recurrent Savings	1,167	525	642	Under review		
6,648	Non Recurrent Savings	-	642	(642)			
15,778	**Total Savings**	**1,167**	**1,167**	**-**	**14,000**	**14,000**	**-**
	Temporary Staffing						
2,408	Agency	188	205	(17)	2,465	1,103	**1,362**
5,334	Bank	421	476	(55)	5,356	4,973	**383**
7,742	**Total Temporary Staffing**	**609**	**681**	(72)	**7,821**	**6,076**	**1,745**
168,716	**Total Gross staff Costs**	**13,176**	**13,506**	(330)	**158,610**	**161,234**	(2,624)
4.6%	**% Temp Staffign Costs**	**4.6%**	**5.0%**	**0.4%**	**4.9%**	**3.8%**	-1.2%

Income & Expenditure

For April, the Trust reported a breakeven financial position, which is in line with the planned target. At this early point in the year and based on M01's performance the Trust is forecasting the delivery of its overall breakeven plan for the year. The Quality & Value Programme achieved £0.5 million in savings during M01, contributing positively to the financial position. This performance has been formally reported to the West Yorkshire Integrated Care Board (WYICB). National level financial reporting will commence from May.

Cash

The Trust's cash position remains strong, with a year-to-date closing balance of £49.6m, surpassing the planned figure by £2.2m. This positive variance is mainly due to additional income from interest, lower than planned decrease in trade payables. The cash operating days, that is to pay short-term liabilities, is 82 days.

Capital Expenditure

The Trust's annual capital plan for 2025/26 is £9.7m, of which £3.4m is in respect of operational capital expenditure and the balance is to fund Right of Use Asset (RoU) leases following the adoption of IFRS 16. The adverse variance to plan in month 1 is related to the timing differences on lease remeasurements (£2.5m) and finalisation of two property leases (£2.5m).

Quality & Value Programme

At the end of April, £5.3m of the £14m Savings target for 2025/26 has been identified recurrently. Work continues to bridge the gap to ensure that by the end of Quarter 1 plans are fully identified, there are no high-risk schemes and all opportunities to achieve the recurrent CIP target are maximised. There remains a high risk that in-year non recurrent measures will be needed to achieve the plan.

Temporary staffing

The metric has been modified for 25/26 to focus on temporary staffing as whole. The trust remains reliant on temporary staffing in several key areas to manage vacancies and sickness absence while ensuring continuity of essential services. In addition to this bank staff usage is being maintained to allow flexibility to deliver service transformation. The vacancy control panel continues to govern planned usage of all temporary staff.

Appendix I – Data pack

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly** It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart, you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers, but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Or do you need to change something?
	Special cause variation of a CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers, but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers, and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers, and you have some-either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits, then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction,** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction,** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

	ASSURANCE			
Variation/Performance	**Excellent** **Celebrate and Learn** • This metric is improving. • Your aim is high numbers, and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** **Celebrate and Understand** • This metric is improving. • Your aim is high numbers, and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Celebrate but Act** • This metric is improving. • Your aim is high numbers, and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** **Celebrate** • This metric is improving. • Your aim is high numbers, and you have some. • There is currently no target set for this metric.
	Excellent **Celebrate and Learn** • This metric is improving. • Your aim is low numbers, and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** **Celebrate and Understand** • This metric is improving. • Your aim is low numbers, and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Celebrate but Act** • This metric is improving. • Your aim is low numbers, and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** **Celebrate** • This metric is improving. • Your aim is low numbers, and you have some. • There is currently no target set for this metric.
	Good **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concern** **Investigate and Act** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** **Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
	Concerning **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers, and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** **Investigate and Act** • This metric is deteriorating. • Your aim is low numbers, and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** **Investigate and Act** • This metric is deteriorating. • Your aim is low numbers, and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** **Investigate** • This metric is deteriorating. • Your aim is low numbers, and you have some high numbers. • There is currently no target set for this metric.
	Concerning **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers, and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** **Investigate and Act** • This metric is deteriorating. • Your aim is high numbers, and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** **Investigate and Act** • This metric is deteriorating. • Your aim is high numbers, and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** **Investigate** • This metric is deteriorating. • Your aim is high numbers, and you have some low numbers. • There is currently no target set for this metric.

Safe - Patient Safety

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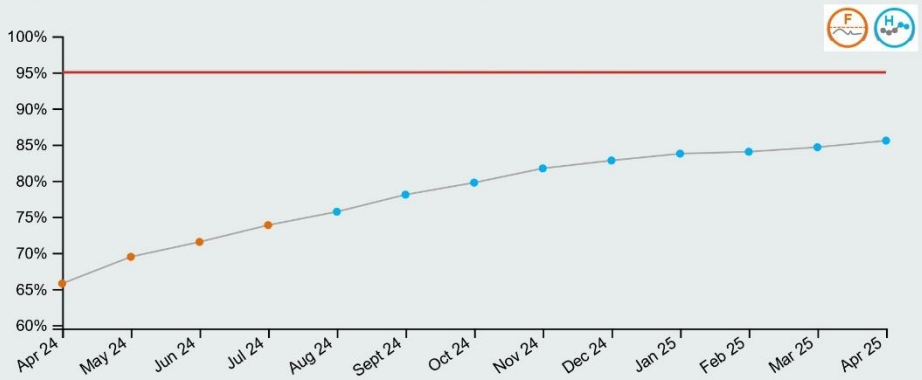
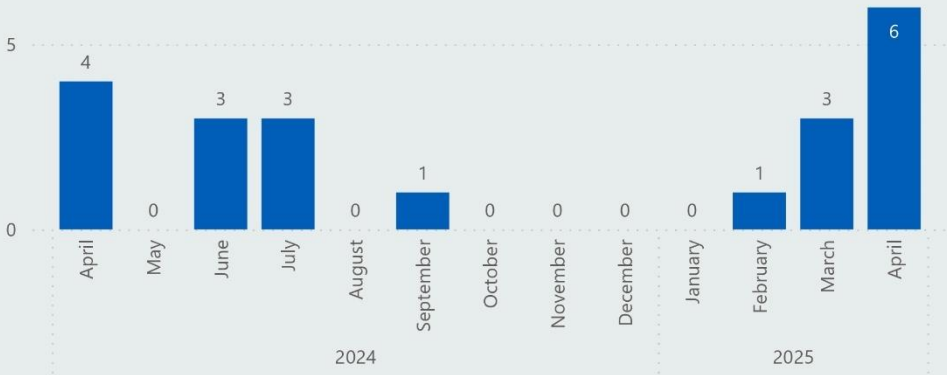
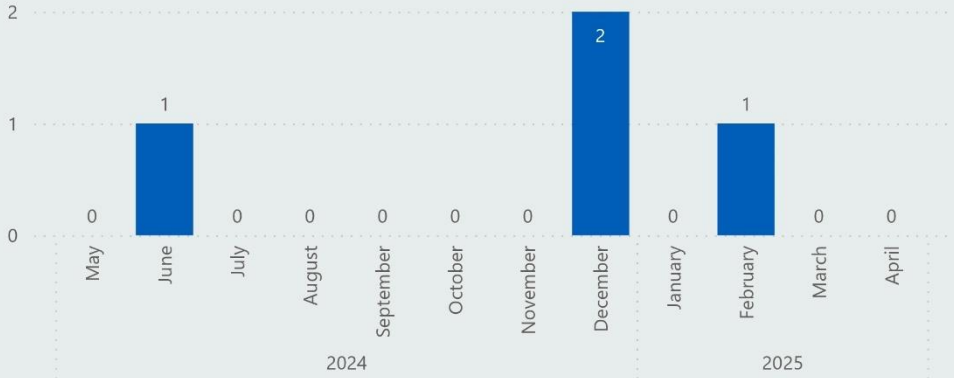
Compliance in Level 1 and 2 Patient Safety Training



Number of overdue PSII actions



Number of Patient Safety Incident Investigations (PSII)



Safe - Patient Safety

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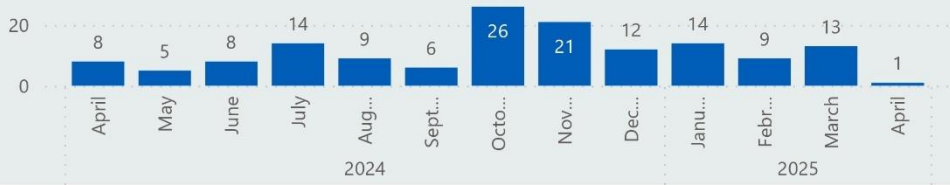
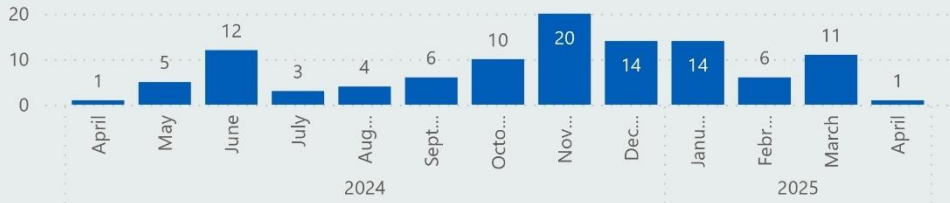
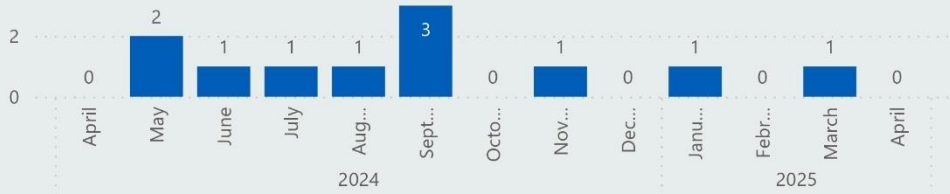
Number of incidents by PSIRP priority - Pressure Ulcers



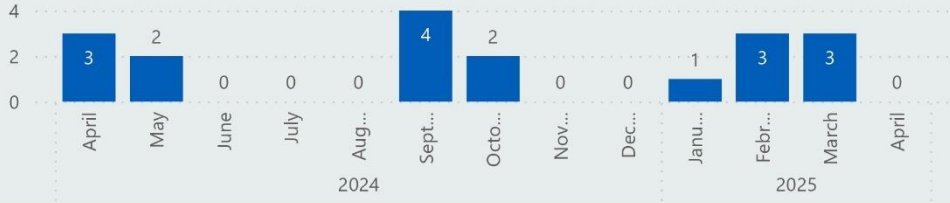
Number of incidents by PSIRP priority - Falls



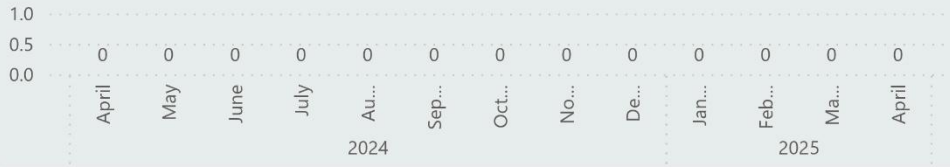
Number of incidents by PSIRP priority - Deteriorating Patient



Number of incidents by PSIRP priority - Meatal Tear



Number of incidents by PSIRP priority - Clinical Triage in Neighbourhood Teams



Safe - IPC

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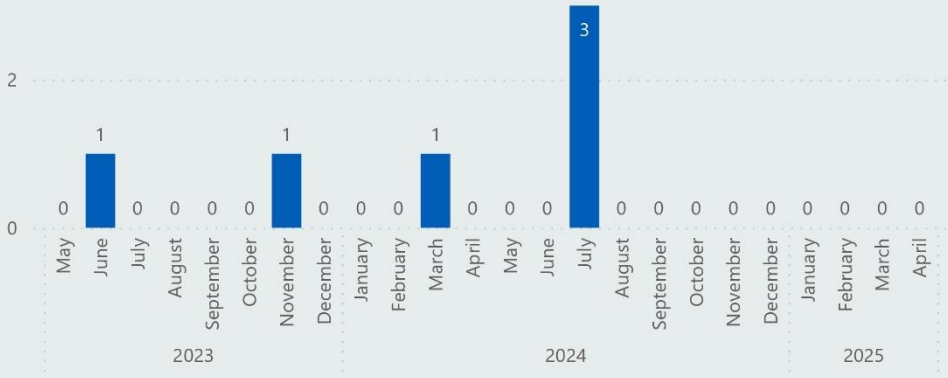
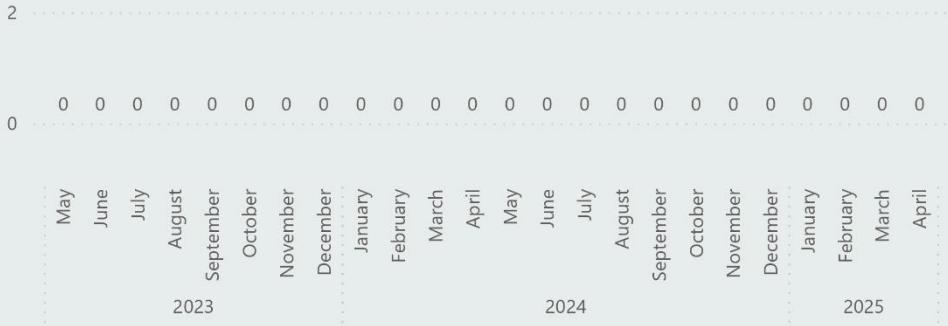
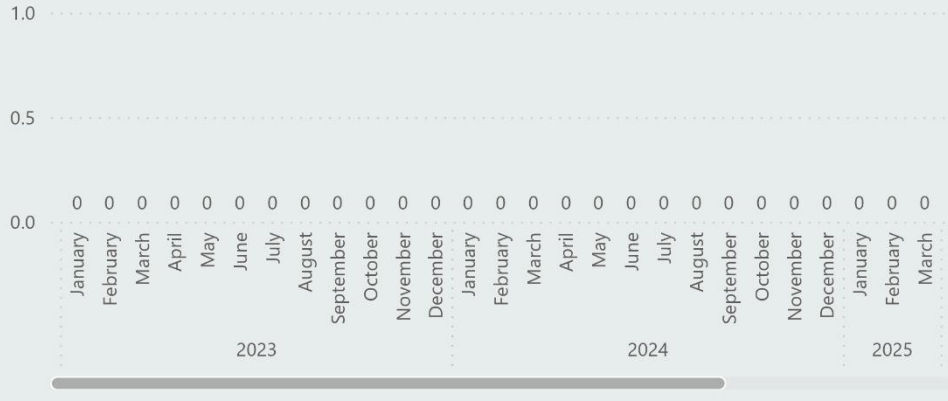
Attributed MRSA Bacteraemia - infection rate**



Clostridium Difficule - infection rate**



Incidents of E.Coli, bacteraemia



Safe - Other

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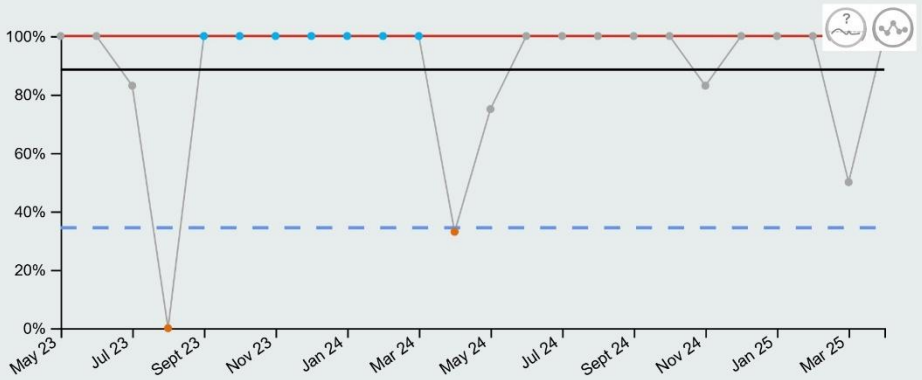
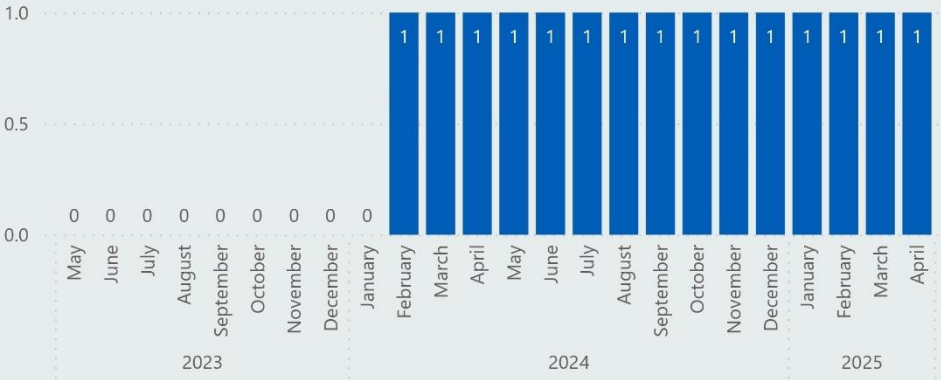
Compliance with statutory Duty of Candour



CAS Alerts Outstanding**



Never Event Incidence**

Safe - Safer Staffing

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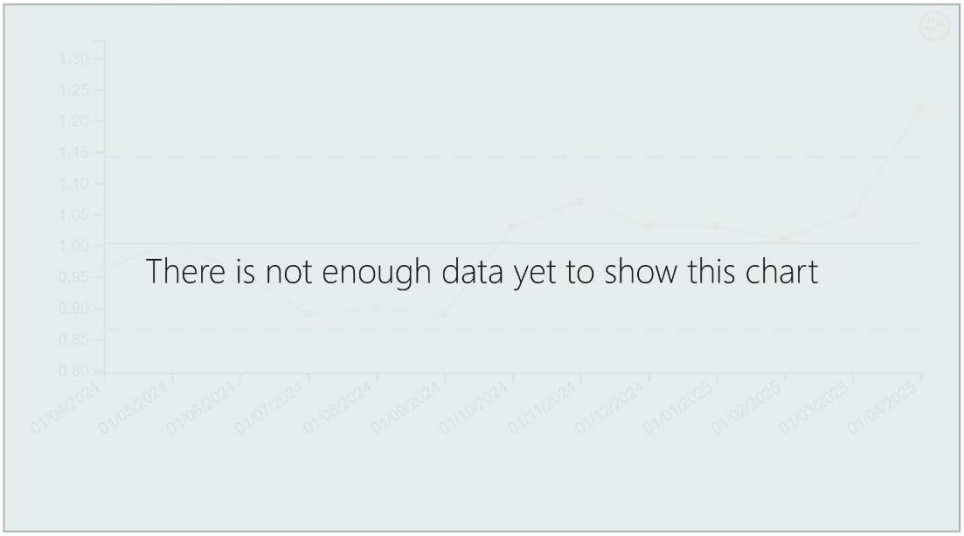
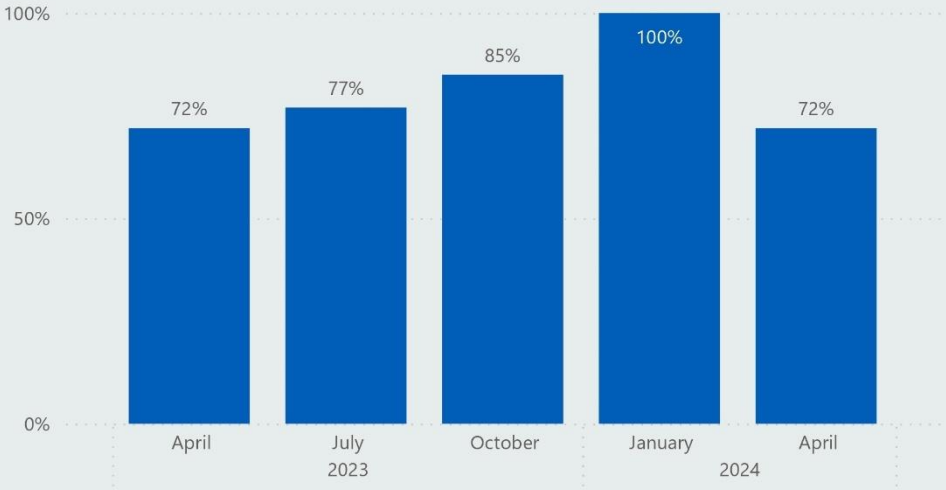
Safer Staffing – Inpatient Services



Number of teams who have completed Medicines Code Assurance Check since 1 April 2023 versus total number of expected returns



Safe - DQMI

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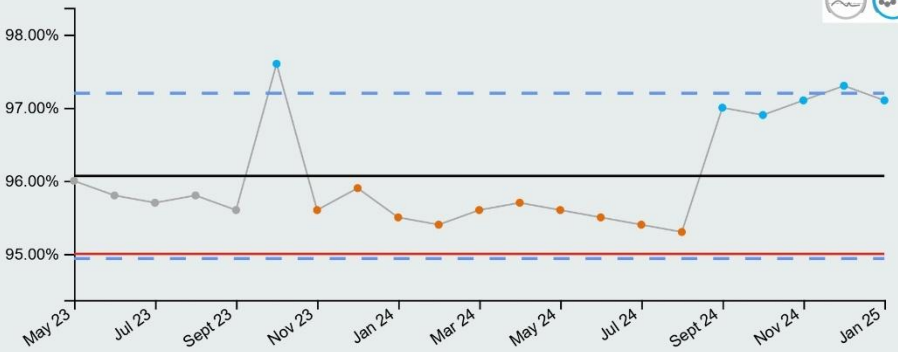
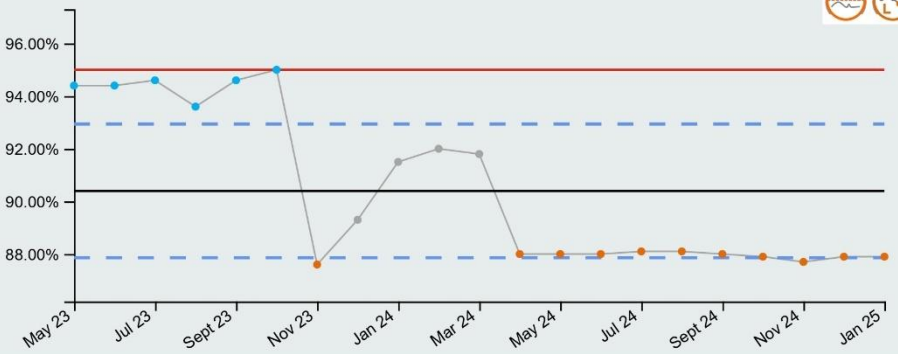
Data Quality Maturity Index (DQMI) - CSDS dataset score**

Data Quality Maturity Index (DQMI) - IAPT dataset score**



Data Quality Maturity Index (DQMI) - MHSDS dataset score**



Caring Domain

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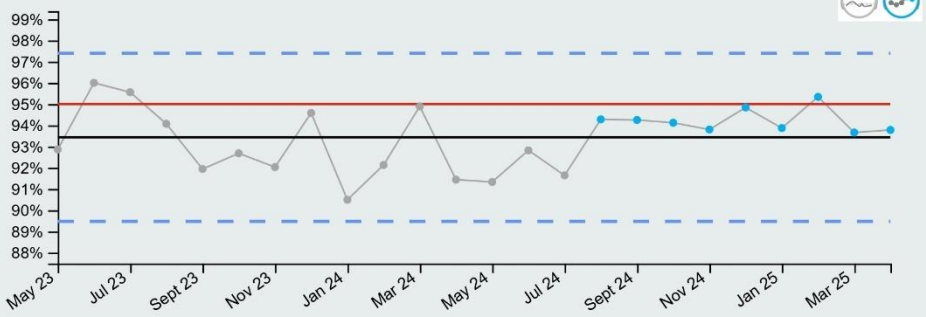
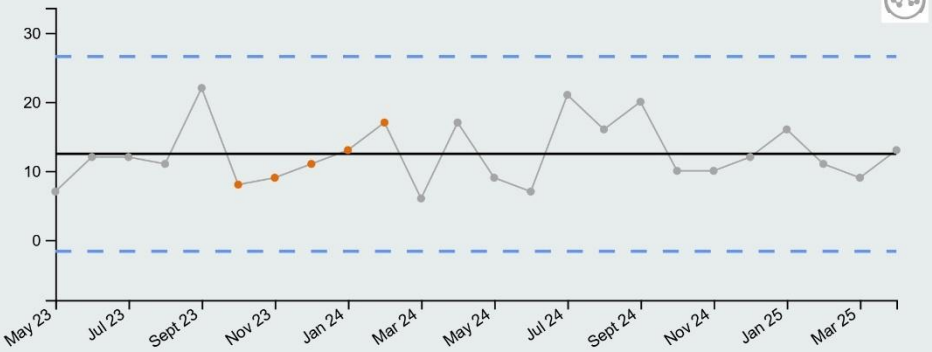
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)



Total Number of Formal Complaints Received



Mixed Sex Accommodation Breaches

No breaches Reported

Effective - Equity

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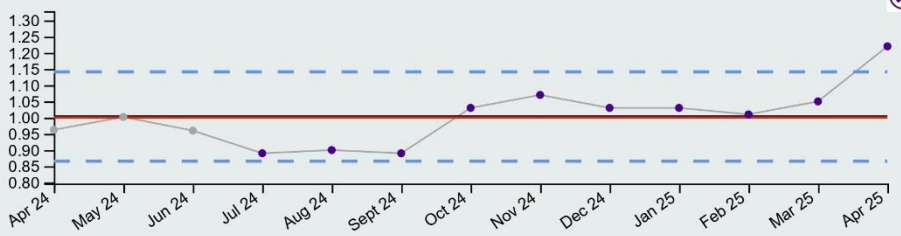
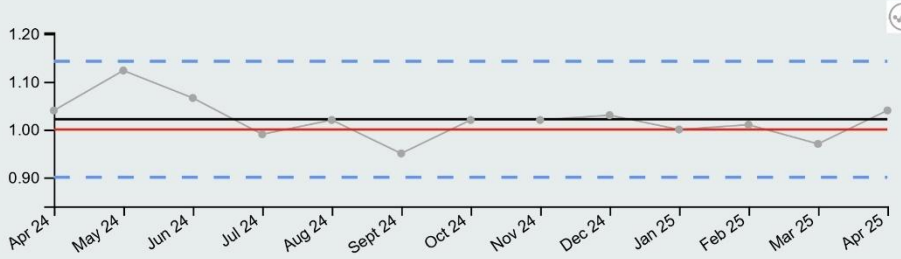
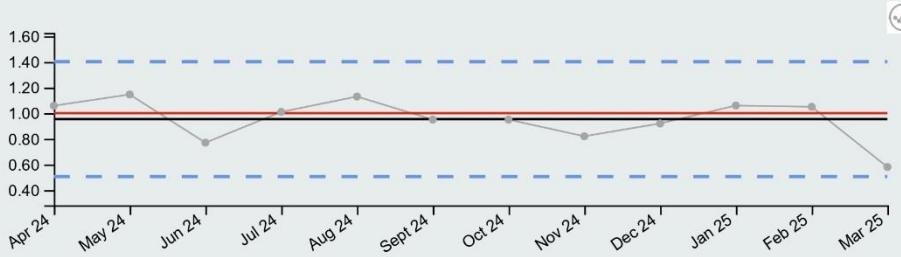
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 18 week standard



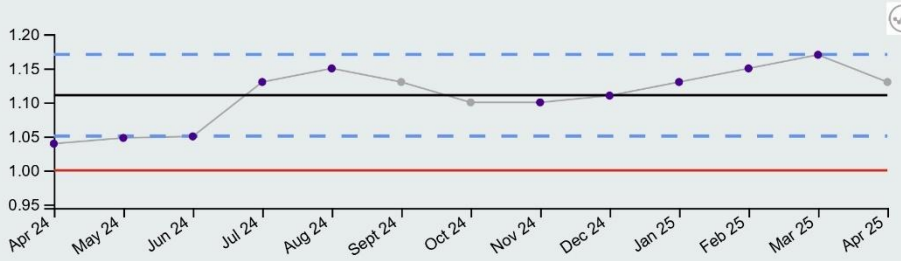
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 52 week standard



Difference in access to services for patients living in IMD1 vs IMD2-10 - DM01 Services



Difference in access to services for patients living in IMD1 vs IMD2-10 - Non-Consultant 18 week standard



Effective - Audit

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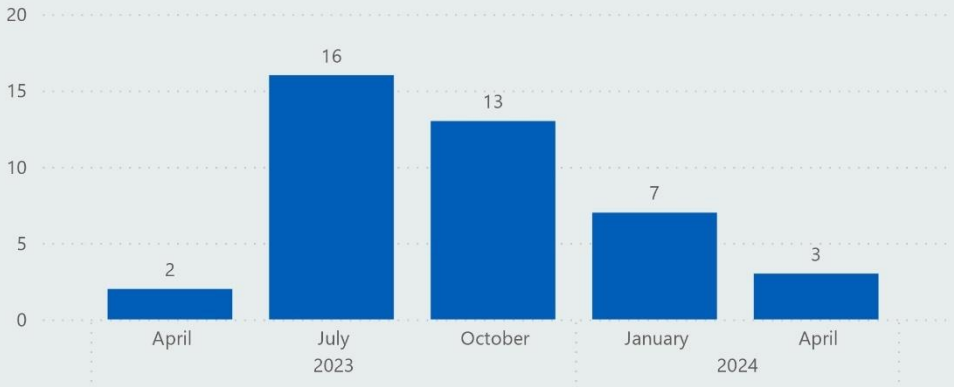
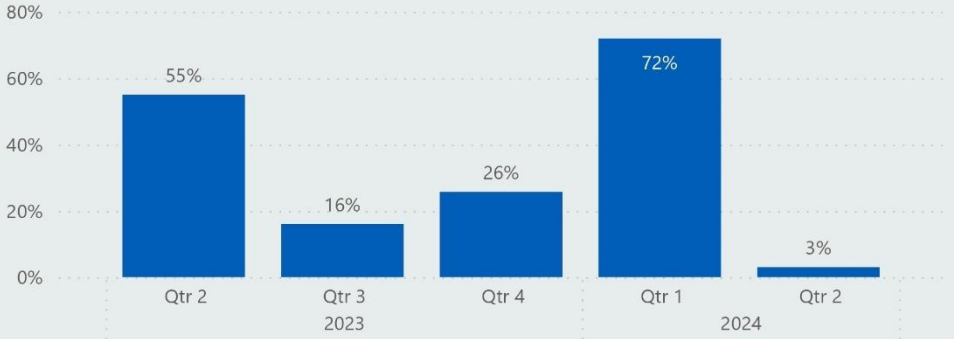
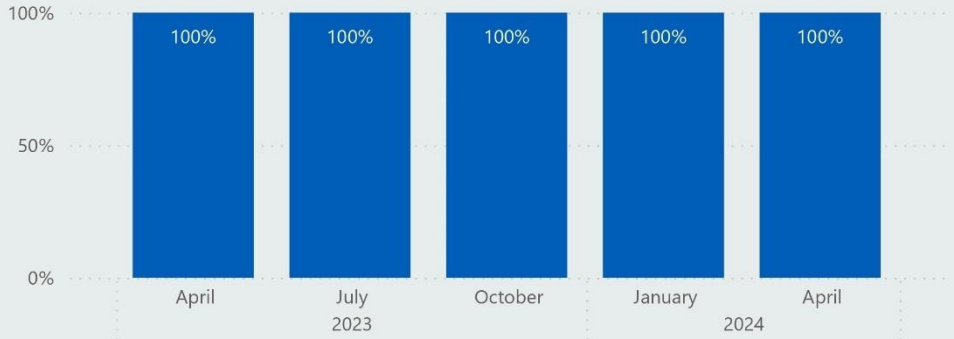
Total number of audits completed in quarter



Priority 2 audits: number completed year to date versus number expected to be completed in 2024/25



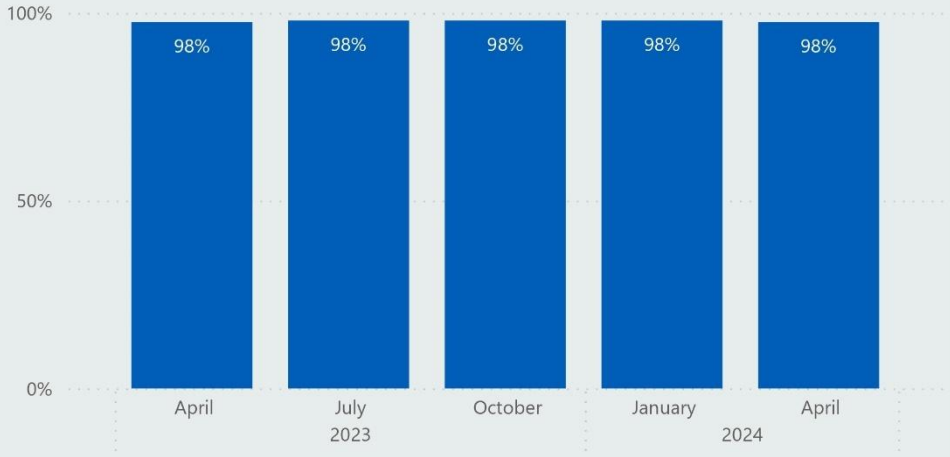
NCAPOP audits: number started year to date versus number applicable to LCH



Effective - NICE Guidance

NHS
Leeds Community Healthcare
NHS Trust

Number of NICE guidelines with full compliance versus number of guidelines published in 2019/20 applicable to LCH



Number of NICE guidelines with full compliance versus number of guidelines published in 2020/21 applicable to LCH

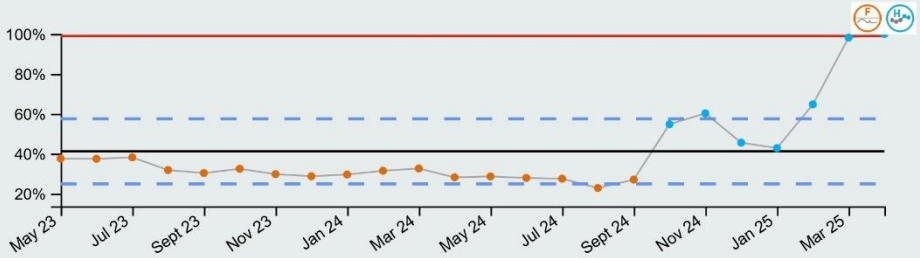
Responsive Domain

NHS
Leeds Community Healthcare
NHS Trust

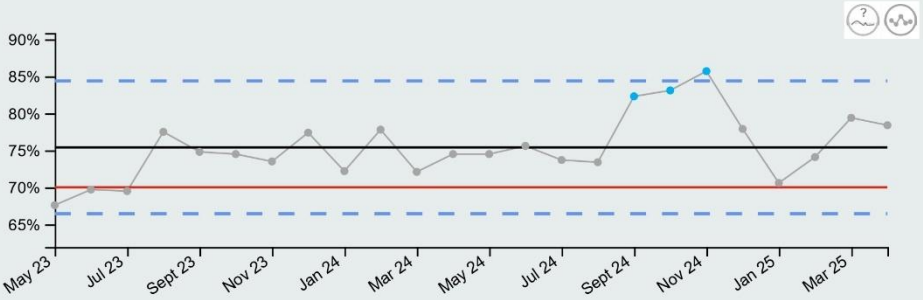
Percentage of patients currently waiting under 18 weeks (Consultant-Led)

% Patients waiting under 18 weeks (non reportable)

Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)



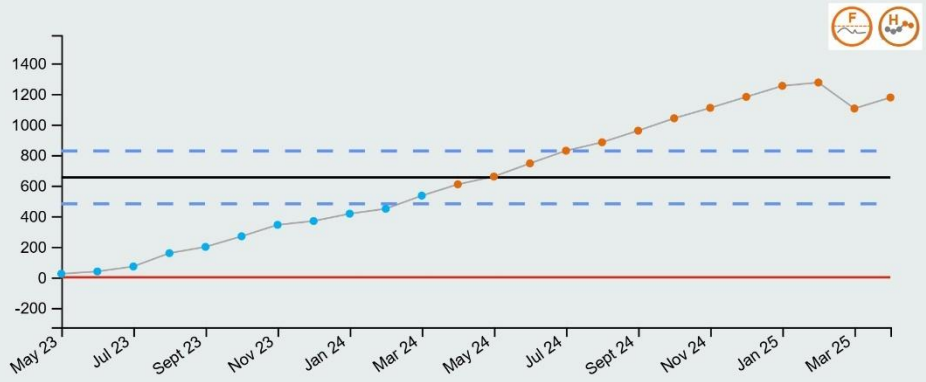
Community health services two-hour urgent response standard



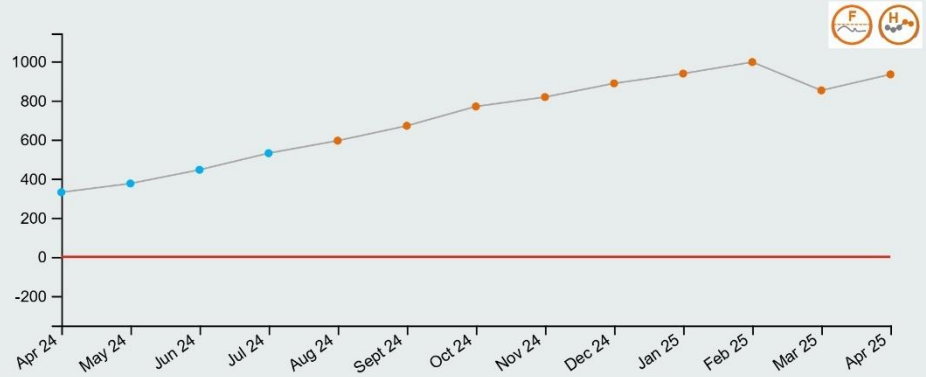
Responsive Domain

NHS
Leeds Community Healthcare
NHS Trust

Number of patients waiting more than 52 Weeks (Consultant-Led)



Zero tolerance RTT waits over 65 weeks for incomplete pathways

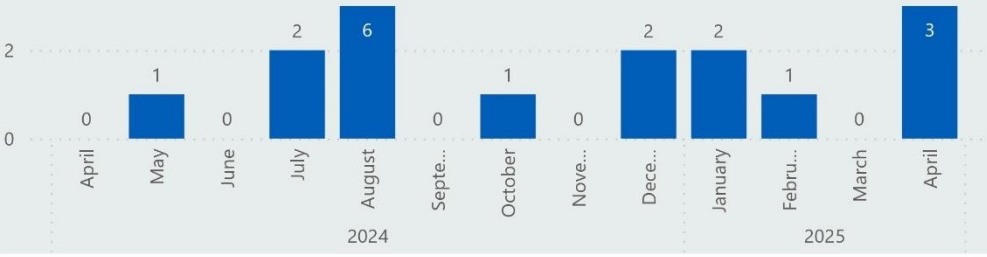


Zero tolerance RTT waits over 78 weeks for incomplete pathways

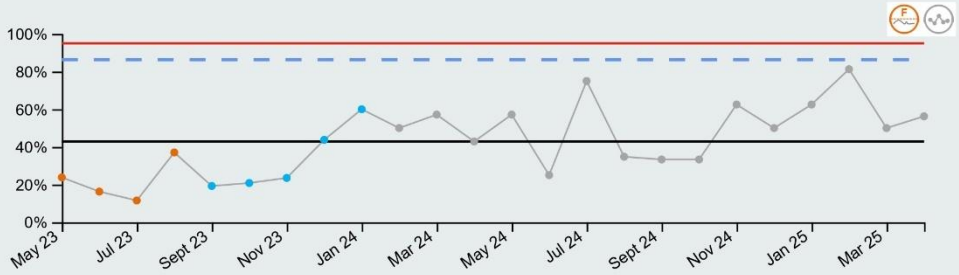
Responsive - CAMHS

NHS
Leeds Community Healthcare
NHS Trust

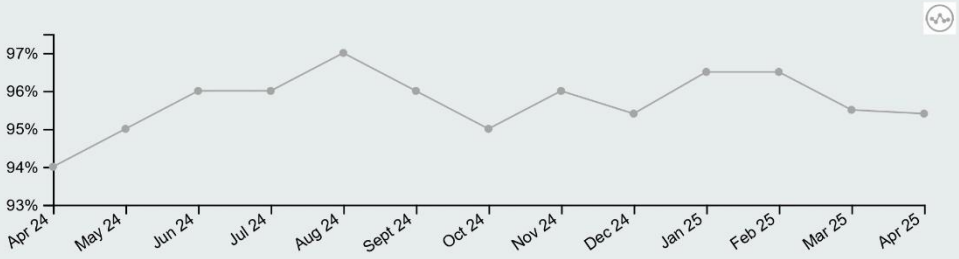
Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care



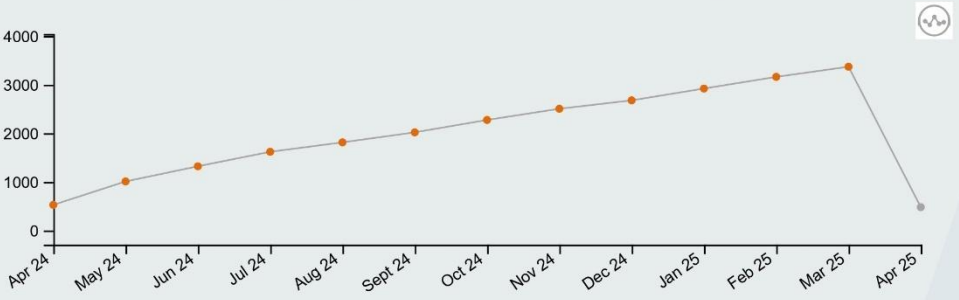
% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment



Percentage of Children over 5 currently waiting more than 18 weeks for a Neurodevelopmental Assessment



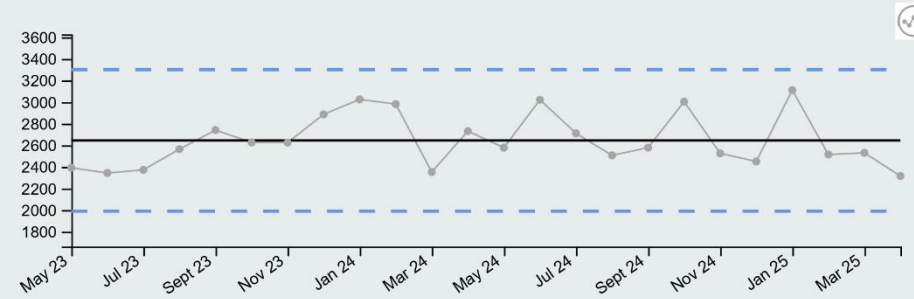
Number of children and young people accessing CAMHS - year to date



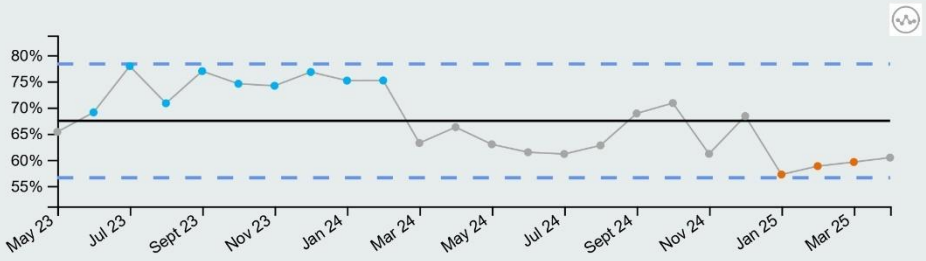
Responsive - LMWS

NHS
Leeds Community Healthcare
NHS Trust

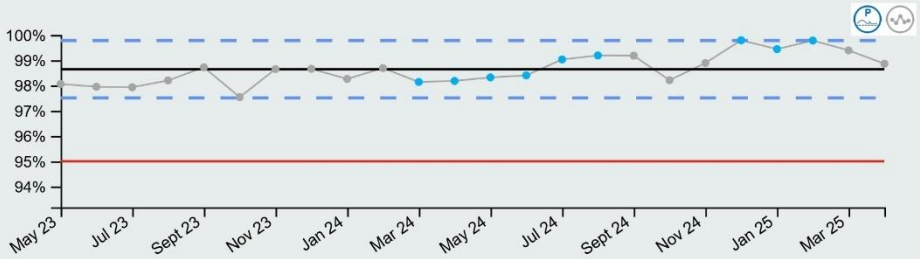
LMWS – Access Target; Local Measure (including PCMH)



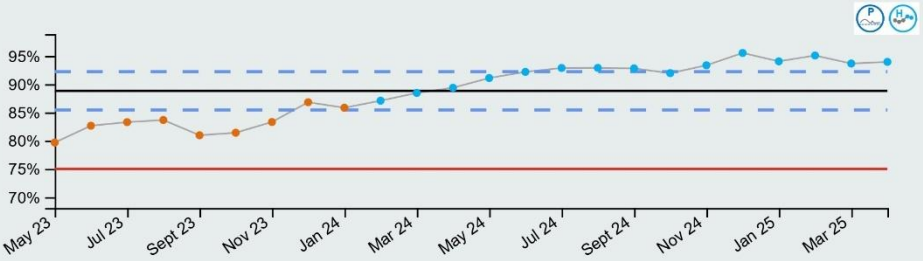
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral



IAPT - Percentage of people referred should begin treatment within 18 weeks of referral



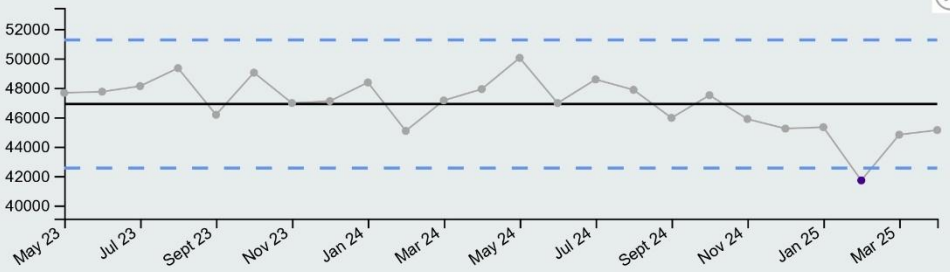
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral



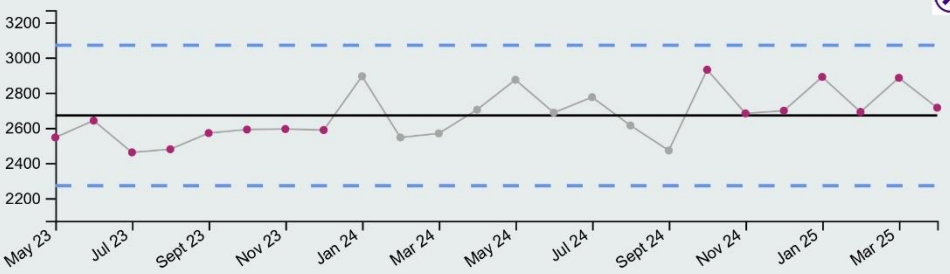
Responsive - NTs

NHS
Leeds Community Healthcare
NHS Trust

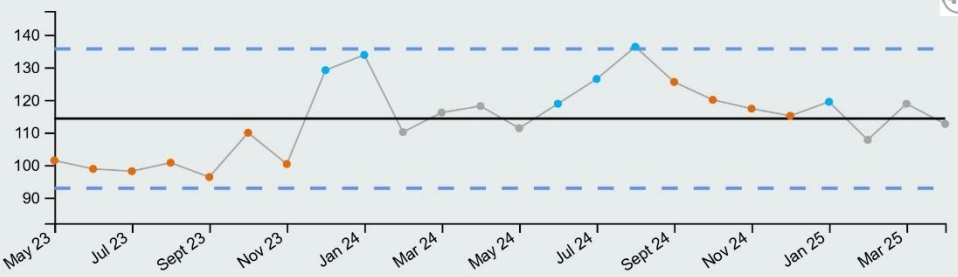
Neighbourhood Team Face to Face Contacts



Neighbourhood Team Referrals (SystmOne only)



Neighbourhood Team Productivity (Contacts per Utilised WTE)



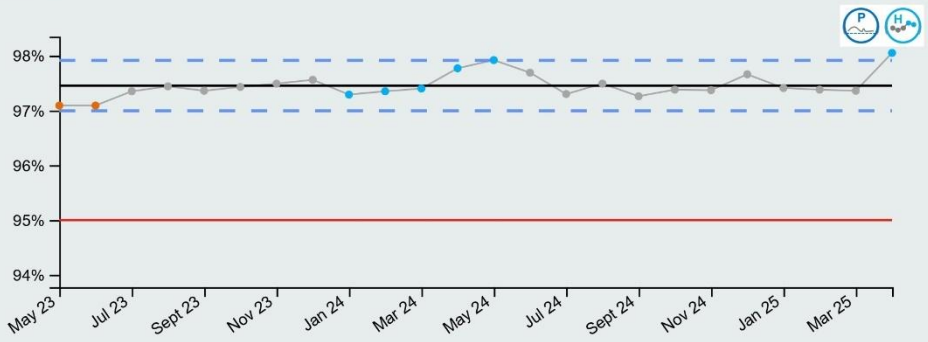
Available virtual ward capacity per 100k head of population

This chart is under development

Responsive - Other

NHS
Leeds Community Healthcare
NHS Trust

Percentage of patient contacts where an ethnicity code is present in the record



Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted

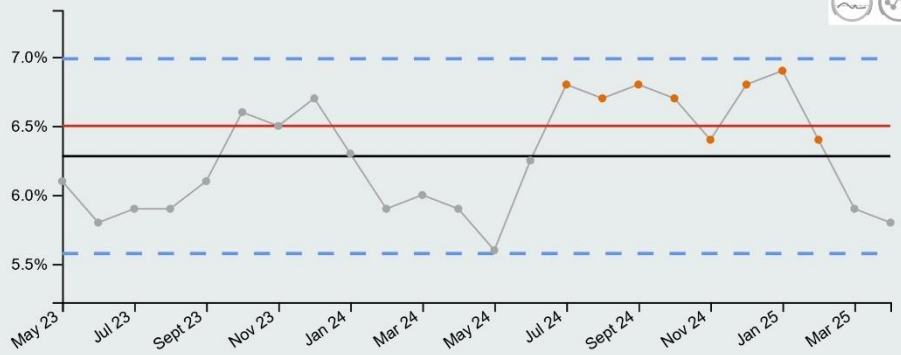
Internal Error! Please file a bug report with the following text:

This chart is under development

Well Led - Workforce

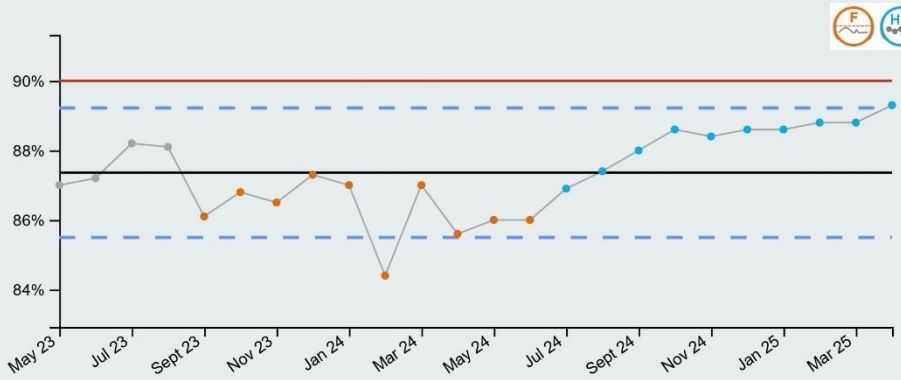
NHS
Leeds Community Healthcare
NHS Trust

Total sickness absence rate (Monthly) (%)



AfC Staff Appraisal Rate

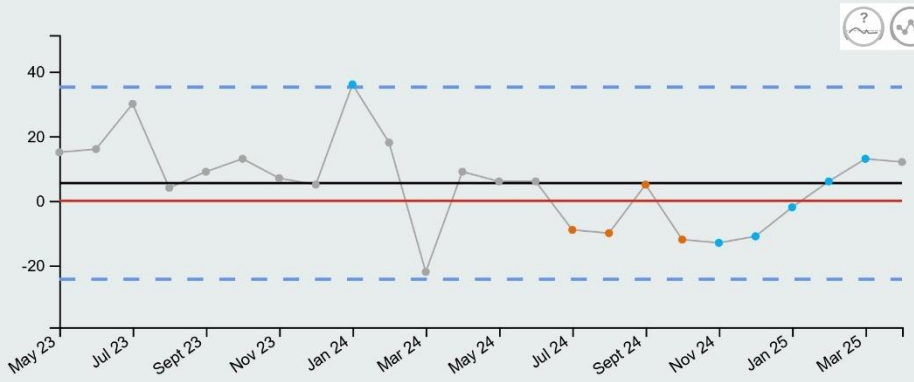
Statutory and Mandatory Training Compliance



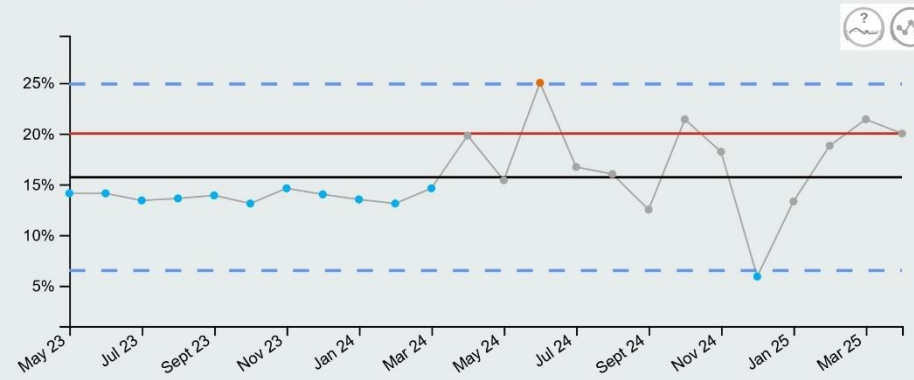
Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

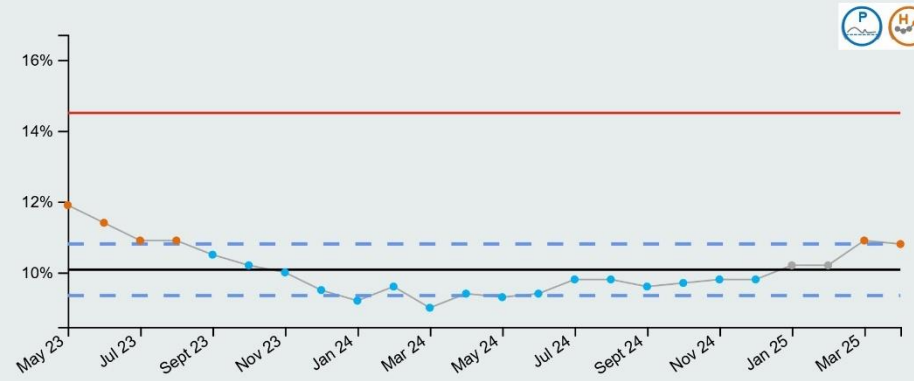
Starters / leavers net movement



Reduce the number of staff leaving the organisation within 12 months



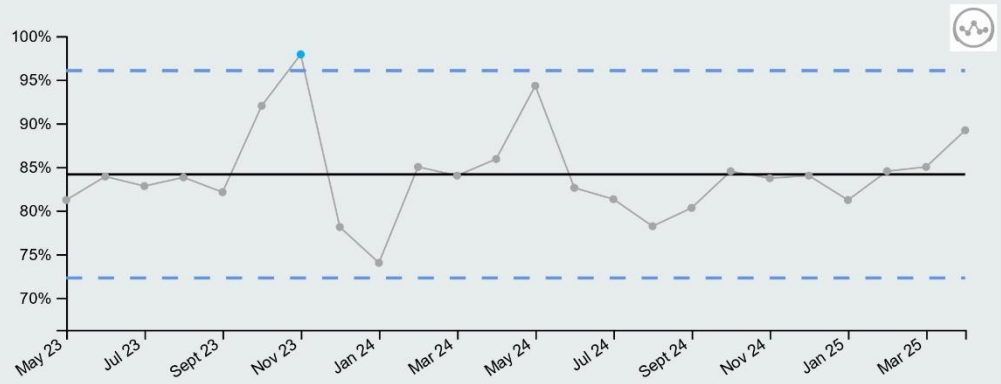
Staff Turnover



Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

Neighbourhood Team Percentage of Funded Posts Utilised

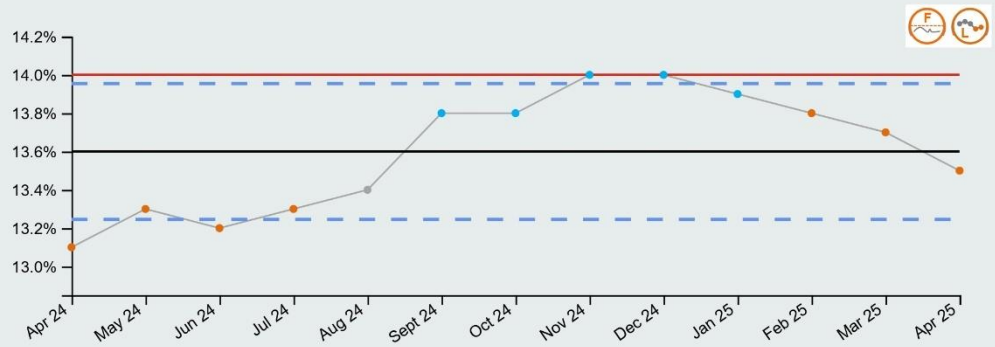


Neighbourhood Team Vacancies, Sickness & Maternity WTE

Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

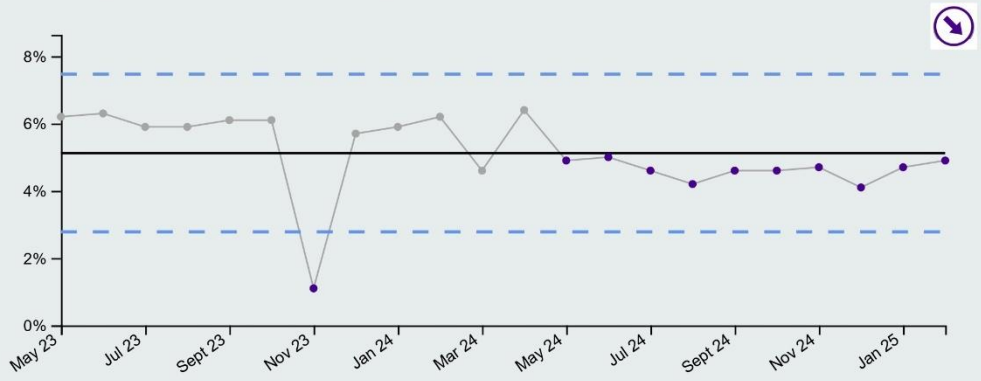
The overall percentage of staff who have identified as BME (including exec. board members)



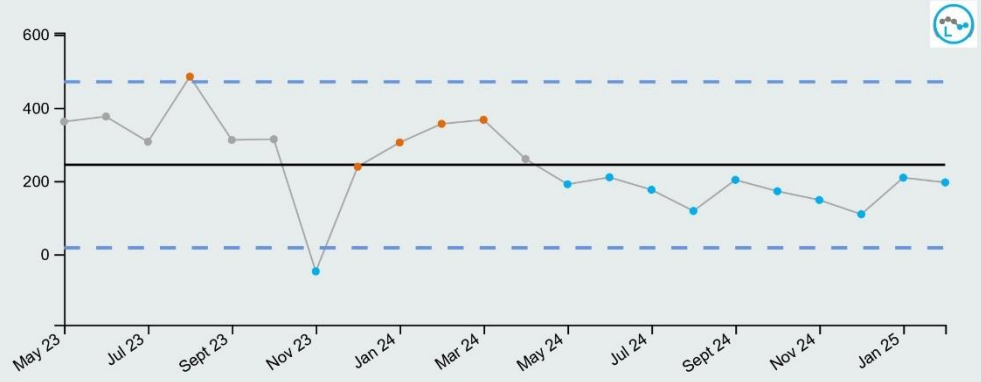
Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

Percentage Spend on Temporary Staff



Total agency cap (£k)



Well Led - Other

NHS
Leeds Community Healthcare
NHS Trust

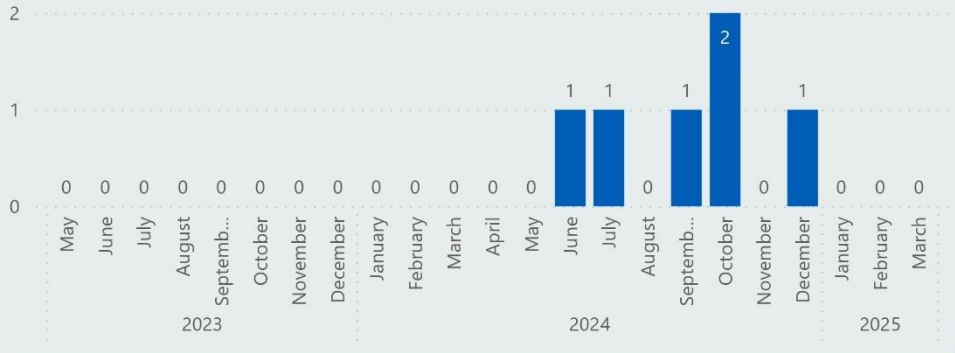
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)

This chart is under development

Percentage of staff who are satisfied with the support they received from their immediate line manager

This chart is under development

'RIDDOR' incidents reported to Health and Safety Executive



Appendix II – High level Indicator Development

Overview

This report gives a summary of the progress to-date and upcoming planned work to improve and develop the assurance given to the Board and Committees through the Performance Brief.

In 2024, plans were developed to use Statistical Process Control (SPC) methodologies as the analytical foundation for the Performance Brief, and eventually as the foundation for all Performance monitoring and management across the Trust.

High Level Indicator Development

Each year, the Board and Committees specify the High-Level Indicators (HLIs) to be selected for the Performance Brief to give assurance on key strategic and operational priorities. The table below gives a summary of the work underway to migrate to SPC approaches.

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Caring	Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	Positive Patient Feedback	Complete	N/A	SPC
Caring	Total Number of Formal Complaints Received	Number of complaints	Complete	N/A	SPC
Caring	Differences in the number of Patient Safety Incident Investigations (PSII) for patients living in IMD1 vs IMD2-10	PSII Equity	Under Development	TBC	SPC
Caring	Mixed Sex Accommodation Breaches**	MSA Breaches	Complete	N/A	Column Chart
Caring	Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 18 week standard	RTT 18 week equity	Complete	N/A	SPC
Caring	Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 52 week standard	RTT 52 week equity	Complete	N/A	SPC
Caring	Difference in access to services for patients living in IMD1 vs IMD2-10 - DM01 Services	DM01 Equity	Complete	N/A	SPC
Caring	Difference in access to services for patients living in IMD1 vs IMD2-10 - Non-Consultant 18 week standard	Non-RTT 18 week equity	Complete	N/A	SPC

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Effective	Number of NICE guidelines with full compliance versus number of guidelines published in 2019/20 applicable to LCH	NICE implemented from 2019	Complete	N/A	Column Chart
Effective	Number of NICE guidelines with full compliance versus number of guidelines published in 2020/21 applicable to LCH	NICE implemented from 2020	Complete	N/A	Column Chart
Effective	NCAPOP audits: number started year to date versus number applicable to LCH	NCAPOP Audits	Complete	N/A	Column Chart
Effective	Priority 2 audits: number completed year to date versus number expected to be completed in 2021/22	Priority 2 Audits	Complete	N/A	Column Chart
Effective	Total number of audits completed in quarter	Total Audits completed	Complete	N/A	Column Chart
Responsive	Percentage of patients currently waiting under 18 weeks (Consultant-Led)	18-week waiting list target (RTT)	Complete	N/A	SPC
Responsive	Number of patients waiting more than 52 Weeks (Consultant-Led)	52 week waiting times (RTT)	Complete	N/A	SPC
Responsive	Zero tolerance RTT waits over 78 weeks for incomplete pathways	78 week waiting times (RTT)	Complete	N/A	SPC
Responsive	Zero tolerance RTT waits over 65 weeks for incomplete pathways	65 week waiting times (RTT)	Complete	N/A	SPC
Responsive	Number of children and young people accessing mental health services as a % of trajectory**	CAMHS Accessing Treatment	Complete	N/A	
Responsive	Available virtual ward capacity per 100k head of population	Virtual Ward capacity per 100k Population	Under Development	TBC	
Responsive	Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Units of Dental Activity	Under Development	TBC	
Responsive	Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care	Eating Disorders 1-week Urgent Target	Complete	N/A	Column Chart

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Responsive	Percentage of Children over 5 currently waiting more than 18 weeks for a Neurodevelopmental Assessment	ND Waiting times (over 5s)	Complete	N/A	SPC
Responsive	Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	Diagnostic 6-week target (DM01)	Complete	N/A	SPC
Responsive	% Patients waiting under 18 weeks (non reportable)	18-week waiting list target (non-RTT)	Complete	N/A	SPC
Responsive	LMWS – Access Target; Local Measure (including PCMH)	LMWS Access	Complete	N/A	SPC
Responsive	IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	NHS Talking Therapies Screening within 2 weeks	Complete	N/A	SPC
Responsive	IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	NHS Talking Therapies 18 week treatment target	Complete	N/A	SPC
Responsive	IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	NHS Talking Therapies 6 weeks treatment target	Complete	N/A	SPC
Responsive	% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	Eating Disorders 4-week Routine Target	Complete	N/A	SPC
Responsive	Neighbourhood Team Face to Face Contacts	NT Contacts	Complete	N/A	SPC
Responsive	Community health services two-hour urgent response standard	UCR 2hour Performance	Complete	N/A	SPC
Responsive	Percentage of patient contacts where an ethnicity code is present in the record	Patient Ethnicity Recording	Complete	N/A	SPC
Responsive	Neighbourhood Team Referrals (SystmOne only)	NT Referrals	Complete	N/A	SPC
Responsive	Neighbourhood Team Productivity (Contacts per Utilised WTE)	NT Productivity	Complete	N/A	SPC
Safe	Number of teams who have completed Medicines Code Assurance Check 1st April 2019 versus total number of expected returns	Medicines Code Assurance Checks	Complete	N/A	Column Chart
Safe	Safer Staffing – Inpatient Services	Safer Staffing - Inpatients	Under Development	TBC	

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Safe	Attributed MRSA Bacteraemia - infection rate**	MRSA Infections	Complete	N/A	Column Chart
Safe	Clostridium Difficule - infection rate**	cDiff Infections	Complete	N/A	Column Chart
Safe	Never Event Incidence**	Never Events	Complete	N/A	Column Chart
Safe	CAS Alerts Outstanding**	CAS Alerts Outstanding	Complete	N/A	Column Chart
Safe	Data Quality Maturity Index (DQMI) - CSDS dataset score**	DQMI - CSDS	Complete	N/A	SPC
Safe	Data Quality Maturity Index (DQMI) - IAPT dataset score**	DQMI - IAPT	Complete	N/A	SPC
Safe	Data Quality Maturity Index (DQMI) - MHSDS dataset score**	DQMI - MHSDS	Complete	N/A	SPC
Safe	Compliance in Level 1 and 2 Patient Safety Training	Patient Safety Training	Complete	N/A	SPC
Safe	Number of Patient Safety Incident Investigations (PSII)	Number of PSIIs	Complete	N/A	Column Chart
Safe	Number of overdue PSII actions	Overdue PSII Actions	Complete	N/A	Column Chart
Safe	Number of incidents by PSIRP priority - Pressure Ulcers	Pressure Ulcers Incidents	Complete	N/A	Column Chart
Safe	Number of incidents by PSIRP priority - Falls	Fall Incidents	Complete	N/A	Column Chart
Safe	Number of incidents by PSIRP priority - Deteriorating Patient	Deteriorating Patient Incidents	Complete	N/A	Column Chart
Safe	Number of incidents by PSIRP priority - Meatal Tear	Meatal Tear Incidents	Complete	N/A	Column Chart
Safe	Number of incidents by PSIRP priority - Clinical Triage in Neighbourhood Teams	NT Clinical Triage Incidents	Complete	N/A	Column Chart

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Safe	Compliance with statutory Duty of Candour	Duty of Candour	Complete	N/A	SPC
Safe	Incidents of E.Coli, bacteraemia**	E.Coli Infections	Complete	N/A	
Well-led	Staff turnover amongst staff from a minoritised ethnic group	BAME Staff Turnover	Under Development	TBC	SPC
Well-led	Reduce the number of “other not known” reasons for leaving	"Other Not Known" Leaving reasons	Under Development	TBC	SPC
Well-led	The overall percentage of staff who have identified as BME (including exec. board members)	BME Staff Proportion	Complete	N/A	SPC
Well-led	Proportion of staff in senior leadership roles (8a and above) filled by staff who have identified as BME	BME Proportion (8A+)	Under Development	TBC	
Well-led	Proportion of staff in senior leadership roles (8a and above) who are women	Female Proportion (8A+)	Under Development	TBC	
Well-led	Proportion of staff in senior leadership roles (8a and above) who have a disability	Disability Proportion (8A+)	Under Development	TBC	
Well-led	Proportion of staff in senior leadership roles (8a and above) who have identified as LGBTQIA+	LGBTQIA+ Proportion (8A+)	Under Development	TBC	
Well-led	Staff Turnover	Staff Turnover	Complete	N/A	SPC
Well-led	Reduce the number of staff leaving the organisation within 12 months	Leavers within 12 months	Complete	N/A	SPC
Well-led	Total sickness absence rate (Monthly) (%)	Sickness Absence	Complete	N/A	SPC
Well-led	AfC Staff Appraisal Rate	Appraisal Rate	Complete	N/A	SPC
Well-led	Statutory and Mandatory Training Compliance	Training Compliance	Complete	N/A	SPC
Well-led	Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	Staff that would recommend LCH	Under Development	TBC	
Well-led	Percentage of staff who are satisfied with the support they received from their immediate line manager	Staff satisfied with line manager support	Under Development	TBC	

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
Well-led	'RIDDOR' incidents reported to Health and Safety Executive	RIDDOR incidents	Complete	N/A	Column Chart
Well-led	Total agency cap (£k)	Agency Spend (£k)	Complete	N/A	SPC
Well-led	Neighbourhood Team Vacancies, Sickness & Maternity WTE	NT Vacancies, Sickness & Maternity WTE	Complete	N/A	SPC
Well-led	Neighbourhood Team Percentage of Funded Posts Utilised	NT Staff funding utilised	Complete	N/A	SPC
Well-led	Starters / leavers net movement	Starters and Leaver Net Movement	Complete	N/A	SPC
Well-led	Percentage Spend on Temporary Staff	Agency Percentage	Complete	N/A	SPC

Agenda item:	2025-26 (39i)

Title of report:	Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024/25

Meeting:	Trust Board Held In Public
Date:	5 June, 2025

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

Executive Summary:	In December 2024 the Trust received the outcome from its second self-compliance assessment against the national EPRR core standards using the new tougher (NHS NE &Yorks) scoring system. Like other Trusts in the region, LCH had improved its compliance scores considerably, but is still rated as non-compliant. The EPRR Improvement Plan requires a number of LCH and ICS actions to be undertaken which are scheduled to be completed by September 2025 (prior to the submission date at the end of October). Internal audit have been scheduled to undertake a review of the ratings/evidence in the summer of 2025. Other requirements such as exercises, training and partnership working have all improved the Trust's understanding/ learning of EPRR risks and have helped to improve the Plans, Policies and other supporting EPRR documentation.

Previously considered by:	Senior Leadership Team – 07/05/2025 LCH Business Committee – 30/04/2025

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	Yes		What does it tell us?	

the report (for patient care and/or workforce)?	No	√	Why not/what future plans are there to include this information?	

Recommendation(s)	The Trust Board is asked to take this report as assurance that progress on the delivery of the EPRR Improvement Plan during 2024\25 will lead to the Trust achieving at least partial compliance in this year's audit process.

List of Appendices:	Appendix 1 – Emergency Planning Annual Report – April 2025 Appendix 2 – EPRR Core Standards Improvement Plan 2024\2025

Appendix 1

Leeds Community Healthcare NHS Trust

Emergency Preparedness, Resilience and Response (EPRR): Annual Report 2024 – 2025

Author:	**Rebecca Todd** **Emergency Planning Manager**
Corporate Lead:	**Sam Prince** **Executive Director of Operations**
Document Version	**v0.1**
Date for presentation to the LCH Business Committee:	**April 2025**
Date issued:	**April 2025**

Report Summary

This report focuses on the Emergency Preparedness, Resilience and Response (EPRR) work carried out within Leeds Community Healthcare NHS Trust for the period October 2023 – October 24. The report once again focuses on compliance ratings, this being the second year since the launch of the new NHSE Annual EPRR Assurance process. There are however areas of emergency preparedness and response which sit outside the compliance agenda, therefore the report will also focus on the establishment of the LCH Learning & Exercising Group and learning from local, regional and national exercises and incidents.

Compliance

Following the substantial changes made to the NHS England Annual EPRR self-assessment process in June 2023 the Trust has remained focused on the EPRR Improvement Plan to continue to improve its compliance. The Trust approached the 2024 audit as previously developing and re-writing plans and accruing supporting evidence ahead of the final submission in October 2024. NHS England responded to the final submission, and although the Trust had shown considerable improvement on a number of key areas, due to the scoring system, the Trust still declared non-compliance for the second year.

LCH Core Standards Assurance Outcomes 2023 and 2024

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

West Yorkshire NHS Organisations EPRR Core Standard Audit Outcomes 2023-2024

Non-Compliant Threshold: 76% or less	Partially Compliant Threshold: 77%-88%	Substantially Compliant Threshold: 89%-99%	Fully Compliant Threshold: 100%
8	4	2	0
WY Range: 47%-75%	WY Range: 77%-83%	WY Range: 92%-93%	WY Range: N\A

The outcome of the Trust's Annual EPRR Assurance 2024 was approved by the Trust Leadership Team, Business Committee and Trust Board and the Improvement Plan has since been prepared to address the outstanding areas in preparation for the 2024\2025 submission.

In light of the above outcomes the EPRR focus over the last year has been to progress the EPRR Improvement Plan to increase the Trust's level of compliance.

Continuous Improvement - learning from exercises, workshops and incidents:
Over the last year LCH has attended a number of workshops, webinars and exercises as part of the regional and local health and care system. The Trust is also linked into the West Yorkshire Resilience Forum Business Continuity Subgroup and has attended workshops as a result:

Event	Learning
LCH Annual Exercise, October 2024 IT Disruption	• Importance of having up to date business continuity plans in place • Importance of having plans that can support a prolonged system failure – ie for a number of months • Process for escalation • Decision making in regard to standing up a Command structure and an Incident Co-ordination Centre • Membership of an Incident Co-ordination Group • Pre-prepared options\alternative ways of working in place in preparation for system failure
LCH Business Continuity Plan exercises	• All business units have exercise dates planned in for winter 2024\25 • Learning to be taken from exercises and any gaps to be addressed ahead of being incorporated into BCPs at their next review. • Services will be encouraged to maintain the incident log within their Business Continuity Plans and review and test at regular intervals to address common themes or develop new systems as required.
West Yorkshire Resilience Forum workshops: • Power Outage • Fuel Exercise	• Communication • How to communicate with staff to make them aware of an incident • The importance of having up-to-date Trust Incident Response Plans • The importance of up-to-date service level business continuity plans • The challenge for organisations to function during a prolonged power outage • Working with partners to continue to deliver care ie LA • Staff safety

The Trust Learning and Exercising Group has been established to gather and share learning from events such as those listed above. The Group will also be supporting On-call colleagues and addressing recurrent issues flagged on the On-call log.
In addition, Business Continuity arrangements will be discussed and tested as the group works through learning from exercises and incidents at national, regional and local level. Trust plans will then be updated to reflect the continuous improvement of our business continuity and emergency response planning arrangements.

Command and Control
The Trust has not been required to establish a formal Command and Control structure over the past year, however the Trust did stand up a Co-ordination Group in response to the Civil Unrest in July 2024 and we have also been an active contributor to the GP Collective Action Group established and led by the ICB in February 2025.

Appendix 1

Emergency Planning Resilience and Response Annual Report 2024\25

Introduction

The Emergency Planning focus over the last year has been to deliver the EPRR Improvement Plan which was developed in conjunction with Internal Audit to address the outcomes of the NHSE EPRR Annual Audit in December 2023. The Trust revisited its EPRR Work\Improvement Plan with a view to improving its compliance rating ahead of the October 2024 submission. Actions were undertaken in line with the recommendations to ensure that the Trust was in a stronger position as we approached this year's NHSE Annual EPRR Assurance process with Audit Committee oversight.

EPRR Improvement and wider Plans

The majority of the Trust's EPRR plans, policies and supporting documentation have been updated to incorporate the latest guidance\best practice to ensure they are fit for purpose and comply with the NHS England Core Standards Framework. All updated EPRR Plans and Policies were finally approved by the Trust Leadership Team, LCH Business Committee and Trust Board in December 2024 in line with the feedback received from NHS England.

Progress in completing the different elements of the improvement plan was steady, and although some of the timescales slipped, the plan was developed to allow for an element of this. EPRR set a target to have most standards compliant by June 2024 ahead of a review by Internal Audit to ascertain the Trust's level of compliance. This timescale then allowed 4 months to complete the outstanding areas ahead of the October submission.

Current areas of concern include EPRR training and our Chemical Biological, Radiological and Nuclear (CBRN) response. Training Portfolios are in the process of being launched for Strategic and Tactical commanders, however availability of training is challenging and impacts the Trust's ability to achieve compliance in this area. The Integrated Care Board have now established regular meetings with EPRR Managers and these incorporate a range of topics including the NHSE Core Standards, CBRN response arrangements and training.

LCH Emergency Preparedness Resilience and Response Workplan

Following the outcome of the 2023 NHS England Annual EPRR Assurance Audit the EPRR Workplan and Improvement Plans have been aligned as many of the priorities remain the same. The EPRR Workplan breaks down the key elements of the annual EPRR Assurance process whilst including areas for improvement from the previous submission and incorporating additional LCH priorities.

Command and Control

The Trust has not been required to formally stand up its Command structure during the past year. System pressures have been managed through the Urgent Care Network led by the ICB and at Citywide system meetings as required. The Boardroom at White Rose Park is now the Primary Incident Co-ordination Centre location with a backup room in place at Chapeltown Health Centre.

LCH Business Continuity Programme

The Leeds Community Healthcare Business Continuity Management System (BCMS) has been re-written in line with feedback from the NHS England Annual EPRR Audit process and was tested at the annual Trust Autumn Exercise in October 2024. The management system ensures that all documentation and processes are aligned to the International Standard ISO 22301. Business Continuity plan testing is to take place across the Trust over the next few months to ensure Business Impact Assessments are completed prior to the completion of Business Continuity Plans, and that Business Continuity Plans are up to date and tested in preparation for the NHSE Assurance process.

LCH Critical Services List

As part of the review of the Trust's Business Continuity process critical services will be revisited to ensure that all emergency plans are aligned and that all services are aware of those services (C1, C2) which must be maintained during a major incident or emergency.

Working in Partnership

The Trust has continued to work closely with partner organisations and is represented at key regional forums such as the West Yorkshire Local Health Resilience Partnership (LHRP), the West Yorkshire Local Resilience Forum (WYLRF), the West Yorkshire Emergency Planning Leads meetings and the Y&H Mental Health & Community EPRR Group. The Trust is also represented at a range of briefings, events and workshops led by NHS England, the West Yorkshire Integrated Care Board (ICB) and the West Yorkshire Resilience Forum Business Continuity Sub-group. The Trust is also a member of the Leeds Pandemic Planning Group led by the Local Authority Public Health Directorate.

LCH Trust Annual Exercise

The NHS England Emergency Preparedness, Resilience and Response Framework stipulates that all NHS Providers must undertake an annual exercise. The Leeds Community Healthcare Annual Exercise – Exercise Barley Mow was held on Wednesday, 2nd October in the Boardroom at White Rose Park. The exercise was based around a prolonged IT disruption affecting health roster and systems linked to health roster. The session ran for 2 hours and was attended by 27 LCH colleagues with the addition of the Cyber Security Principal Consultant from NHS England.

Service Level exercises

In line with ISO 22301 each service is required to test its service level Business Continuity Plan on an annual basis and this is monitored through the Business Continuity Management audit process. The Emergency Planning Manager has offered to support in the planning and delivery of Business Continuity exercises including the annual Informatics exercise.

Learning from incidents and exercises is reviewed on a regular basis and where appropriate incorporated into plans at either service or wider Trust level such as the LCH Incident Response Plan and the On-call Pack.

Training

100% of our Trust 2nd On-call Managers have attended the NHS England Principles of Health Command Training Strategic (Gold) level and a high percentage of our 1st On-call Managers have attended the Tactical (Silver) Training. Following an upcoming review of the LCH on-call process we will be focusing on 1st on-call colleagues attending the Tactical level training. A number of colleagues have also attended the JESIP (Joint Emergency Service Interoperability Programme) training which is delivered through the West Yorkshire Resilience Forum and involves a set of principles to support a co-ordinated incident response. A wider range of core courses are now becoming available through NHS England.

Commander Training Portfolios - NHS England have launched the new Commander Training Portfolios in line with the National Occupational Standards. Performance is being monitored through the Integrated Care Board and the WY Local Health Resilience Partnership (LHRP). A target date for full implementation was set at April 2025.

Incident response

The Trust has not been required to take part in a live incident response during the past year, however a Co-ordination Group was established by the Accountable Emergency Officer (AEO) in response to the Civil Unrest which took place in July 2024, and the Trust Deputy AEO also attended the ICB-led GP Collective Action Group meetings to plan the system response. Although a full incident response was not required the Trust complied with national reporting and undertook a formal lessons learned process following each event.

Additional EPRR Work areas:

- LCH Lockdown Plan – EPRR have been working alongside the Security and Facilities Team to develop the LCH Lockdown Plan. A number of meetings have taken place through the year to take this work forward.
- The Emergency Planning Manager attends the Infection Prevention Co-ordination Group and work is underway to review pandemic planning.
- Work continues on the Trust's response plan for a Chemical, Biological, Radiological and Nuclear incident. We are working closely with Yorkshire Ambulance Service and partners to agree proportionate arrangements for the Trust.
- The Trust On-call Manual is in the process of being re-written to ensure the contents are relevant and up to date in preparation for the outcomes of the review of Trust on-call arrangements.
- Climate change is now being reflected on the Trust Risk Register and within our Trust Adverse Weather Plan.

09/04/2025
Rebecca Todd
Emergency Planning Manager

NHS
Leeds Community Healthcare
NHS Trust

EPRR Core Standards Action Plan – 2024\2025

Ref	Domain	Action	By Whom	Date
Governance				
CS2	EPRR Policy Statement	• Final draft to be reviewed and sent to business committee	EPRR Manager	**Completed**
CS5	EPRR Resource	• Governance structure • Terms of reference for Senior Leadership Team • Terms of reference for EPRR Exercise and Learning Group • Improvement plan showing resources required.	EPRR Manager	**Completed**
Duty to Maintain Plans				
CS9	Collaborative Planning	• LCH to share Plans\Policies on WY EPRR Managers MS Teams channel.	EPRR Manager	March 2025
CS11	Adverse Weather Plan	• Comms to provide evidence of cascade process for severe weather alerts.	Comms	Dec 2024
CS12	Infectious Disease	• Local plan to be written alongside Leeds infectious diseases plan.	IPC	June 2025
CS13	New and Emerging Pandemics	• First draft plan circulated • Need to work with IPC and clinical leads on amendments.	EPRR \ IPC	June 2025
CS14	Countermeasures	• Trust plan to be produced/ updated alongside Leeds plan • New citywide group formed Sept 24.	IPC	June 2025
CS15	Mass Casualty	• Additional LCH Annex to be developed outlining LCH responsibilities during mass casualty events.	Service Leads \ EPRR	Feb 2025
CS16	Evacuation & Shelter	• Final draft to be produced (action cards), circulated and approved • Discussions around MOU with LTHT.	EPRR Manager	**Completed** Nov 2024

CS17	Lockdown Plan	• Clarification on responder roles to be agreed • Paper to Trust Leadership Team • Site risk assessments/profiles to be completed.	EPRR \ Facilities \ Security	June 2025
CS18	Protected Individuals	• Existing plan to be updated	Comms	Oct 2024
Training & Exercising				
CS22	EPRR Training	Clarification sought regarding; • Scope of responder training in the Trust • Methodology around offering/capturing training events • Review of portfolios • How competences can be tested • General availability of training.	AEO	Feb 2025
CS23	EPRR Exercising & Testing programme	• Establish Learning and Exercising Group • Write Terms of Reference • Develop testing programme	EPRR Manager	**Completed**
CS24	Responder Training	Clarification sought regarding; • Scope of responder training in the Trust • Methodology around offering/capturing training events • Review of portfolios • How competences can be tested • General availability of training.	AEO	Feb 2025
CS25	Staff Awareness & Training	• Y&H Community and Mental Health group reviewing this standard.	EPRR Manager	March 2025
Response				
CS27	Access to Planning arrangements	• Hard copies to be made available • Sequential numbering to be put in place.	EPRR Manager	March 2025

CS29	Decision Logging	• Check the list of Loggists • Advertise Loggist role in MyLCH • Organise training of any new volunteers\or refresher training as required	EPRR	**Completed**
Warning & Informing				
CS33	Warning & Informing	• Update comms pack to include a formal warning plan.	Comms	March 2025
CS34	Incident Communication Plan	• Update Comms Pack.	Comms	March 2025
CS35	Communication with partners and stakeholders	• Update Comms Pack.	Comms	March 2025
CS36	Media Strategy	• Update Comms Pack.	Comms	March 2025
Co-operation				
CS39	Mutual Aid Arrangements	• Advice required around the co-ordination and agreement of ICS and Place plans • Framework being developed by ICB.	ICB	TBC
CS43	Information Sharing	• Further information sharing agreements to be scoped, agreed and signed.	EPRR Managers across Leeds	Jun 2025
Business Continuity				
CS44	Business Continuity Policy Statement	• Final draft to be circulated and reviewed prior to BC approval.	EPRR Manager	**Completed**
CS45	Business Continuity Management System scope and objectives	• Final draft to be circulated and reviewed prior to BC approval.	EPRR Manager	**Completed**
CS46	Business Impact Analysis\Assessment (BIA)	• Final draft to be circulated and reviewed prior to BC approval.	EPRR Manager	**Completed**
CS48	Testing and Exercising	• Internal audit review of Business Continuity Management System (BCMS)	Internal Audit	**Completed**

CS50	BCMS Monitoring and Evaluation	• System to monitor performance/ KPIs and report to Board.	EPRR	June 2025
CS51	BC Audit	• Audit overdue.	EPRR \ Internal Audit	**Completed**
CS52	BCMS Continuous Improvement Process	• Establish Learning and Exercising Group • Write Terms of Reference • Develop testing programme.	EPRR Manager	**Completed**
CS53	Assurance of commissioned providers\suppliers BCPs	• Agreement on what level of assurance is required from suppliers.	Senior Leadership Team	Jan 2025
CBRN				
CS63	HAZMAT\CBRN Training Resource	• Train the Trainer courses being run by YAS to be rolled out.	EPRR Manager	Jan 2025
CS64	Staff Training - recognition and decontamination	• EPRR to receive training records from Front of House.	EPRR \ Admin Team Leaders	Jan 2025

EPRR Manager
10/12/2024
V0.1
Revised – 03/01/2025
V0.2

Agenda item:	2024-2025 (40)

Title of report:	Guardian Of Safe Working Hours- Quarter 4 update

Meeting:	Trust Board Meeting Held In Public
Date:	5 June 2025

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

Executive Summary:	**Main issues for consideration** • Upcoming changes to managing exception reporting system

Previously considered by:	Nil

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

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

Recommendation(s)	• Support GSWH with the work in relation to implementation of changes for exception reporting system/pathway.

List of Appendices:	Nil

Guardian of Safe Working Hours report

1 Introduction

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

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

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

2 Current position/main body of the report

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

Department	No.	Grade	Status
Adults	0		LCH contract
Foundation year	2	FY1	Honorary contract
CAMHS	3	ST	LCH contract
	0	ST	Honorary contract
	3	CT	Honorary contract
Community Paediatrics	3	ST Level 1	LCH contract
	5	ST Level 2/ Grid trainee	Honorary contract
Sexual Health	2	ST	LCH contract
GP	2	GPSTR	LCH contract
Community Gynae	1	ST	Honorary contract
Dental Services	1		Honorary contract

3 Impact

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

- **Quality**

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

- **Resources**

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

Rota Gaps (number of night shifts needing cover)		Mar 2025		Apr 2025		May 2025	
		CT	ST	CT	ST	CT	ST
	Gaps	n/a	7	n/a	5	n/a	6
	Internal Cover	n/a	3	n/a	3	n/a	2
	External cover	n/a	4	n/a	2	n/a	4
	Unfilled	n/a	0	n/a	0	n/a	0

- **Risk and assurance**

Feedback from Junior doctors
Resident Doctors Forum (RDF) was held on MS teams on 03/04/2025.

It was agreed to review and monitor CAMHS non-resident on call rota. Resident doctors raised concerns about shifts where there is staff shortage of specialist nurse practitioners during their non resident on call. This is impacting on their on call workload. This was raised as a concern to the relevant CAMHS team and admin cover who have investigated the matter to ensure adequate cover is in place. GSW encouraged Resident doctors to exception report these events if they happen in the future.

Resident doctors voiced their thoughts about payment for locum shifts at LCH and how the amount differs significantly from what other trusts in Leeds are paying. GSWH has taken this issue through LNC and it was discussed at LNC meeting on 12/05/25 and a plan is in place to review the current rates.

CAMHS Historic ST rota issue

The grievance case is ongoing. There has not been any further update since the last Trust board meeting.

Exception reporting reforms

The BMA resident doctors committee (UKRDC) has secured an agreement on exception reporting reform in April 2025, as agreed as a part of the 2024 pay deal.

There will be significant changes as agreed under the new framework that are related to – exception reporting software system, onboarding of resident doctors on to the reporting system, processing of exception reports, all educational exception

reports to be sent to DME and changes to the time period in which exception report is filed.

GSWH has requested People operation team to work on the reforms and will be linking in with the team along with head of medical education, DME, DMD and BMA IRO to review the next steps of implementation.

GSWH has requested if LCH can access the software reporting system that is used by LYPFT for filing exception reports as this will be mandatory from September 2025. Currently, exception reporting at LCH is via email to GSWH and clinical supervisor.

4 Next steps

GSWH will continue to work with Key people to implement exception reporting reforms.

5 Recommendations

The Board is recommended to:

- Support GSWH with the work in relation to implementation of changes for exception reporting system/pathway.

Name of author Nagashree Nallapeta
Title Guardian for Safe Working Hours
Date paper written 20/05/2025

Agenda item:	2025-26 (41i)

Title of report:	People and Culture Committee Terms of Reference

Meeting:	Trust Board Meeting Held In Public
Date:	5 June 2025

Presented by:	Rachel Booth, Committee Chair, and Jenny Allen / Laura Smith, Director of Workforce					
Prepared by:	Helen Robinson, Company Secretary					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	x

Executive Summary:	Draft Terms of Reference for the new People & Culture Committee.

Previously considered by:	People & Culture Committee – 21 May 2025 Recommended for Board approval following addition of further references to culture and equity, and some amendments to the membership.

Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	
	Enable our workforce to thrive and deliver the best possible care	x
	Collaborating with partners to enable people to live better lives	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?	
	No	x	Why not/what future plans are there to include this information?	N/A

Recommendation(s)	To review and approve the draft Terms of Reference for the People & Culture Committee.

List of Appendices:	Appendix 1 – People and Culture Committee ToR May 2025 v1 DRAFT

Committee Terms of Reference

Leeds Community Healthcare NHS Trust

People and Culture Committee

Document History:

Version:	1
Date:	21 May 2025
Last version received by:	People and Culture Committee (v1, May 2025)
Approved by:	Leeds Community Healthcare NHS Trust Board
Date approved:	*5 June 2025*
Name of author:	Director of People, OD and System Development Company Secretary
Name of responsible committee:	Leeds Community Healthcare NHS Trust Board
Date issued:	*v1 5 June 2025*
Review date:	March 2026
Target audience:	Leeds Community Healthcare NHS Trust Board People & Culture Committee

Contents

People and Culture Committee
Terms of Reference

1. Introduction

1.1. The People and Culture Committee is a sub-committee of Leeds Community Healthcare NHS Trust Board. Its constitution and terms of reference is as set out below.

1.2. The People and Culture Committee is authorised by the Trust's Board to act within its terms of reference. All members of staff are directed to co-operate with any request made by the People and Culture Committee.

1.3. The role of the People and Culture Committee is to:

- Promote best practice in workforce culture, HR, learning and development and leadership and help to identify priorities and risks on a continuing basis.
- Provide assurance that the Trust understands its strategic workforce needs (including wellbeing, culture, recruitment, retention, development of people, and organisational design) and to oversee the development and monitoring of plans to progress their delivery.
- Ensure that equality and inclusion and due consideration to the Equality Act 2010 are embedded in all aspects of the committee's work.

It does not remove from the Board the overall responsibility for this area, but provides a forum for a more detailed consideration of people matters.

1.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

1.5 The People and Culture Committee is authorised to obtain such information as is necessary and expedient to the fulfilment of its functions.

2. Constitution

2.1. The Board hereby resolves to establish a committee of the Board to be known as the People and Culture Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2.2. The Committee will refer to the other Board Committees (the Quality Committee, Audit Committee and the Business Committee) matters considered by the Committee deemed relevant for their attention. The

Committee will consider matters referred to it by those Committees or the Board of Directors.

2.3. The Committee will provide assurance to the Trust Board on all areas within its remit based on the evidence received by the Committee using standard classification, i.e.

- **Substantial assurance** based on a conclusion that there is a robust system of internal control and governance in place which will deliver the Trust's corporate objectives (clinical, quality or business) and that controls and management actions are consistently applied
- **Reasonable assurance** based on a conclusion that there is a generally sound system of internal control and governance to deliver the clinical, quality or business objectives and that controls and management actions are generally being applied. Some weakness in the design and/or application of controls and management actions put the achievement of particular objectives at risk. Improvements are required to enhance the controls to mitigate these risks.
- **Limited assurance** based on a conclusion that the design and/or application of controls and management actions are insufficient and the weaknesses put the achievement of clinical, quality or business objectives at risk. Significant improvements are required to improve the adequacy and effectiveness of the controls to mitigate these risks.
- **No assurance** based on a conclusion that there is a fundamental breakdown in or absence of controls and management actions which could result (or have resulted) in failure to achieve the clinical, quality or business objectives. Immediate action is required to improve the controls to mitigate these risks.

3. Membership

3.1. The People and Culture Committee's membership will be:

- Three non-executive directors, or two non-executive directors and one associate non-executive director (one of whom will Chair the Committee; the second will cover as Deputy Chair)
- Director of People, OD and System Development
- Executive Director of Nursing and AHP's

3.2 The Chief Executive and Chair have a standing invitation to attend any of the Board's sub-Committees. Other members of the Executive Team also have a standing invite to attend particularly when items within their portfolio are included on the agenda.

4. Attendance

4.1. The following will be invited to be in attendance at the meeting:

Executive Medical Director
Executive Director of Operations
Executive Director of Finance and Resources
Head of Communications
Associate Director of Strategy, Change, and Improvement
Freedom to Speak Up Guardian
Staff Network Chairs (on rotation, one network per meeting)
Company Secretary
Associate Director – People Solutions
Associate Director – People Operations
Representation from each Business Unit (as and when required related to topic)
Guardian for Safe Working Hours (as and when required related to topic)
Staff Side Chair (as and when required related to topic)

4.2. Other directors or senior managers will be invited to attend where their areas of business are being discussed.

4.3. Leeds Community Healthcare NHS Trust's advisers and auditors may also attend the meetings to provide professional advice as and when required.

4.4. The composition of the Committee, along with attendance information will be reported in the Committee's annual report.

5. Meetings and quorum

5.1. The Chair will preside at all meetings. In extraordinary circumstances where the Chair cannot attend, the nominated Deputy Chair will preside.

5.2. A quorum shall be two members of the Committee, including either the Chair or the Deputy Chair and at least one executive director. In the absence of any member, he or she will have the right to nominate a suitable person to attend the Committee on behalf of the absent member. The number of deputies who will count towards a quorum shall not exceed two for any meeting. Where a quorum cannot be established the Committee will continue to meet but will be unable to approve any documentation.

5.3. Meetings shall be held regularly in line with the annual workplan with an expectation of four meetings a year. Additional meetings may be called at the Chair's discretion.

5.4. Members are expected to attend all meetings. Apologies must be received by the Chair in advance of the meetings. All members will be required to attend a minimum of two meetings annually unless due to extenuating circumstances.

5.5. If any member has a pecuniary interest in any matter and is present at the meeting at which the matter is under discussion, he / she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the Committee's consideration has been completed.

5.6. The Chair of the Committee in consultation with one other member may also act on urgent matters arising between meetings of the Committee.

5.7. Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

5.8. The Chair of the People and Culture Committee and one of the other members, in consultation together, may also act on urgent matters arising between meetings of the Committee in accordance with the Scheme of delegation and the Procedure for emergency powers and urgent decisions (Chief Executive and Chair's actions and Committee urgent matters). Any such action will be reported to the next meeting and be recorded in the minutes of that meeting.

6. Authority

6.1. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of others with relevant experience and expertise if it considers this necessary.

7. Role and duties of the People and Culture Committee

7.1. The Committee will promote best practice in workforce culture, HR, learning and development and leadership and help to identify priorities and risks on a continuing basis.

7.2. The Committee will ensure that equity and inclusion and due consideration to the Equality Act 2010 are regarded in all aspects of the committee's work.

7.3. Specific duties include but are not limited to:

7.3.1. Developing and overseeing implementation of the Trust's People Strategy and providing assurance to the Board of Directors that this is being delivered in line with the annual planning process.

7.3.2. Monitoring and reviewing workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors. This should include but not be limited to metrics monitoring the use of bank and agency staff, recruitment and attendance.

7.3.3. Reviewing any changes in practice required following any internal enquiries that significantly impact on workforce issues.

7.3.4. Reviewing and approving partnership agreements with staff side.

7.3.5. Seeking assurance to ensure that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues, including but not limited to equality and diversity.

7.3.6. To monitor cases of Freedom to Speak Up and escalate as appropriate to the Board.

7.3.7. Oversight of the monitoring of staff engagement levels and views as evidenced by the results of the national and any other staff surveys; and Trust actions in response to these.

7.3.8. Oversee and support the Trust's progress towards its workforce equity and inclusion ambitions, with particular regard to NHS requirements and the perspectives of LCH Staff Networks

7.3.9. Oversee the development of relationships with further and higher education institutions to ensure the Trust is able to influence the supply of practitioners and professionals with the skills and competencies required by the organisation.

7.1.10 Receive assurance on the effectiveness of staff health and wellbeing programmes, including the delivery of Occupational Health services.

7.1.11 Approving the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings.

7.1.12 Receipt and review of relevant risks (including those referred from other committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those

risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required.

7.1.13 Receiving and considering issues from other Committees when appropriate and taking any necessary action.

7.1.14 Receive reports (in full or summary) from internal audits which relate to the responsibilities of the Committee.

7.1.15 Review quantitative and qualitative indicators to consider the extent to which the culture that the Trust seeks to create and sustain, embodied by the Trust Values and Behaviours, is embedded; identifying any areas where additional assurance is required.

8. Administration arrangements

8.1. The Committee will receive appropriate administrative support. Duties will include:

- preparing and circulating the agenda and papers with the Chair
- maintaining accurate records of attendance, main discussion points and decisions taken and issue necessary action logs within five working days of the meeting
- drafting minutes for circulation to the Chair within five working days of the meeting
- maintaining an electronic record of any documents discussed and / or approved and recall them to the Committee when due and filing and maintaining records of the work of the Committee

9. Relationships and reporting

9.1. The Committee will report in writing to the Board through the Committee's Chair's assurance report (produced after each Committee meeting). The report records key issues, actions and decisions and the level of assurance provided to the Board by the Committee's consideration of the relevant item. Minutes of the Committee's meetings will be produced promptly for approval at the subsequent Committee meeting. Approved minutes will be presented to the next formal Board meeting.

9.2. The Audit Committee will monitor the effectiveness of the Committee through receipt of an Annual Report, work plan and self-assessment, in accordance with best practice.

9.3. The Equality, Diversity and Inclusion Forum and No Bystanders Group will report to the People and Culture Committee by providing the notes and

actions from the meetings to the Committee and highlighting issues that require escalation.

10. Review of terms of reference

10.1. The People and Culture Committee will review the Terms of Reference annually. Any amendments required will be put before a meeting of the Trust's Board for approval.

Committee Escalation and Assurance Report

Name of Committee:	People & Culture	**Report to:**	Trust Board 5th June 2025
Date of Meeting:	21st May 2025	**Date of next meeting:**	TBC

Introduction

Inaugural meeting of this new sub-committee. Most of the discussion focussed on future business of the committee including membership and attendance, work plan/papers, cross referencing between sub-committees. Other NEDs are also members of Business and Quality Committees which we agreed would help ensure appropriate oversight of issues across the committees. The P&C Committee welcomed the Chair of the Race Equality Network, the respective Chairs of each staff network will be invited to the P&C Committee as attendees in rotation to capture the voice of these staff groups. Good conversation about how the committee hears the voice of the Trust staff and how it gains effective insight into the Trust culture.

Alert	Action

Advise

- Workforce Director provided some helpful context setting for the committee, noting that there is an external context; a NHS/system context and a LCH context which is relevant for all discussions and considerations of a diverse workforce and fostering a positive and inclusive culture.
- The Committee received a paper updating on employee relations and F2SU activity, noting individual cases arising since April or currently under management. The question of whether the F2SU Guardian should become a member of the P&C Committee, it was decided that he would be invited to be in attendance at future meetings.
- The Committee received a paper, following up on themes discussed at the last Board workshop, it was agreed that members would provide offline feedback and comments on the paper.
- The Chair of the Race Equality Network talked about the network activity and the Committee discussed how to make the most of the Network Chairs' time at P&C Committees, including what the Networks and the Trust ask of each other. Committee agreed to explore how to ensure an effective communication flow between the Committee and the Networks. Also discussed the concept of the "staff story" for future meetings.

Assurance

- Draft terms of ref presented for discussion and approval ahead of Trust Board. Some suggested amendments put forward including references to internal comms and to equity/equality.
- Committee received an update on the Trust People Strategy which will be included at all P&C Committee meetings ahead of Board. May update included a summary of strategic pillars achieved and proposed focus areas for 2025/26 as well as headlines on recent activity.

Committee Escalation and Assurance Report

- The Green Plan refresh was presented and the Committee acknowledged that this plan would be relevant for the Business Committee from a finance perspective. The paper was discussed purely in terms of staff impact. Discussed the need to engage all people across the trust and build engagement on sustainability activity and progress and empower people to embrace green initiatives.
- The Committee received a number of data sets showing aspects of people performance including health & wellbeing, equality, resourcing and development. The Committee discussed what additional data it would like to see in future meetings and areas of triangulation with other data sets, such as staff survey data mapped to BUs and services. Continuing on the data theme, the Committee was also given a subset of the Q&V pack showing the human factors data flowing from the programme. It was noted that the Business Committee Chair had escalated an item to P&C around evidence of a decline in wellbeing arising from some of the Q&V activity which was reflected in some of the staff survey comments included in the pack. The Committee was assured that action plans had been developed following the latest survey results.

Risks Discussed and New Risks Identified

- The Director of Nursing advised that the risks relevant to the P&C Committee's work were in the process of being extracted from Datix to provide a comprehensive view of people related risks across the Trust and that this paper would be available for oversight and discussion at future meetings.
- The Company Secretary advised that the P&C Committee would be responsible for assurance against two strategic risks in the BAF framework which was still being worked through, the Committee was unable to attest to assurance against the BAF at this meeting but was satisfied that no specific risks had emerged during the meeting which would be of concern in relation to assurance.

Author:	Rachel Booth
Role:	Committee Chair
Date:	23/05/25

Agenda item:	2025-26 (43)

Title of report:	Compliance with the Code of Governance

Meeting:	Trust Board Held In Public
Date:	5 June 2025

Presented by:	Helen Robinson, Company Secretary					
Prepared by:	Helen Robinson, Company Secretary					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	x

Executive Summary:	This report sets out the Trust's ongoing compliance against the requirements of the new Code of Governance which came into force on 1 April 2023.

Previously considered by:	N/A

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?	
	No	N/A	Why not/what future plans are there to include this information?	

Recommendation(s)	The Board is requested to: • Note the requirements of the Code of Governance for provider trusts, and the assurance that will be provided in due course by External Audit against the publication within the Annual Report. • Reflect on the self-assessment of the comply or explain against the statements of the Code and approve this as an accurate reflection of the Board and practices at LCH.

	• Approve the inclusion of a declaration within the Annual Report as below: *The Board recognises the importance of the Code of Governance and has undertaken a review of compliance. There have not been any contraventions of the Code but there is one area where further work is indicated to declare full compliance going forwards.* (This is highlighted amber within Schedule A).

List of Appendices:	N/A

Executive Summary

This report sets out the requirements of the Code of Governance which came into force on 1 April 2023 and reports the Trust's compliance against the standards.

Main issues for consideration

At the end of October 2022 NHS England issued the Code of Governance (the Code) for provider Trusts, which set out a series of standards based on best practice of corporate governance from the private sector and replaced the Monitor Code of Governance establish some years ago for NHS Foundation Trusts. This also reflects the developments of governance across Integrated Care Systems (ICSs). The updated Code applies to all providers – both NHS Trusts and Foundation Trusts.

The Code sets out a series of standards whereby the Trust is required to include information within the Annual Report or via a comply or explain statement (as set out within the supporting Appendix to this report) which by means of this report to public Board can also be referenced within the Annual Report. As part of the yearend processes, External Audit are required to review the Annual Report to ensure the content reflects the specified requirements.

NHS England recognises that departure from the specific provisions of the code may be justified in particular circumstances. Reasons for non-compliance with the code should be explained, with the Trust illustrating how its actual practices are consistent with the principle to which the particular provision relates. It should set out the background, provide a clear rationale and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the Trust should indicate when it expects to conform to the provision.

There is one statement, D 2.5, relating to the Trust having a policy on its purchase of non-audit services from its external auditor, for which an explanation has been provided. Although the Trust can evidence the process for appointing the external auditors through Auditor Panel and Board reports, work needs to be undertaken to develop this specific policy. However, it should be noted that the external auditors have not undertaken any non-audit work during the period of their contract with the Trust. This provision has therefore been marked as non-compliant but the intent to comply confirmed and a policy will be developed during 2025/26.

The Code, with the comply or explain statements and publication requirements within the Annual Report, although not a specific KLOE defined within the current requirements of the CQC Well-led, will be a key tool to assess corporate governance practices within the Trust.

Schedule A of the code sets out which provisions fall into which category.

Recommendations

The Board is requested to:

- Note the requirements of the Code of Governance for provider trusts, and the assurance that will be provided in due course by External Audit against the publication within the Annual Report.
- Reflect on the self-assessment of the comply or explain against the statements of the Code and approve this as an accurate reflection of the Board and practices at LCH.
- Approve the inclusion of a declaration within the Annual Report as below: *The Board recognises the importance of the Code of Governance and has undertaken a review of compliance. There have not been any contraventions of the Code but there is one area where further work is indicated to declare full compliance going forwards. (This is highlighted amber within Schedule A).*

Appendix 1

Schedule A: Disclosure of corporate governance arrangements

Trusts are required to provide a specific set of disclosures to meet the requirement of the Code of Governance. These should be submitted as part of the annual report (as set out for Foundation Trusts in the NHS foundation trust annual reporting manual and for NHS Trusts in DHSC group accounting manual.

The provisions listed below require a supporting explanation in a Trust's annual report, even in the case that the Trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

NB Blue text is only applicable to NHS Foundation Trusts

Provision	Requirement	Evidence	Comply
Section A, 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Annual Report Quality Account Third Sector Strategy	Annual Governance Statement

Section A, 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Annual Report NHS Staff Survey Quarterly Pulse surveys	Accountability Report, Annual Governance Statement, Performance Overview and Analysis Report
Section A, 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision- making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Annual Report Standards of Partnership Governance Individual Partnership arrangements	Performance Overview and Analysis Report
Section B, 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent.	Annual Report - NEDs described in Board structure	Accountability Report (Directors' Report)
Section B, 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Annual Report Minutes of Board and	Accountability Report (Directors' Report), Annual Governance Statement (Directors' attendance tables)

		Committee meetings	
Section B, 2.19	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.		N/A
Section C, 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.		N/A
Section C, 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.		N/A
Section C, 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	Annual Report Trust website – About the Board	Accountability Report (Directors' Report)

Section C, 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Mersey Internal Audit Agency Report Annual Report	Compliant. A developmental Well-led review was undertaken during 2024/25 and reference made in the Annual Governance Statement.
Section C, 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served	Annual Report Nominations and Remuneration Committee Annual Report Annual Equality, Diversity & Inclusion Report that evidences compliance with the Public Sector Equality Duty (evidenced through Business Committee and Board minutes)	Annual Governance Statement – Nominations and Remuneration Committee summary, and Equality and Diversity section

	• the gender balance of senior management and their direct reports.		
Section C, 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.		N/A
Section D, 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Annual Report Process for appointment of auditors	Annual Governance Statement

Section D, 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Annual Report	Statement of Directors' responsibilities
Section D, 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Annual Report Board Assurance Framework Process	Annual Governance Statement
Section D, 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Annual Report Audit Committee risk management reports	Annual Governance Statement
Section D, 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will	This is described in the Annual Accounts - Finance	Going Concern Statement

	continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.		
Section E, 2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings	Requirement noted - should this ever be the case this would be described in the Annual Report and Accounts	N/A

For the provisions listed below, **the basic 'comply or explain' requirement applies**. The disclosure in the annual report should therefore contain an explanation in each case where the trust has departed from the code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn. In providing an explanation for any variation from the code, the trust should aim to illustrate how its actual practices are consistent with the principles to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the trust expects to conform to the provision.

Provision	Requirement	Comply
Section A, 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.	Trust vision and values agreed for 2024/25. The Board also agreed its five strategic goals and a number of priorities that are aimed at supporting the delivery of the strategic goals. The strategic goals inform the Trust's Strategic and Operational plans. The Board receives quarterly reports on progress towards achieving its priorities. When setting its strategic priorities, the Board will take account of the ICB's strategic priorities, both at ICB and Leeds Place level.
Section A, 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	The Board regularly review performance using the Performance Brief in Board Committees and within the Board meeting to measure and monitor the quality, effectiveness and efficiency of healthcare delivery.

Section A, 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.	All executive directors and non-executive directors, through the Board sub-committees have an opportunity to receive and influence the Internal Audit Plan for areas of high risk prior to it being signed off by the Audit Committee. Should the Board require, the internal auditors can be asked to look at any areas of concern for the Board; internal auditors can be commissioned by the Audit Committee where the Board or NEDs have concerns about areas of performance. The Business Committee and the Board of Directors receives annual performance reports which show data relating to WRES and WDES.
Section A, 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	The Board has formally approved its Board sub-committee structure including the Quality Committee which receives assurance on clinical governance and quality matters. Assurances on clinical governance and clinical quality are made to the Board of Directors through reports made by the chair of the Quality Committee. The Trust produces a Quality Report which sets out progress against the Trust's quality improvement priorities.
Section A, 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear	Engagement with stakeholders is reported to Public Board via the Chief Executive's report and within the Annual General Meeting.

	understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.	
Section A, 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	The Trust has a Freedom to Speak Up Guardian (FTSUG) and FTSUG Ambassadors. The Board receives a six-monthly report from the FTSUG. There is a nominated FTSU Board Champion who meets regularly with the FTSUG.
Section A, 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.	The Trust has a Managing Conflicts of Interest Policy and Procedure which includes Standards of Business conduct. Registers are in place and available on request. Registers of Director interests are published within the Annual Report.
Section A, 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	Requirement noted. If and when applicable resignations would be reported to Board.
Section B, 2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that	Agendas for the Board are prepared by the Chair, CEO and Company Secretary.

	adequate time is available for discussion of all agenda items, in particular strategic issues.	
Section B, 2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	The Chair takes an active role in specifying the format of the information provided to directors. The Chair is clear as to the timeframe in which information should be distributed to the Board of Directors.
Section B, 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	The Chair ensures that there is effective contribution from all members of the Board, in particular the non-executive directors and the opportunity to challenge the executive directors. The Code of Conduct contains information about our values and makes reference to the Nolan Principles. The Chair allows sufficient time for discussion at Board meetings. The Board encourages its sub-committees to look at areas in detail where needed. Board and sub-committee meetings run in accordance with Trust values.
Section B, 2.4 (NHS foundation trusts only)	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	N/A

Section B, 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	The Chair of the Trust and the Chief Executive abide by the division of responsibilities as set out in the standing orders and standing financial instructions. The roles of the Chair and Chief Executive are undertaken by two different individuals. The Chair of the Trust has completed a declaration as to their independence. Whilst the Chair is required only to do this on appointment we test this (as for all other NEDs) on an annual basis. The Chair of the Trust has not previously been the Chief Executive of the Trust. The Board has identified a deputy chair and a senior independent director. The Audit Committee is not attended by the Chair of the Trust on a regular basis; however, an invitation is extended for them to attend once a year.
Section B, 2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	The Board comprises 5 non-executive directors excluding the Chair in comparison to 5 executive directors, therefore, at least half the Board comprises non-executive directors. On appointment and annually thereafter the NEDs are required to declare their independence. All the non-executive directors have been determined to be independent.
Section B, 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	This is evidenced through the annual declaration of interest forms.

Section B, 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	The Board has made a clear determination as to the membership of the committees in the agreed terms of reference. The Trust has two NEDs with clinical backgrounds, other NEDs have a diverse range of skill sets.
Section B, 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Requirement noted and included within the Terms of Reference.
Section B, 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.	The Senior Independent Director undertakes the annual appraisal of the Chair.

Section B, 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	The CEO reports directly to the Chair, with Executive Directors reporting to the CEO. Appointment of Executive Directors include the relevant NED on the interview panel and inclusion of others with the assessment centre process. Annually the CEO reports formally to the Nominations and Remuneration Committee on their appraisal meetings and objective setting with each Executive. The Chair holds a quarterly meeting with the non-executive directors as a group without the executive directors present.
Section B, 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	The expected time commitment is set out in the letter of appointment and in accepting the appointment Directors confirm that they are able to allocate sufficient time to the role.
Section B, 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	Comply – Company Secretary in post.

Section B, 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	The Board acts as a unitary Board and challenge is made by both the executive and non-executive directors. The non-executive directors will in particular challenge on the performance of the executive directors in achieving the standards, targets and measures set.
Section B, 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.	The Board acts as a unitary Board, with Executive and Non-Executive Directors sharing the same liabilities and joint responsibilities for all decisions taken by the Board. A schedule of matters reserved for the Board is in place.
Section B, 2.18	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	The Board acts as a unitary Board and challenge is made by both the executive and non-executive directors. The non-executive directors will in particular challenge on the performance of the executive directors in achieving the standards, targets and measures set.
Section B, 2.19	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.	The Board meets in public seven times per year and meets privately for Board development sessions or workshops six times per year. There are also extraordinary meetings held when required. A schedule of matters reserved for the Board is included in the standing orders and standing financial instructions, and

		this is reviewed annually by the Audit Committee and agreed by the Board to ensure it remains fit for purpose.
Section C, 2.1 (NHS foundation trusts only)	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.	Comply – use of external recruitment and adherence to recommendations for selection panel. Nominations and Remuneration Committee has received reports on succession planning.
Section C, 2.2 (NHS foundation trusts only)	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of	N/A

	both executive and nonexecutive directors, including the chair.	
Section C, 2.3 (NHS foundation trusts only)	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	N/A
Section C, 2.4 (NHS foundation trusts only)	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	N/A
Section C, 2.5 (NHS foundation trusts only)	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors.	N/A
Section C, 2.6 (NHS foundation trusts only)	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of nonexecutive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	N/A

Section C, 2.7 (NHS foundation trusts only)	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	N/A
Section C, 3.1 (NHS trusts only)	NHS England is responsible for appointing chairs and other nonexecutive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, nonexecutive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	Requirement noted – appointments conducted in accordance with this.

Section C, 4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	All new Board members are required to sign a self-attestation form. DBS checks are completed for all new Board members, and Board Member References requested where applicable. All Board members are compliant with the revised requirements in the FPPT Framework following the Kark review. This is reported to Board annually in March.
Section C, 4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.	Comply - The Trust Chair has served five years to date, with a further six years as a NED prior to that. The term ends in August 2025 and a process to recruit a new Chair will shortly commence. At present, two of the NEDs have exceeded six years in post. However, in both cases their terms have been agreed with NHS England.

Section C, 4.4 (NHS foundation trusts only)	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	N/A
Section C, 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.	Each member of the Board is subject to an annual appraisal. Each Committee of the Board produces an annual report, reporting delivery against annual work plan and objectives. The Audit Committee reviews the annual reports from Committees.
Section C, 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director	All Board members have an appraisal with agreed personal development plan.

	should engage with the process and take appropriate action where development needs are identified.	
Section C, 4.8 (NHS foundation trusts only)	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors • communicating with their member constituencies and the public and transmitting their views to the board of directors • contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.	N/A

Section C, 4.10 (NHS foundation trusts only)	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.	N/A
Section C, 4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	Requirement noted. The Nominations and Remuneration Committee undertakes succession planning for Director roles.

Section C, 4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	Comply – would adhere to this if ever required.
Section C, 5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	Induction programme and training offered to Board members.
Section C, 5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.	Comply – addressed within appraisal and mid year review processes.

Section C, 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	Comply – available to all.
Section C, 5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	Induction programme and training offered to Board members.
Section C, 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Comply – addressed within appraisal and mid year review processes.
Section C, 5.6 (NHS foundation trusts only)	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	N/A

Section C, 5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	The Chair of the Trust ensures that directors receive information in a format they require and within a timescale that will allow sufficient time to prepare for the meetings. The Chair also allows sufficient time and opportunity for clarification questions to be asked in the meeting. Directors are also encouraged to seek clarification outside of the meeting in order to assist discussion at the Board meetings. There are opportunities to input to how the reports will be presented and the information they contain.
Section C, 5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	Comply – as above.

Section C, 5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	Appropriate papers and reports are presented to the Board of Directors. The Board has an annual business cycle which sets out the standard papers that will be presented to them, and the Board can also agree to receive a report on any matter if it requires. The Board of Directors will from time-to-time ask for information it requires to allow it to carry out its role and to be assured of performance. Any member of the Board of Directors can request any item to be reported to Board meetings and may also ask for this to be looked at in more detail in the Board sub-committee structure.
Section C, 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	The Board of Directors seeks assurance directly and through its committees via assurance and escalation reports. On occasions the Board and its committees invite senior staff to provide presentations to the Board. Non-Executive Directors can request external assurance as appropriate.

Section C, 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of nonexecutive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	All directors have access to professional independent advice at the Trust's expense (including legal advice and access to auditors).
Section C, 5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	Committees are supported by the relevant executive director, senior manager/s and Trust staff.
Section C, 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	This would be explored in appraisal and mid year review and be raised as a separate issue if this was not taking place. The non-executive directors will challenge the executive directors if papers are not sufficiently detailed or clear. The non-executive directors will use their skills and experience to challenge the decisions of the executive in an appropriate and professional manner having due regard to necessary standards of care required in such a role.

Section C, 5.16 (NHS foundation trusts only)	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.	N/A
Section C, 5.17	The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	Comply – cover is renewed each year and overseen by the Company Secretary
Section D, 2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a	The Trust's Audit Committee comprises three independent non-executives and is chaired by a non-executive director with recent and relevant financial experience. The Trust Chair is not a member of the Audit Committee.

	whole should have competence relevant to the sector in which the trust operates.	
Section D, 2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee	Comply – evidenced in the Audit Cttee annual report to June Public Board each year.

	composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities.	
Section D, 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should retender its external audit at least every 10 years and in most cases more frequently than this.	The Trust's external auditors were re-appointed in 2025 following a process overseen by the Auditor Panel. There are no concerns about the performance of the current auditors and there is a high level of experience of the systems in place at the Trust.

Section D, 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	**Explain** Although the Trust can evidence the process for appointing the external auditors through Auditor Panel and Board reports, work needs to be undertaken to develop this specific policy. However, it should be noted that the external auditors have not undertaken any non-audit work during the period of their contract with the Trust. This provision has therefore been marked as non-compliant but the intent to comply confirmed and a policy will be developed during 2025/26.
Section E, 2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long term interests of the public and patients.	The Trust complies with the national guidance on VSM remuneration with respect to bonuses, and has paid these to some VSMs in some years – any decisions about this are made by the Nominations & Remuneration Committee.

	• Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	

Section E, 2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Remuneration for the Chair and NEDs set in accordance with this guidance.
Section E, 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	Has not arisen - requirement noted.
Section E, 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	Comply – should this ever be required.
Section E, 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	The Nominations and Remuneration Committee has delegated responsibility for setting all executive director remuneration, and for other senior managers not covered by the Agenda for Change terms and conditions of service. This is evidenced in the Committee's terms of reference and the Standing orders and Standing Financial Instructions.

The provisions listed below require information to be made **available to governors,** even in the case that the trust is compliant with the provision.

Provision	Requirement	Comply
Section C, 4.9 (NHS foundation trusts only)	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors.	N/A
Section C, 5.7 (NHS foundation trusts only)	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.	N/A

The provisions listed below require supporting information to be made **available to members**, even in the case that the trust is compliant with the provision.

Provision	Requirement	Comply
Section C, 2.9 (NHS foundation trusts only)	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	N/A

The provisions listed below require information to be made **publicly available,** even in the case that the trust is compliant with the provision. This requirement can be met by making supporting information available on request.

Provision	Requirement	Comply
Section B, 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.	This is outlined in the Standing orders, standing financial instructions and scheme of reservation and delegation of powers which is available on the Trust's external website.

Section C, 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	Statement on Board of Directors page on Trust's external website.
Section E, 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	The terms of reference of the Nominations and Remuneration Committee are published on Board and Committee Governance page on Trust's external website.

Agenda item:	2025-2026 (44)

Title of report:	Audit Committee Annual Report 2024/25

Meeting:	Trust Board meeting in Public
Date:	5 June 2025

Presented by:	Khalil Rehman, Chair of Audit Committee					
Prepared by:	Helen Robinson, Company Secretary					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	✓

Executive Summary:	The purpose of this report is to fulfil the annual review of the Trust's governance processes. As such a revised draft of the Audit Committee's annual report is attached for approval. The terms of reference for each committee require that the committee's chair submits an annual report which demonstrates how the committee has fulfilled its duties as delegated to it by the Board and as set out in the terms of reference and committee's work plan. This report presents the Audit Committee's annual report for 2024-25. The report provides an overview of the workings of the Committee and demonstrates that the Committee has complied with the respective terms of reference.

Previously considered by:	

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

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

Recommendation(s)	The Board is asked to: • Approve the Audit Committee's annual report.

List of Appendices:	Audit Committee TOR April 2025 V13 Draft

Audit Committee: Annual Report 2024-25

1 Introduction

1.1 This report aims to provide a summary of the Audit Committee's activities during 2024/25.

1.2 The terms of reference for the Committee require that the Committee's Chair submit an annual report, which demonstrates how the Committee has fulfilled its duties as delegated to it by the Trust's Board and as set out in the terms of reference and the Committee's work plan.

1.3 The terms of reference for the Committee were last updated for changes and approved by the Trust Board in June 2024 (version 12). A revised version of the terms of reference is attached for review by the Audit Committee. The Committee is asked to consider whether any further amendments are required to the terms of reference.

1.4 The sections below describe:

- Duties of the Committee
- Membership and attendance
- Review of Committee's activities
- Review of effectiveness
- Areas for future development

2 Background: duties of the committee

2.1 The Audit Committee is one of five committees established as sub-committees of the Trust's Board.

2.2 The Committee is well established and has been conducting a portfolio of business on behalf of the Board since the establishment of the Trust.

2.3 The Committee provides an overarching governance role and ensures that the work of other committees provides effective and relevant assurance to the Board and the Audit Committee's own scope of work.

2.4 The duties of the Committee can be categorised as follows:

- **Governance, risk management and internal control:** reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.
- **Internal audit:** ensuring that there is an effective internal audit function that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.
- **Counter fraud and security management:** ensuring satisfactory arrangements in place for countering fraud, managing security and shall review the annual plan and outcomes of work.
- **Data security and information governance:** ensuring the Trust has robust information governance processes and that it complies with National Data Security Standards.
- **External audit:** reviewing the work and findings of the appointed external auditor and considering the implications of and management's responses to their work.
- **Financial reporting and annual accounts review:** including: monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance; ensuring that systems for financial reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board; reviewing the annual statutory accounts before they are presented to the Board of Directors to determine their completeness, objectivity, integrity and accuracy and reviewing all accounting and reporting systems for reporting to the Board.
- **Standing orders, standing financial instructions and standards of business conduct**: reviewing the operation of and proposed changes to the standing orders, standing financial instructions and standards of business conduct, the constitution, codes of conduct and scheme of delegation.

2.5 The Information Governance Approval Group (formerly the Data Protection and Cyber Security Panel) is a subgroup of the Audit Committee. The Group discharges a range of duties as delegated by the Audit Committee and recorded in a Committee approved set of terms of reference. The Group is responsible for ensuring that the Trust has effective policies and management arrangements covering all aspects of information governance in line with the Trust's Information Governance Management Framework Policy. Minutes or an assurance report from the Group are received by the Audit Committee.

3 Membership and attendance

3.1 The terms of reference for the Audit Committee set out the Committee's membership, which is currently as follows:

- Three non-executive directors, including one non-executive director with significant, recent and relevant financial experience and who serves as the chair of the committee
    - Khalil Rehman (Chair)

- Richard Gladman (until 30 June 2024)
- Professor Ian Lewis
- Rachel Booth – (Associate Non-Executive Director until 30 September 2024 then Non-Executive Director from 1 October 2024)
- Lynne Mellor - (Associate Non-Executive Director from 1 November 2024)

3.2 In addition to the membership, the following participants attend meetings on a regular basis:

- Executive Director of Finance and Resources
- Company Secretary
- Internal audit representative
- External audit representative
- Counter fraud specialist

3.3 The Chief Executive attends to discuss the process for assurance that supports the annual governance statement, and the annual report and accounts.

3.4 In addition, the Chief Executive, other executive directors and senior managers may attend for discussions when the Committee is discussing areas of risk or operational management that are their responsibility.

3.5 The Committee has met formally seven times in the last 12 months and has been quorate on all occasions. In addition, there was one informal meeting. A table recording attendance is shown below.

Attendee	19 April	12 May Page turner informal	18 June	12 July	11 Oct	13 Dec	11 Mar	Total (7)
Richard Gladman (until June 2024)	√	√	√					3/3
Ian Lewis	√	√	√	√	√	√	√	7/7
Khalil Rehman	√	√	√	√	√	√	√	7/7
Rachel Booth Associate 1 April-30 September 2024. Substantive 1 October 2024	X	√	√	√	√	X	√	5/7
Lynne Mellor Associate Non-Executive Director 1 November 2024						x	√	1/2
Andrea Osborne* Interim from 5 February 2024. Substantive from 1 July 2024	√	√	√	X	√	√	√	6/7

*Executive Director in attendance

3.6 In line with its terms of reference, the Committee has had regular private meetings with auditors prior to each formal meeting.

4 Review of Committee's activities

4.1 The Audit Committee has an approved annual work plan. Topics scheduled for consideration at each meeting reflect a mix of scheduled items drawn from the work plan and occasional further items that have arisen as a result of specific issues brought to the Committee's attention from internal or external sources.

4.2 *Governance, risk management and internal control*

4.2.1 The Committee reviewed the annual governance statement for 2024-25 on 15 April 2025 prior to it being submitted for approval by the Board. In considering the statement, the Committee reviews assurances from a range of sources including the final Head of Internal Audit opinion which it expects to receive in April 2025.

4.2.2 Annual reports have been received from internal audit, counter fraud, security management, risk management and Board sub-committees during the year.

4.3 *Internal audit and counter fraud services*

4.3.1 The Audit Committee has delegated authority to ensure the trust has an effective internal audit function. Audit Yorkshire, the internal auditors provide an essential part of the trust's system of internal control.

4.3.2 The Committee reviewed and agreed an annual internal audit plan for 2024/25. Topics included a broad mix of financial, governance, operational and quality topics.

4.3.3 As the audit plan progressed, the Committee reviewed a wide-ranging portfolio of reports, considered recommendations, adopted action plans and has overseen progress. The outcome of internal audits was shared with the relevant Board committee, which provided the opportunity to consider the robustness of actions to address recommendations and the associated timescales.

4.3.4 In addition to monitoring progress of the audits, the Committee also regularly monitored progress against internal audit management recommendations and associated actions. The Committee requested and received further explanation and background on the major and moderate recommendations from the audits which have been agreed to be delivered by a certain date but not completed on time. The Committee also reviewed the robustness of the proposed actions and provided feedback.

4.3.5 The Committee closely monitored progress against the internal audit plan in an effort to avoid slippage and over running toward the end of the financial year.

4.3.6 In April 2025, the Head of Internal Audit indicated that their Head of Internal Audit Opinion based on the work carried out was likely to be reasonable assurance that there were adequate and effective management and internal

control processes to manage the achievement of the Trust's objectives. A final opinion would be presented to the Committee in June 2025.

4.4 *Counter fraud and security management*

4.4.1 The Committee received the local counter fraud annual report in July 2024 and the security management annual report in October 2024. The Committee also received a mid-year update on progress against the counter fraud plan for 2024/25, which noted local counter fraud activity, and introduced lessons learnt from fraud incidence from elsewhere.

4.5 *Data Security and Information Governance*

4.5.1 The Committee pursued evidence of compliance with data security requirements and received regular reports, which provided assurance that risks associated with data security were being adequately managed.

4.5.2 Updates in relation to information governance and level of compliance with the Data Security & Protection Toolkit were considered by the Committee in March 2025 and it was noted that the Trust may not achieve full compliance and there was a possibility that an action plan would be required for the final submission on 30 June 2025.

4.5.3 In October 2024 the Committee received a six-monthly update on the Board Assurance Framework (BAF) activity. The role of the committees that are assigned BAF strategic risks is to check that the controls are working by agreeing the sources of assurance needed, reviewing the evidence (sources of assurance) and inform the Board whether the sources of assurance indicate that those risks are being effectively controlled.

4.6 External audit

4.6.1 In June 2024, Mazar's presented their audit completion report for 2023/24. It stated that the auditors' had issued an unqualified opinion on the Trust's 2023/24 financial statements and concluded that there were no significant matters arising from their 2023/24 audit work.

4.7 *Financial reporting and annual accounts review*

4.7.1 The Committee reviewed the annual report and accounts in detail in May 2024 prior to recommending the annual report and accounts for 2023-24 to the Board for approval.

4.7.2 The Committee reviewed the Charitable Funds annual report and accounts in December 2024 prior to approval by the Charitable Funds Committee.

4.7.3 The Committee also discharged a number of further aspects of financial reporting, including: schedules of debtors and creditors, losses and special payments and overpayments and underpayments.

4.8 *Standing orders, standing financial instructions and standards of business conduct*

4.8.1 The Committee reviewed waivers to tendering procedures, the reference costs process, and the register of gifts and hospitality.

4.8.2 The Committee was advised in December 2024 that no amendments to the Trust's standing orders and standing financial instructions were proposed at the time, but a review would be undertaken once the findings from the well-led developmental review were known.

4.9 Whistleblowing

4.9.1 The Committee has not dealt with any whistleblowing issues during 2024/25.

5 Strategic Risks

5.1 During 2024-25 the Audit Committee was charged with providing assurance to the Board that one of the strategic risks was being controlled. The Committee reviewed the sources of assurance (papers) that it received against the strategic risk and determined if the sources were of sufficient variety, focus, depth and frequency to enable the Committee to form an opinion of the level of assurance the papers, when presented, would collectively provide:

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.

The Committee agreed that the sources of assurance provided over the year provided a reasonable picture of assurance for this risk.

6 Self-assessment of Committee's effectiveness 2024/25

6.1 In the March 2025 meeting the Committee was asked to consider the responses from the recent self-assessment questionnaire. Members were invited to discuss the key themes arising from the process, which included:

- What steps could be taken to allow the Committee to focus on both quality and financial assurance, and which is potentially lacking currently?
- How could the agenda be changed to reflect quality, data quality, performance targets and financial control?
- Should we establish agenda setting meetings with the Committee Chair/lead Exec and at that point agree which/if any Executive Directors should be invited to accompany specific reports?
- How could information flow between Committees be improved to support the work of this Committee?
- Should more be done to ensure the Board understands the remit of the Audit Committee and receives adequate assurance from it?

It was interesting to note that unlike other Committees, the quality, relevance and timeliness of papers was not raised as an issue this year.

7 Development

The following suggestions arose from the discussion:

- The suggestion that responsible Executive Directors attend meetings for the discussion about specific Internal Audit reports was welcomed as this would allow more robust conversations to take place about audits which had received limited assurance and also where there were delays in the implementation of recommendations.
- Some thought was needed about improving the information flow between Committees.
- The establishment of agenda setting meetings with the Committee Chair/lead Exec and Company Secretary should be taken forward.

Committee Terms of Reference

Leeds Community Healthcare NHS Trust

Audit Committee

Executive Summary:

The Audit Committee provides an overarching governance role The duties of the Committee are categorised as follows:

- Governance, risk management and internal control
- Internal audit
- Counter fraud and security management:
- External audit
- Financial reporting and annual accounts review
- Standing orders, standing financial instructions and standards of business conduct

Document History:

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Name of author:	Executive Director of Finance and Resources Company Secretary
Name of responsible committee:	Leeds Community Healthcare NHS Trust Board
Review date:	April 2026
Target audience:	Leeds Community Healthcare NHS Trust Board Audit Committee

Contents

Changes made to this version (13)
Paragraph 5.4 – reference to 15 minutes removed. Paragraph 8.1.8 Addition of 'Other external advisers may be called upon where specialist assurance is required, with the prior agreement of the Committee Chair.'. Addition of 8.7.6 Receive regular cyber security reports, including updates on cyber-related workstreams and activities.

Audit Committee
Terms of reference

1. Introduction

1.1. These terms of reference build on original work based around the Cadbury Committee and Combined Code and subsequent guidance and best practice in the private and public sector. They use the model from the NHS Audit Committee Handbook 2011 alongside sector best practice

1.2. The terms of reference reflect the particular nature of Audit Committees in the NHS and the growing role of the Committee in developing integrated governance arrangements and providing assurance that NHS bodies are well managed across the whole range of their activities.

2. Constitution

2.1. The Board has resolved to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

3. Purpose

3.1. The Committee provides an overarching governance role and ensures that the work of other committees provides effective and relevant assurance to the Board and the Audit Committee's own scope of work.

3.2. The duties of the Committee can be categorised as follows:

- Governance, risk management and internal control
- Internal audit
- Counter fraud and security management:
- External audit
- Financial reporting and annual accounts review
- Standing orders, standing financial instructions and standards of business conduct

3.3. The Committee will provide assurance to the Trust Board on all areas within its remit based on the evidence received, using standard classification, i.e

- **Substantial assurance** based on a conclusion that there is a robust system of internal control and governance in place which will deliver the Trust's corporate objectives (clinical, quality or business) and that controls and management actions are consistently applied
- **Reasonable assurance** based on a conclusion that there is a generally sound system of internal control and governance to deliver the clinical, quality or

business objectives and that controls and management actions are generally being applied. Some weakness in the design and/or application of controls and management actions put the achievement of particular objectives at risk. Improvements are required to enhance the controls to mitigate these risks.

- **Limited assurance** based on a conclusion that the design and/or application of controls and management actions are insufficient and the weaknesses put the achievement of clinical, quality or business objectives at risk. Significant improvements are required to improve the adequacy and effectiveness of the controls to mitigate these risks.
- **No assurance** based on a conclusion that there is a fundamental breakdown in or absence of controls and management actions which could result (or have resulted) in failure to achieve the clinical, quality or business objectives. Immediate action is required to improve the controls to mitigate these risks.

4. Membership

4.1. The Committee shall be appointed by the Board from amongst the non-executive directors of Leeds Community Healthcare NHS Trust and shall consist of not less than three members, one of which should have significant, recent and relevant financial experience. One of the members will be appointed Chair of the Committee by the Board.

4.2. The Chair of the Trust shall not be a member of the Committee. The Senior Independent Director may not be the Chair of the Committee but may be the Deputy Chair or a member of the Committee.

4.3. The Committee should select one of its remaining two members to be Deputy Chair.

5. Attendees

5.1. The Executive Director of Finance and Resources, Company Secretary, a representative from internal audit and a representative from external audit will normally attend meetings.

5.2. The Chief Executive will be invited to attend and should discuss at least annually with the Audit Committee the process for assurance that supports the annual governance statement. The Chief Executive should also attend when the Committee is discussing the annual report and accounts.

5.3. The Chief Executive, other executive directors and senior managers will be invited to attend for discussions when the Committee is discussing areas of risk or operation that are their responsibility.

5.4. The external and internal auditors will be invited to a private meeting with the Audit Committee Chair and members at the beginning of each Audit Committee meeting.

6. Meetings and quorum

6.1. The Chair will preside at all meetings. In extraordinary circumstances, where the Chair cannot attend, the Deputy Chair shall preside.

6.2. A quorum shall be two members of the Committee. If the Committee is not quorate the meeting may be postponed at the discretion of the Chair. If the meeting does take place and is not quorate, no decision shall be made at that meeting and such matters must be deferred until the next quorate meeting.

6.3. Meetings shall be held not less than four times a year. The external auditors or Head of Internal Audit may request additional meetings, through the Chair of the Committee, if they consider that one is necessary.

6.4. Members are expected to attend all meetings.

6.5. If any member has a pecuniary interest in any matter and is present at the meeting at which the matter is under discussion, he or she will declare that interest as early as possible and will not participate in the discussions. The Chair will have the power to request that member to withdraw until the Audit Committee's consideration has been completed.

6.6. The Chair of the Committee and one of the other members, in consultation together, may also act on urgent matters arising between meetings of the Committee in accordance with the Scheme of delegation and the Procedure for emergency powers and urgent decisions (Chief Executive and Chair's actions and Committee urgent matters). Any such action will be reported to the next meeting and be recorded in the minutes of that meeting.

6.7 Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

7. Authority

7.1. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

7.2. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7.3. The Committee's delegated decision making will be in accordance with the Trust's scheme of delegation as approved by the Board.

7.4. The Committee is authorised by the Board to establish such sub-groups (duly constituted and operating within approved terms of reference) as it deems necessary to discharge responsibilities of the Committee. The Committee will receive minutes from the sub-group, receive papers on any matters escalated to the Committee and periodically review the effectiveness of the sub-group in discharging its delegated responsibilities. The sub-group currently constituted is:

- Information Governance Approval Group

8. Duties

The Audit Committee will provide an overarching governance role and review the work of other governance committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. The duties of the Committee can be categorised as below.

8.1. Governance, risk management and internal control

8.1.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the organisation's activities that supports the achievement of the organisation's objectives.

8.1.2. The Committee will review the adequacy and effectiveness of:

- The Trust's general risk management structures, processes and responsibilities including all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of strategic risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to fraud and corruption as required by the NHS Counter Fraud Authority

8.1.3. The Committee will ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance.

8.1.4. The Committee will review the Board Assurance Framework's sources of assurance for strategic risks assigned to the committee, for appropriateness, independence, and frequency, and evaluate whether these can effectively evidence that the controls are working.

8.1.5 Review Board Assurance Framework assurance activity and assess whether the assurance process is being effectively applied.

8.1.6. The Committee will ensure that appropriate governance is in place to ensure that the Trust can comply with its statutory duties relating to information governance.

8.1.7. In addition, the Committee will be the custodian of the Board and sub-committee annual effectiveness process and the review of the adequacy of the governance of the Board sub-committees and their reporting

groups. This will include the receipt of annual self-assessments and reports.

8.1.8. In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions but it will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control. Other external advisers may be called upon where specialist assurance is required, with the prior agreement of the Committee Chair. The Committee will use an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

8.2. Internal audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation or dismissal
- Review and approval of the internal audit strategy, annual audit plan and more detailed organisation as identified in the assurance framework
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Considering the performance of internal audit and undertake an annual review of the effectiveness of internal audit
- Approval of the appointment and termination of the Head of Internal Audit and/or the internal audit service

8.3. External audit

The Committee shall review the work and findings of the external auditor and consider the implications of and management's responses to their work. This will be achieved by:

- Consideration of the appointment of the external auditors, in line with regulations as far as the rules governing the appointment (discharged through establishment of an auditor panel).
- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

8.4. Financial reporting and annual accounts review

The Committee shall:

8.4.6. Monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

8.4.7. Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board

8.4.8. Review schedules of debtors and creditors balances over six months old and over £5,000 and require explanations and action plans

8.4.9. Review, at least annually, all losses and special payments

8.4.10. Review the annual statutory accounts before they are presented to the Board to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes
- Areas where judgement has been exercised
- Adherence to accounting policies and practices
- Explanation of estimates or provisions having material effect
- The schedule of losses and special payments
- Any unadjusted statements
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved
- The letter of representation
- Qualitative aspects of financial reporting.

8.4.11. Review the annual report before it is submitted to the Board to determine completeness, objectivity, integrity and accuracy.

8.4.12. Review all accounting and reporting systems for reporting to the Board including in respect of budgetary control.

8.4.13. Approve the investment policy (as applicable).

8.4.14. Approve the treasury management policy (as applicable).

8.5. Standing orders, standing financial instructions and standards of business conduct

The Committee shall:

8.5.6. Review, on behalf of the Board, the operation of and proposed changes to the standing orders, standing financial instructions and scheme of delegation.

8.5.7. Receive a report on, and review, all instances of waivers to standing orders.

8.5.8. Receive reports on any non-compliance with standing orders and standing financial instructions and any justification for non-compliance and the circumstances around the non-compliance.

8.6. Counter fraud

The Committee shall:

8.6.1 Satisfy itself that the Trust has adequate arrangements in place for countering fraud

8.6.2 Review the annual plan and outcomes of counter fraud work and receive an annual report from the local counter fraud specialist

8.7 Information Governance

The Committee shall:

8.7.1 Receive escalation reports (including significant data breach incidents) as required and minutes from the Information Governance Approval Group.

8.7.2 Receive notification of any significant data security risks (scoring high or extreme) and review controls and mitigating actions in order to provide assurance to the Board.

8.7.3 Provide assurance to the Board that the Trust is compliant with relevant legislation and national guidance.

8.7.4 Review the Data Security and Protection Toolkit prior to submission.

8.7.5 Receive the Information Governance Approval Group's annual report and review and approve proposed changes to the Group's terms of reference as appropriate.

8.7.6 Receive regular cyber security reports, including updates on cyber-related workstreams and activities.

8.8 Other matters

The Committee shall:

- Review any reported incident of fraud, corruption or possible breach of ethical standards or legal or statutory requirements that has a significant impact on the Trust's published financial accounts or reputation.

- Investigate any matter within its terms of reference, having the right of access to any information relating to the particular matter under investigation.
- Receive an annual report from the local security management specialist on the effectiveness of security management arrangements within the Trust.
- Review at least annually, hospitality and sponsorship registers.
- Review at least annually, a register of contracts for services held by the Trust.

8.8. The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where there are implications for the governance of the organisation. The Committee will, wherever it feels necessary, seek reports and assurances from directors and managers focussing on the over-arching systems of integrated governance, risk management and internal control and their effectiveness.

9. Administrative arrangements

9.1 The Committee will receive appropriate administrative support. Duties will include:

- preparing and circulating the agenda and papers
- maintaining accurate records of attendance, main discussion points and decisions taken and issue necessary action logs within five working days of the meeting
- drafting minutes for circulation to the Chair within five working days of the meeting
- maintaining an electronic record of any documents discussed and / or approved and recall them to the Committee when due and filing and maintaining records of the work of the Committee

10. Reporting

10.1 The minutes of Audit Committee meetings will be formally recorded for approval at the subsequent Committee meeting prior to being submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

10.2 The Committee will report in writing to the Board through the Committee's Chair's assurance report (produced after each Committee meeting). The report records key issues, actions and decisions and the level of assurance provided to the Board by the Committee's consideration of the relevant item.

10.3 The Committee will report to the Board annually on its work in support of the annual governance statement.

10.4 As part of the annual report, the Committee will identify specific areas where the Committee has made important positive differences to the governance of the Trust.

10.5 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board.

10.6 The Audit Committee will monitor the effectiveness of the Committee and report this through receipt of an annual report which, once approved, is also presented to the Board.

10.7 The Audit Committee will review the effectiveness of such sub-groups as established by the Committee.

11. Review of terms of reference

11.1 This document will be reviewed annually or sooner if agreed by the Audit Committee or Trust Board.

11.2 Any amended Terms of Reference will be agreed by the Audit Committee for recommendation to a subsequent meeting of the Trust Board for its approval.

Agenda item:	2025-26 (45)

Title of report:	Significant Risks and Risk Assurance Report

Meeting:	Trust Board Held In Public
Date:	5 June 2025

Presented by:	Lynsey Yeomans, Executive Director of Nursing, Allied Health Professionals and Quality					
Prepared by:	Anne Ellis, Risk Manager					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	This report is part of the governance processes supporting risk management in that it provides information about the effectiveness of the risk management processes and the controls that are in place to manage the Trust's most significant risks. There are two risks on the Trust risk register that have a score of 15 or more (extreme). There are a total of 13 risks scoring 12 (very high).

Previously considered by:	Trust Leadership Team 28 May 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?	N/A

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

List of Appendices:	No appendices

Significant Risks and Risk Assurance Report

1. Introduction

1.1 The risk register report provides the Board with an overview of the Trust's material risks currently scoring 15 and above (extreme risks). It describes and analyses all risk movement, the risk profile, themes and risk activity since the last risk register report was received by the Board (April 2025).

1.2 The Board's role in scrutinising risk is to maintain a focus on those risks scoring 15 or above (extreme risks) and to be aware of risks currently scoring 12 (high risks).

1.3 The report seeks to reassure the Board that there is a robust process in place in the Trust for managing risk. Themes identified from the risk register have been aligned with BAF strategic risks to advise the Board of potential weaknesses in the control of strategic risks, where further action may be warranted.

2. Risk register movement

2.1 The table below summarises the movement of risk since the last risk register report.

	Current	Previous (April)
Total Open Risks	82	76
Risks Scoring 15 or above	2	2
New Risks	10	10
Closed Risks	4	2
Risk Score Increasing	5	0
Risk Score Decreasing	5	7

2.2 The following updates have been provided for risks scoring 15 (extreme) or above since the last risk register report.

Risk	Risk Type	Current Score	Previous Score (April 2025)
1048: Mind Mate SPA increasing backlog of referrals (system-wide risk).	**Operational**	**15**	**15**
LCH is in the process of working with Northpoint to deliver the SPA from September 2025. Work is ongoing to understand workforce needs and comms to the wider system. In the meantime, work is ongoing to maintain the right level of staffing to manage risk in the referrals coming into SPA. Digital solutions are being reviewed along with an options appraisal for different EPR systems that might support better triage and onward referral. (update 29/4/25)			
1179: Impact/Management of Neurodevelopmental Assessment Waiting List.	**Operational**	**15**	**15**

Risk	Risk Type	Current Score	Previous Score (April 2025)
Assessments for preschool children on the waiting list have been outsourced using 2024/5 underspend which means there are no preschool waiters over 18 weeks waiting for an autism assessment. Locum paediatricians brought in via the Access LCH initiative has allowed for some sole assessor piloting. School age ND is being considered as part of a Northpoint package transfer with MindMate SPA. (update 29/4/25)			

3. Summary of risks scoring 12 (high)

3.1 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by the Board is not limited to extreme risks. Senior managers are sighted on services where the quality of care or service sustainability is at risk; many of these aspects of the Trust's business being reflected in risks recorded as 'high' and particularly those scored at 12. The Quality and Business Committees have oversight of risks categorised as 'high' (risks scored at 8 – 12).

3.2 The table below details risks currently scoring 12 (high risks)

ID	Description	Rating (current)	Rating (previous)	Status
877	Risk of reduced quality of patient care in neighbourhood teams (NT) due to an imbalance of capacity and demand	12	12	Unchanged
954	Diabetes Service waiting times	12	9	Increased
957	Increase in demand for the adult speech and language therapy service.	12	9	Increased
1042	Provision of equipment from Leeds Community Equipment Services (LCES)	12	12	Unchanged
1125	National supply issues with enteral feeding supplies by Nutricia	12	9	Increased
1187	Insufficient IT Resilience leading to the risk of extended outages of the infrastructure	12	12	Unchanged
1198	Impact of ADHD medication waiting list	12	12	Unchanged
1221	Likelihood of a cyber attack	12	12	Unchanged
1250	Staff shortage Domestic Services (cleaners)	12	6	Increased
1294	Clinical Governance Team capacity and resilience due to vacancies and absence	12	12	Unchanged
1295	Primary Care Industrial Action	12	12	Unchanged
1303	Out of compliance mobile phones (Operating system not compliant with CE+)	12		New

ID	Description	Rating (current)	Rating (previous)	Status
1313	Climate Adaptability Resilience Planning	12		New

Seven of the risks scoring 12 have not changed since the last report (static), the target dates to reduce these risks by are not yet due.

None of the risks have been static for over 12 months. When risk scores have been static for over 12 months, they are flagged to TLT and the Quality and Business Committees. Static risks are also included in the scope of the Risk Management Group (RMG). The next meeting of the RMG will be held on 31 July 2025.

4. Risk profile – all risks

4.1 The total number of risks on the risk register is currently 82. Of these there are 24 clinical risks and 58 operational risks. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	1	1	0	0	2
4 - Major	0	6	5	0	0	13
3 - Moderate	3	12	27	8	1	49
2 - Minor	1	7	4	3	1	16
1 - Negligible	1	0	1	0	0	2
Total	5	26	38	11	2	82

5. Risks by theme and correlation with Board Assurance Framework strategic risks

5.1. During May, the Trust Leadership Team have redrafted the Board Assurance Framework (BAF) strategic risks based on the discussions held at the Board workshop on 1 May 2025. For this report the high risks (scoring 8 and above) on the risk register have been themed where possible according to the nature of the hazard and the effect of the risk and then linked to the proposed strategic risks for 2025/26. This themed approach gives a holistic view of the risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance on the management of risk.

5.2 Themes within the current risk register are as follows:

Theme One: Patient Safety	
The strongest theme across the whole risk register is patient safety due to staff working outside their role, lack of incident management, workload	The BAF strategic risks directly linked to patient safety are: BAF Risk 1 Failure to deliver quality of care and improvements

pressures, capacity to complete clinical supervision, clinically essential training, and safe operation of medical devices. Specifically, Eighteen risks relate to patient safety [1]	BAF Risk 2 Failure to respond to increasing demand for services BAF Risk 3 Failure to comply with legislative and regulatory requirements
Theme Two: Demand for Services	
The second strongest risk theme is demand for services exceeding capacity, due to an increase in service demand and high numbers of referrals[2].	The BAF strategic risks directly linked to demand for services are: BAF Risk 2 Failure to respond to increasing demand for services BAF Risk 6 Failure to effectively engage staff and leaders as well as to support their health and well-being in the current context BAF Risk 7 Failure to reduce inequalities experienced by the population we serve
Theme Three: Compliance with Standards/Legislation	
There is also a risk theme relating to compliance with standards/ legislation[3] This includes health and safety, compliance with information governance and cyber security, and business continuity and emergency planning.	The BAF strategic risks directly linked to compliance with standards / legislation is: BAF Risk 3 Failure to comply with legislative and regulatory requirements BAF Risk 5 Failure to maintain business continuity
Theme Four: Quality and Value Programme	
Three risks relate to the Quality and Value programme and concern the impact on staff and patients and the risk that financial balance is not achieved.[4]	The BAF strategic risks directly linked to the Quality and Value programme are: BAF Risk 1 Failure to deliver high-quality, equitable care and continuous improvement BAF Risk 4 Failure to deliver financial sustainability
Theme Five: Digital Transformation	
Three risks relate to digital transformation, including capacity to deliver transformation[5]	The BAF strategic risk directly linked to digital transformation are: BAF Risk 1 Failure to deliver quality of care and improvements BAF Risk 2 Failure to respond to increasing demand for services

[1] Risks: 877, 1109, 1125, 1139, 1168, 1169, 1187, 1196, 1231, 1278, 1284, 1285, 1295, 1298, 1301, 1307, 1308, 1309
[2] Risks: 772, 874, 913, 954, 957, 994, 1015, 1042, 1048, 1098, 1179, 1198, 1311
[3] Risks: 902, 1089, 1178, 1204, 1206, 1221, 1223, 1242, 1243, 1250, 1294, 1296, 1303, 1313
[4] Risks: 1227, 1228, 1318

[5] Risks: 1217, 1220, 1224

6. Impact

6.1 Risk and assurance

This report is part of the governance processes supporting risk management in that it provides information about the effectiveness of the risk management processes and the controls that are in place to manage the Trust's most significant risks.

7. Next steps

Risks will continue to be managed in accordance with the risk management policy and procedure and the Board will receive an update report at the meeting to be held on 4th September 2025.

8. Recommendations

The Board is recommended to:

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

Author: Anne Ellis, Risk Manager
Date written: 20 May 2025

Agenda item:	2025-2026 (46i)

Title of report:	Board Assurance Framework – Update on Review Process for 2025-26

Meeting:	Trust Board Held In Public
Date:	5 June 2025

Presented by:	Helen Robinson, Company Secretary					
Prepared by:	Helen Robinson, Company Secretary					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	✓

Executive Summary:	It is a requirement for all Trust Boards to ensure there is an effective process in place to identify, understand, address, and monitor risks. This includes the requirement to have a Board Assurance Framework (BAF) that sets out the risks to the strategic plan by bringing together in a single place all the relevant information on the risks to the Board being able to deliver the organisation's objectives. This report summarises the process undertaken to review the BAF in readiness for the 25/26 financial year, and shares the draft Strategic Risks with the Board for review and approval.

Previously considered by:	

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

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

Recommendation(s)	The Board is asked to: • Note the process for review of the strategic risks, gaps in controls and sources of assurance for 2025/26. • Approve the Strategic Risks for 2025/26 or make recommendations for further amends.

List of Appendices:	Appendix 1 – 2025_26_BAF Summary of Proposed Strategic Risks for Board

Board Assurance Framework – Update on Review Process for 2025/26

1. Introduction

1.1 The contents of the Board Assurance Framework (BAF) require an annual review to ensure the strategic risks remain relevant. At its workshop on 1 May 2025, the Trust Board discussed the Trust's strategic framework for 2025/26. As a result of this discussion, it was agreed that the number of Strategic Risks would be reduced from 10 to 8, and the remaining 8 would be updated to reflect the current local, regional and national context.

2. Review of Strategic Risks

2.1 During May, the Trust Leadership Team have redrafted the Strategic Risks based on the discussions held at the Board workshop. The proposed Strategic Risks for 2025/26 are attached to this report for review and approval by Trust Board. Table 2 in the appendix shows the revised Strategic Risks mapped against the Trust's five Strategic Goals.

3. Next Steps

2.1 Once the Strategic Risks have been agreed, a full review of the BAF will be undertaken by the Trust Leadership Team during June 2025 to ensure that it is reflective of the associated high-level risks aligned to the Trust's strategic objectives.

2.2 All strategic risks will continue to be assigned to an Executive Director and to a Committee(s) for oversight. Controls to manage the new or amended strategic risks and the required sources of assurance will be drafted in conjunction with the assigned Executive Directors. The Executive Directors will then maintain oversight of the strategic risks assigned to them and will review these risks on a quarterly basis to continually evaluate the effectiveness of the controls in place that are managing the risk and identify any gaps that require further action.

2.3 The revised draft BAF will be shared at the July meetings of the Business, Quality and Audit Committees, and the Committees will be asked to review and agree their proposed risks and sources of assurance.

2.4 The Trust's risk appetite will be reviewed at the Board workshop on 10 July 2025 and this information will be fed into the revised BAF.

3 Ongoing Assurance

3.1 The Committees will continue to be required to report to the Trust Board following each meeting via the Committee Chair's assurance reports on whether the risks to the success of its strategic objectives are being managed effectively.

3.2 The BAF will subsequently be reviewed on a quarterly basis and the outcome shared with the Board.

4 Recommendations

The Board is recommended to:

- Note the process for review of the strategic risks, gaps in controls and sources of assurance for 2025/26.
- Approve the Strategic Risks for 2025/26 or make recommendations for further amends.

Helen Robinson
Company Secretary

19 May 2025

Summary of Proposed Strategic Risks as of 22 May 2025

Ref	24/25 Strategic Risk	Proposed Strategic Risk for 25/26	Lead Director(s)	Current Score (May 2025)	Target Score (2025/26)	Key changes agreed at the Board workshop on 1 May 2025
1	**Failure to deliver quality of care and improvements:** If the Trust fails to identify and deliver quality care and improvement in an equitable way, then services may be unsafe or ineffective leading to an increased risk of patient harm.	**Failure to deliver high-quality, equitable care and continuous improvement:** If the Trust fails to identify, deliver, and sustain high-quality care, promote learning, and drive continuous improvement in an equitable manner, there is an increased risk of unsafe or ineffective services. This may lead to preventable harm, poor patient outcomes, and a diminished patient experience.	Exec Director of Nursing and AHPs	TBC	TBC	Reworded to reflect: - - learning and continuous improvement - - reference to patient experience - - include preventable harm
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.	**Failure to respond to increasing demand for services:** If the Trust fails to respond to population growth and presentation, and the consequent increase in demand, then the impact will be potential harm to patients, inability to strengthen equity of access, additional pressure on staff, financial consequences and reputational damage.	Exec Director of Operations	TBC	TBC	Reworded to reflect: - both managing and responding to demand - to include reference to future growth
3	**Failure to implement the digital strategy.** If the Trust fails to implement the agreed digital strategy, then, services could be inefficient, software may be vulnerable, and the impact will be delays in caring for patients and less than optimum quality of care.					SR removed, to be replaced with a digital risk domain in the risk appetite.
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.	**Failure to comply with legislative and regulatory requirements:** If the Trust is not compliant with legislation and does not adhere to relevant national frameworks, including embedding the findings from the Well-led developmental review, there is a risk to patient safety, governance, and performance which could impact on staff and patient safety.	Chief Executive	TBC	TBC	Reworded to reflect: - needed reference to well-led - to include patient and staff safety - owner to change from TLT to the CEO - to also be aligned to the People & Culture Committee (in addition to QC and BC)
5	**Failure to deliver financial sustainability:** There is a risk that the Trust will not be financially sustainable which will jeopardise delivery of all our strategic goals and priorities.	**Failure to deliver financial sustainability:** If the Trust cannot manage its resources effectively, ensuring that spending does not exceed available funding, then this could jeopardise delivery of our strategic goals and priorities.	Executive Director of Finance and Resources	TBC	TBC	Reworded to reflect: - Format of 'if…then…'
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.					SR removed, part of SR 5 for 25/26 rather than a separate SR
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.	**Failure to maintain business continuity:** If the Trust is unable to maintain business continuity in the event of significant disruption, then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.	Exec Director of Operations	TBC	TBC	Reworded to reflect: - reference to cyber security removed from title - owner to just be Exec Dir of Operations rather than shared with DoF
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.	**Failure to effectively engage staff and leaders as well as to support their health and well-being in the current context:** If the Trust is unable to effectively engage and motivate all staff including leaders through impactful health and well-being interventions, a focus on inclusion, excellent leadership development and support in the current challenging context, then the impact will be a reduction in the overall quality of	Director(s) of Workforce	TBC	TBC	Reworded to reflect: - thriving in the current climate: resilience/diversity/retention/engagement/morale/wellbeing - to be aligned to the People & Culture Committee

Ref	24/25 Strategic Risk	Proposed Strategic Risk for 25/26	Lead Director(s)	Current Score (May 2025)	Target Score (2025/26)	Key changes agreed at the Board workshop on 1 May 2025
		care and staff wellbeing and a possible misalignment with the key objectives of the Trust.				
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.	**Failure to reduce inequalities experienced by the population we serve:** If the Trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently delivering unfair access or care and exacerbating inequalities in health outcomes within some cohorts of the population.	Medical Director	TBC	TBC	Reworded to reflect: - removing 'preventing harm' - including staff or stakeholders - replacing 'patients' with 'population'
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.	**Failure to collaborate:** If the Trust fails to develop further partnerships across a wide range of stakeholder organisations, then the system will not provide integrated service offers, achieve the best outcomes for citizens, or optimise business development opportunities.	Chief Executive	TBC	TBC	Reworded to reflect: - include partnerships - being outward-looking - collaboration with other sectors, not just NHS

Proposed Strategic Risks for 2025/26 mapped to the Strategic Goals

Strategic Goals	1. Work with communities to deliver personalised care	2. Use our resources wisely and efficiently both in the short and longer term	3. Enable our workforce to thrive and deliver the best possible care	4. Collaborating with partners to enable people to live better lives
	5. To embed equity in all that we do			
Strategic Risks	**Risk 1 Failure to deliver high-quality, equitable care and continuous improvement:** If the Trust fails to identify, deliver, and sustain high-quality care, promote learning, and drive continuous improvement in an equitable manner, there is an increased risk of unsafe or ineffective services. This may lead to preventable harm, poor patient outcomes, and a diminished patient experience. **Quality Committee** (Exec Director of Nursing and AHPs)	**Risk 4 Failure to deliver financial sustainability:** If the Trust cannot manage its resources effectively, ensuring that spending does not exceed available funding, then this could jeopardise delivery of our strategic goals and priorities. **Business Committee** (Executive Director of Finance and Resources)	**Risk 6 Failure to effectively engage staff and leaders as well as to support their health and well-being in the current context:** If the Trust is unable to effectively engage and motivate all staff including leaders through impactful health and well-being interventions, a focus on inclusion, excellent leadership development and support in the current challenging context, then the impact will be a reduction in the overall quality of care and staff wellbeing and a possible misalignment with the key objectives of the Trust. **People and Culture Committee** (Director(s) of Workforce)	**Risk 8 Failure to collaborate.** If the Trust fails to develop further partnerships across a wide range of stakeholder organisations, then the system will not provide integrated service offers, achieve the best outcomes for citizens, or optimise business development opportunities. **Business Committee** (Chief Executive)
	Risk 2 Failure to respond to increasing demand for services: If the Trust fails to respond to population growth and presentation, and the consequent increase in demand, then the impact will be potential harm to patients, inability to strengthen equity of access, additional pressure on staff, financial consequences and reputational damage. **Quality Committee and Business Committee** (Exec Director of Operations)			
		Risk 5 Failure to maintain business continuity: If the Trust is unable to maintain business continuity in the event of significant disruption, then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss. **Business and Audit Committees** (Exec Director of Operations)		
	Risk 3 Failure to comply with legislative and regulatory requirements. If the Trust is not compliant with legislation and does not adhere to relevant national frameworks, including embedding the findings from the Well-led developmental review, there is a risk to patient safety, governance, and performance which could impact on staff and patient safety. **Quality, Business and People and Culture Committees, and Trust Board.** (Chief Executive)			
	Risk 7 Failure to reduce inequalities experienced by the population we serve: If the Trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently delivering unfair access or care and exacerbating inequalities in health outcomes within some cohorts of the population. **Quality Committee / Trust Board** (Medical Director)			

Agenda item:	2025-26 (47)

Title of report:	Register of Sealings March – May 2025

Meeting:	Trust Board Meeting Held In Public
Date:	5 June 2025

Presented by:	Sara Munro, Chief Executive					
Prepared by:	Helen Robinson, Company Secretary					
Purpose: (Please tick ONE box only)	Assurance	x	Discussion		Approval	

Executive Summary:	In line with the Trust's standing orders, the Chief Executive is required to maintain a register recording the use of the Trust's corporate seal. The corporate seal had been used once in March 2025 and once in April 2025 and a copy of a section of the register is presented to the Board.

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)	The Board is asked to note the use of the corporate seal.

List of Appendices:	N/A

Register of affixing of corporate seal and signatories to legal documents

OCCASION	PARTIES INVOLVED	DOCUMENT APPROVED & SEAL ATTESTED BY	DATE
Lease (engrossment): Part of Ground and First Floors St George's Centre, Middleton	Leeds Community Healthcare Leeds City Council	Director of Workforce and Deputy Director of Nursing and Quality	27.03.2025
Deed of Surrender – Part of Ground and First Floors St George's Centre, Middleton	Leeds Community Healthcare Leeds City Council	Executive Director of Operations and Deputy Director of Nursing and Quality	09.04.2025

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (49i)

Title of report:	Quality Strategy Implementation Plan 2024-2027

Meeting:	Trust Board Held In Public
Date:	5 June 2025

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

Executive Summary:	This paper provides the detail of the proposed operational implementation and therefore outcome measures to underpin the 2024-2027 quality strategy principles that were agreed by Board in December 2024. The intention has been to align this activity with the following improvement areas to support a consistent streamlined approach to how we demonstrate effective quality across the Trust: • MIAA well-led feedback (development theme 4: Quality & Quality Improvement) • Revision of effectiveness measures across the Trust (output from previous Quality Committee / QAIG workshop) and how this dovetail in to the Trust Performance Brief and Trust priority for high quality care. The document reflects our five previously agreed principles, under the domains of quality (safe, effective and patient experience) and the plan for years 1, 2 and 3 of this 3 year strategy.

Previously considered by:	Quality Committee

Link to strategic goals:	Work with communities to deliver personalised care	X
	Use our resources wisely and efficiently	X

(Please tick any applicable)	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?	
	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 implementation plan and measures for the Trust Quality Strategy

List of Appendices:	

NHS
Leeds Community Healthcare
NHS Trust

Quality Strategy Implementation Plan 2024-2027

Gil Ramsden, December 2024. Version 6.0

Quality Strategy Priorities
2024-2027

NHS
Leeds Community Healthcare
NHS Trust

Our priorities:

Safe
Ensuring patient safety is our top priority

Effective
Providing care that achieves the best care and outcomes for people

Experience
Creating a positive experience to improve how satisfied people are when engaging with our services

We will gather feedback from service users to track progress towards our priorities so that we can stay on track and improve care.

What we will do to continually improve:

We will improve patient safety by fully implementing the National Patient Safety Strategy.

We will improve outcomes by delivering evidence-based care and comply with statutory and regulatory standards

We will improve patient experience by fully implementing the Parliamentary and Health Service Ombudsman (PHSO) standards and building partnerships with the people who use our services

Priorities for implementation:

Safety: Ensuring patient safety is our top priority

1. We will regularly ask if people felt safe in our care and we will use that insight to improve our care for everyone through the implementation of PSIRF

Effectiveness: Providing care that achieves the best care and outcomes for people

2. Our processes will fully comply with Care Quality Commission (CQC) standards.

3. Feedback will inform and improve safety and quality of care

Experience: Creating a positive experience to improve how satisfied people are when engaging with our services

4. We will implement PHSO standards to ensure effective feedback

5. We will consider quality & equity in our quality and safety improvements

SAFE

SAFE: Key Priority 1 (Aligns with CQC Quality statements 3, 4. 10, 14, 15, 16, 17, 18, 20, 21, 23, 25, 26, 27, 29, 32, 33)

We will regularly ask if people felt safe in our care and we will use that insight to improve our care for everyone through the implementation of PSIRF

	Strategic action:		What we will do:		Evidence:
Year 1 1 April 2024 – 31 March 2025	1.1.1	We will have trained and supported six LCH Patient Safety Specialists (PSS), in line with the national patient safety syllabus (level 3 and 4 training). They will have undertaken specific training, allowing them to focus on broad patient safety initiatives, conduct investigations, analyse data, and implement systemic improvements across LCH	1.1.1	Our patient safety specialists will use investigation tools to promote system thinking and quality improvement methodology in 100% of their reports and will explain the process to colleagues involved in the learning process, so more colleagues can take the learning methodology forward.	**1.1.1**: Certificate of completion for all Patient Safety Specialists The safety team will hold a database of all investigations and those involved in investigations
			1.1.1b	100% patient safety incident investigations (PSII) will be conducted in line with the Patient Safety Incident Response Framework (PSIRF) and the LCH Patient Safety Incident Response Plan (PSIRP), ensuring a thorough and balanced response that prioritises learning and indicates how services will evidence / measure improvement.	**1.1.1** **6** monthly report to Board for learning from PSII
	1.1.2	We will ensure that we offer adequate support to colleagues affected by patient safety incidents, and we will be able to demonstrate our 'just culture'*	1.1.2	80% of staff involved in incidents will be issued with verbal information explaining where to access support, including via the LCH Health and Wellbeing Hub . A survey will be developed to monitor impact and identify ongoing process improvements, so we know our staff are as well supported as possible	**1.1.2:** Feedback will inform improvements
	1.1.3	We will report our incidents to the national Learn from Patient Safety Events (LFPSE) system.	1.1.3	LCH will contribute to the LFPSE system national system to improve learning and help make care safer	**1.1.3**: Exception reporting through Performance Brief if LFPSE uploads do not take place
	1.1.4	We will ensure all appropriate system-wide patient safety incidents led by LCH are carried out as a joint investigation with partners to ensure patients / families receive one single joined up response.	1.1.4	We will demonstrate collaboration through joint investigations in 100% appropriate situations, and the lessons leaned will be shared across the organisation / system in a way that is transparent to patients / families	**1.1.4** Multi-agency Patient Safety Incident Investigations will be evident
	1.1.5	We will develop dashboards for use by the Chairs of the Trust Improvement Groups which align to the LCH Patient Safety Incident Reporting Plan (PSIRP)	1.1.5	Review of the data visualised in the dashboard will reveal trends in activity supporting the interrogation of the information to be understood and remedial action implemented when necessary.	1.1.5: Information and assurance will be reflected in reports to QAIG and by exception to Quality Committee

SAFE	Key Priority 1 continued			
	Year 2 1 April 2025 – 31 March 2026	1.2.1	We will support and train 15 Learning Response Leads (LRLs) to work on improving patient safety, recognising and addressing unwarranted variation in care delivery in line with the national patient safety syllabus. They will lead investigations, gather views from patients, families, and staff, analyse data to find trends and areas to improve, make changes to prevent future incidents via a range of internal processes by involving the Patient Safety Specialists (PSS).	1.2.1 Our 15 LRLs will have successfully completed selected Health Services Safety Investigations Body (HSSIB) modules, in line with national requirements and availability of the national training) 1.2.1b We will be able to demonstrate a greater understanding of the gap between 'work-as-done' and 'work-as-imagined' and the improvement activity needed to reduce this. 1.2.1c 100% of staff involved in incidents will be issued with written information explaining where to access support, including via the LCH Health and Wellbeing Hub. A survey will be developed to monitor impact and identify ongoing process improvements, so we know our staff are as well supported as possible 1.2.1d We will ask for feedback from all service users who have been involved in a patient safety incident to ensure we focus on the things that are important for our service users when investigating and improving safety	**1.2.1**: Safety Team maintain a record of training undertaken and refresher dates **1.2.1b**: This will be reflected in the improvement activity undertaken in the Trust. **1.2.1c**: Feedback will inform improvements **1.2.1d**: Feedback will inform improvements
		1.2.2	We will contribute to the development of the 'LCH Learns' platform for all staff and then work with our Patient Safety Partners (PSP) to extend the learning platform to our patients, carers and stakeholders when it is appropriate	1.2.2 The PSP journey will have been shared at Board and we will have: • Evidence of co-produced system learning to reduce harm and innovate through new ways of working together. • Evidence of patient, staff and others involved in patient safety incidents throughout our quality and safety assurance process. It will be inclusive of people with any protected characteristics • The Patient Safety Partner Policy PL390 will be updated in partnership with our Patient Safety Partners by March 2025 • The Trust's quarterly Patient Safety Summit will be formalised within the Trust governance structure for sharing learning from a variety of feedback sources	**1.2.2**: Learning and improvements to be captured in PSII reports to Board Those involved in investigations will be captured in PSII reports signed off by Trust Executive Directors Policy to be accessible on Trust intranet Evidence of shared learning at safety summit and feedback in to Trust governance processes as agreed
	Year 3 1 April 2026 – 31 March 2027	1.3.1	We will make a strategic shift from learning reactively when failures and errors have already occurred (Safety-I) to include learning from things that are going well (Safety-II)	[illegible] system thinking and human factors science, to identify meaningful quality and safety improvements.	**1.3.1**: Evidence in PSIIs of application of new learning tools

Effective (CQC)

Key Priority 2 (Applies to CQC Quality Statements 1, 2, 4, 5, 6, 9, 10,11, 13, 20, 23, 25, 26, 31)

Our process will fully comply with Care Quality Commission standards (CQC).
By working closely with you, we will ensure that our care not only meets regulatory standards but is also truly responsive to your needs and preferences

	Strategic action:	What we will do:	Evidence
Year 1 1 April 2024 – 31 March 2025	2.1.1 We will use our Quality Challenge Plus (QC+) programme to align with the CQC Single Assessment Framework (SAF). This includes the self-assessment process to gather evidence around the CQC quality statements which be uploaded directly to the CQC portal, once this is available to the Trust.	2.1.1 • Pilot of the proposed approach to be undertaken by 0-19 PHINS, Neuro Rehab, CAMHS and Diabetes to establish training requirements and documentation required. • Services will pilot the evidence matrix to ensure all key questions are answered • 100% of LCH clinical services will have a named SAF Champion by March 2025 who is responsible for: i. Attending CQC SAF internal training and keeping their team / service fully informed of change. ii. Ensuring the QC+ self assessment form and improvement plan is completed accurately, on time and shared with CET.	**2.1.1** Feedback from pilot to inform final model **2.1.1i**: CET will maintain a record of training undertaken, achieved and refresher dates **2.1.1ii:** CET maintain a database of all QC+ assessments and outcomes
	2.1.2 To explore the potential for a digitalised Clinical Effectiveness Plan to provide an automated approach to oversight - enabling identification of non-compliance and to inform reporting and assurance	2.1.2 CET to initiate and track progress of conversations re concept of digital clinical effectiveness plan by February 2025, setting realistic milestones for design and analysis. Start to engage with commercial teams / procurement. Aim to have consensus within 6 months to enable development of business case.	**2.1.2:** Business case to be developed in year 2 after scoping in year 1

Effective (CQC)	Key Priority 2				
	Year 2 1 April 2025 – 31 March 2026	2.2.1	We will implement our approach to the CQC Single Assessment Framework	2.2.1	• Develop a training programme for SAF Champions to disseminate; attendance at service-level training will be monitored against a plan developed by March 2025. • All Services will be prepared and ready to action their live submissions to the CQC Provider Portal • Work with SAF Champions and ensure that as an organisation we are developing key principles • Services will collect examples of evidence according to each of the five key questions • Services will use the evidence matrix to ensure all key questions are answered • The CET will ensure Director approval then upload to the CQC portal.	**2.2.1** CET will maintain a record of training undertaken, achieved and refresher dates CET will maintain a database CQC portal will be in active use
		2.2.2	To progress concept of digital clinical effectiveness plan including engagement with commercial teams / procurement if agreement to proceed with business case and funding approved.	2.2.2	• Develop a business case and take it through standard processes including sourcing potential funding • If successful, monitor progress of procurement conversations / commercial teams involved, ensuring successful agreements and smooth processes or escalating delays / concerns. • If a digital solution is not possible, work with the Chief Information Officer (CIO) and Business Intelligence Team (BI) to create a good oversight tool (compliance spreadsheet) until a case for change is developed / funding made available.	**2.2.2:** See priority 2.4

Effective (CQC)	Key Priority 2				
	Year 3 01 April 2026 – 31 March 2027	2.3.1	We will improve the processes implemented in year 1 and 2 in relation to the SAF, embedding 5 principles to demonstrate effectiveness: • Is it person-centred? • Is it inclusive? • Is it evidence-based? • Is it ambitious? • Is it affordable?	2.3.1	• The Trust will seek to improve ways of gathering and using data, including the impact of patient experience, working in conjunction with Patient Experience Team (PET). • The Trust will continue involving patients, families, and staff in learning and improvements and include this feedback in the evaluation of the 2024-27 strategy and inform the successor document • Seek and apply learning from SAF design process and incidents to continually improve. • Service level CQC Champions will ensure service-level sign-off • Service-level CQC Champions will quality assure all evidence and save in the specified secure drive and confirm action complete via the CET	**2.3.1**: Evidence of feedback informing quality and safety improvements Case studies to be added to patient information hub
		2.3.2	Implement the most cost and clinically effective compliance tool, making the most use of innovations and funding streams available	2.3.2	• Deliver on the implementation of any successful business case	**2.3.2**:Clinical effectiveness compliance tool to be operationalised

Effective

Key Priority 3 (Applies to CQC Quality Statements: 2, 3, 4, 5, 7, 9, 10, 11, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 31, 32, 33)

Feedback will inform and improve safety and quality of care

Strategic actions			What will we do:		Where to find the evidence:
Year 1 1 April 2024 – 31 March 2025	2.4.1	We will make patient data more available and accessible so we can improve how we address equity and health outcomes	2.4.1	A series of follow-up meetings is booked between the Chief Information Officer, Business Intelligence Manager and other strategic leads following an initial QAIG and QC workshop (held 28/10/2024 with a range of strategic colleagues). They will enable LCH to reach a consensus on which metrics are deemed most appropriate to measure effectiveness across the organisation.	**2.4.1:** Agreed metrics to be included in Trust reporting
	2.4.2	We will strengthen our commitment to evidence-based practice by addressing consistency in the ways we work, especially regarding compliance with local and national requirements in: • Clinical audit • Clinical and corporate policies • Equity and Quality Impact assessments (EQIAs) • National Institute for Health and Care Excellence (NICE) This will ensure clinical effectiveness remains a priority throughout LCH as we deliver against the quality and value programme and other innovations and transformation across the Trust	2.4.2	We will move from efficiency-based metrics to outcome and impact-based metrics to demonstrate learning and improvement aligned with the Trust key performance indicators	**2.4.2**: These metrics will be reported on within appropriate existing reports to Board +/- sub-committees Relevant audit against Trust policies reflected in annual clinical audit plan and reported to QAIG and Quality Committee through existing corporate governance arrangements

Effective	**Key Priority 3**				
	Year 2 1 April 2025 – 31 March 2026	2.5.1	We will ensure the Trust uses all feedback to evidence +/- improve quality care	2.5.1	• Ensure feedback is gathered from all service user groups so all voices are heard • 100% services will fully align their 2025/26 clinical audit plan to LCH vision, priorities and risks. • CET will undertake quality assurance checks on at least 25% clinical audits and policies to assess adherence to agree processes. • Provide advanced training for staff to enhance their skills in applying evidence-based practices across teams; develop broader training networks where they add value • Use analytics and research skills to review patient level data so we can better understand how protected characteristics affect patient experience and outcomes and identify health disparities for redress. • Collaborate with university research partners to learn how to deliver and monitor effective, evidence-based care when there is insufficient evidence or assurance	**2.5.1:** Board and relevant sub-committees to be informed about feedback through existing reporting structure 2025/26 clinical audit plan to reflect the alignment to Trust priorities and risks Increase in research activity to be reflected in information shared to QAIG The Trust will ensure they are able to identify and report on the number of staff trained on how to use data analysis and interpretation tools / methodology

Effective	**Key Priority 3**				
	Year 3 1 April 2026 – 31 March 2027	2.6.1	We will ensure the Trust has embedded and sustained a range of robust feedback mechanisms to gather insights and information to assess if the workplace supports effective care delivery	2.6.1	• Use agreed clinical effectiveness measures (including FFT) to provide assurance around new ways of working / service improvement • Ensure that the improvements made re priority 2 in years 1 and 2 are sustained and become part of LCH culture. • Introduce new evidence-based practices and innovative solutions to enhance clinical effectiveness, using insight from audit / EQIAs undertaken between 2024 - 2026 • Measure the impact of initiatives introduced in priority 1 and 2 to track and report key outcomes. • Share best practices and success stories within LCH and with external local / regional / national stakeholders via social media and appropriate networks, including the Future Collaboration Platform. • Seek recognition for achievements through awards and certifications.	2.6.1: Reporting of quality metrics through governance reports Quality Committee workplan Quality account to note local and national awards

Key Priority 4 (Applies to CQC Quality Statements: 1, 2, 3, 4, 5, 6, 7, 8, 13, 14, 18, 23, 24, 27, 29, 31, 32, 33, 34)

We will implement PHSO standards to ensure effective feedback

	Strategic action:		How will we do it:		Evidence:
Experience **Year 1 1 April 2024 – 31 March 2025**	3.1.1	We will have identified required improvements to embed the 2023 Parliamentary Health Service Ombudsman Standards into our Patient Experience / Complaint pathway	3.1.1	By March 2025 we will have: • Completed a PHSO benchmarking exercise to inform required improvements • Identified training requirements • Sought staff and patient feedback to inform improvements • Improve how we analyse 3C information collected via the incident management platform to align with Leeds priorities • Undertake a baseline audit of compliance with complaint processes to inform improvements • Develop a process to gather patient feedback regarding complaints process, from all patients and understand whether we receive feedback from all patient groups • Utilise a new dashboard for monitoring trends and themes	**3.1.1:** Improvement plan to be in place and evidence of progression, reported through Patient Experience reports and clinical fellow activity

Key Priority 4

Experience **Year 2 1 April 2025 – 31 March 2026**	3.2.1	We will further embed the 2023 Parliamentary Health Service Ombudsman Standards into our Patient Experience / Complaint pathway	3.2.1	• We will deliver training and act on feedback • We will ensure resources are easily accessible for staff • 100% of complainants will be offered a resolution meeting • 100% of staff participating in resolution meetings will be asked for their feedback • We will ensure and evidence that we are communicating with people in line with their communication needs and that we record and act on reasonable adjustments	**3.2.1:** Metrics will be reported through governance processes Feedback will inform improvements

Key Priority 4

Experience **Year 3 1 April 2026 – 31 March 2027**	3.3.1	We will confirm we are a mature organisation that has significant and proven development in handling complaints and is an exemplar site.	3.3.1	We will be able to demonstrate evidence of shared decision making in line with NICE guidance	**3.3.1:** Evidence of compliance with PHSO standards

Experience (EQIA)

Key Priority 5 (Applies to CQC Quality Statements: 1, 2, 3, 4, 14, 15, 16, 18, 19, 23, 24, 25, 28, 29, 31, 32, 33)

We will consider quality & equity in our quality and safety improvements

Strategic actions:			What will we do:		Evidence:
Year 1 1 April 2024 – 31 March 2025	3.7.1	• We will establish and evolve the EQIA process across the Trust	3.7.1	• We will deliver training which will include the need for system-level engagement and patient inclusion. • Case studies and impact statements will be added to our intranet and extranet so all can see the impact we are making. • We will develop a dashboard, using data extracted from the incident management platform (Datix) to evidence progress and highlight where attention should be focused next	**3.7.1:** EQIA dashboard to provide updates to Quality & Value Board

Experience (EQIA)

Key Priority 5

Year 2 1 April 2025 – 31 March 2026	3.8.1	• We will consider if and how we can improve digitalisation of the EQIA process in embedding the processes as business as usual	3.8.1	• We will incorporate patient feedback at every opportunity, and we will invite Patient Safety Partners to join our EQIA panel, to strengthen the patient voice • We will request feedback from services 12m after their EQIA has become embedded as business as usual, to identify unexpected learning and impact that can be shared with others • We will set up a system to get feedback from service users to see if they notice any changes in the services we provide, as required by Section 242 of the National Health Service Act 2006	3.7.1: Evidence of appropriate involvement through EQIAs, signed off by Executive Directors

Experience (EQIA)

Key Priority 5

Year 3 1 April 2026– 31 March 2027	3.9.1	• We will audit and evidence the Trusts approach to equality and quality in care delivery changes	3.9.1		

Leeds Community Healthcare NHS Trust

Agenda item
2025-26
(50)

Public Board workplan 2024-26
Version 11: 23 05 2025

TOPIC	Frequency	Lead officer	BAF Strategic Risk	7 June 2024	19 June 2024- Annual Report and Accounts only	3 September 2024	4 October 2024	6 December 2024	6 February 2025	1 April 2025	5 June 2025	25 June 2025- Annual Report and Accounts only	4 September 2025	2 October 2025	4 December 2025	5 February 2026
STANDING ITEMS																
Declaration of interests (table from Declare)	every meeting (from April 2024)	cs	N/A	X	X	X	X	X	X	X	X	X	X	X	X	X
Minutes of previous meeting	every meeting	CS	N/A	X		X	X	X	X	X	X		X	X	X	X
Action log	every meeting	CS	N/A	X		X	X	X	X	X	X		X	X	X	X
Board workplan	every meeting	CS	N/A	X		X	X	X	X	X	X	X	X	X	X	X
Patient story	every meeting	EDN&AHPS	N/A	X		X	X	X	X	X	X		X	X	X	X
STRATEGY AND PARTNERSHIPS																
Chief Executive's report	every meeting	CE	All	X		X	X	X	X	X	X		X	X	X	X
System flow (part of CE report from Sept 2024)	every meeting	EDO	SR 10	X												
Operational Plan (Trust) priorities (for the coming year) for approval	Annual April	EDFR	SR 6,8							X						
Operational Plan (Trust priorities) update	3x year (Feb, June and Oct)	EDFR/EDN&AHPS	SR 6,8	X			Deferred to December 2024 X	X	Deferred June end of year update X		X -end of year update			X		X
Third Sector Strategy	2x year (Feb and Sept)	EDO	SR 10			X			Deferred for this meeting				X			X
Estate Strategy	2xyear (April and Oct)	EDFR	SR 6				X -Blue box Deferred				X -Blue box				X -Blue box	
Digital, Data and Technology Strategy	2x year (Sept and Feb)	EDFR	SR 3,6	Deferred to Oct 2024			X	X					X			X
Business Development Strategy (Private Item from April 2025)	2xyear (April and Oct)	EDO				X -Blue box Deferred										
Business Intelligence Strategy -part of Digital Strategy September 2024	2x year (Feb and Sept)	EDFR				X -Blue box Deferred										
Learning and Developement Strategy	annual	EDN&AHPS	SR 1							Deferred X -Blue box						
Patient Safety Strategy Implementation Update	Final report to Board Dec 24	EDN&AHPS	SR 1,2,4				X Deferred to December 2024	X Final update report								
Health Equity Strategy	Annual (Sept)	EMD	SR1,9			X							X			
Quality Strategy	2xyear(June and December)	EDN&AHPS	SR 1,4	X - Blue box item				X - Blue box item			X - Blue box item				X - Blue box item	
People Headlines and Strategy update	3x year (Feb, June and Oct)	DW	SR 4,8	X			X		X		X			X		X
Research and Development Strategy	annual	EMD				X										
QUALITY AND SAFETY																
Quality Committee Chair's Assurance Report	every meeting	CS	SR 1,2,3,4	X		X	X	X	X	X	X	X	X	X	X	X
Quality account	annual	EDN&AHPS	SR 1	X							Taken in Private Session X	X Final sign off				
Mortality reports	4x year (June plus annual report, September, December and February)	EMD	SR 1,4	X				X -Blue box	X		X +Q4 and Annual Report		X		X	X
Patient safety (including patient safety incident investigations) update report	2 x year (April and October)	EDN&AHPS	SR 2,4				X -Blue box			X -Blue box				X -Blue box		
Patient experience: complaints and concerns report	2 x year (Feb and Sept)	EDN&AHPS	SR 1,2			X			X				X			X
Infection prevention control assurance framework	2x year(April and October)	EDN&AHPS	SR 1,4				X -Blue box			X -Blue box				X -Blue box		
Infection prevention control annual report	annual (Sept)	EDN&AHPS	SR 1			X							X			
Care Quality Commission inspection reports	as required	EMD	All													
Safeguarding -annual report	annual	EDN&AHPS	SR 1,4			X							X			
FINANCE PERFORMANCE AND SUSTAINABILITY																
Business Committee Chair's Assurance Report	every meeting	CS	SR 2,3,4,5,6,7,8	X		X	X	X	X	X	X		X	X	X	X
Audit Committee Chair's Assurance Report	as required	CS	SR7	X		X		X	X	X	X		X		X	X
Charitable Funds Committee Update Report	2x year (June and Dec)	EDN&AHPS	N/A								X			X		
Emergency Preparedness, Resilience & Response Statement of Compliance	(December/ June Annual Report)	EDO	SR2,7					X			X				X	
Emergency Preparedness, Resilience & Response Policies	annual	EDO	SR2,7					X							X	
Charitable Funds Committee Chair's Assurance Report	4 x year (April, Sept, Oct and Feb)	EDN&AHPS	N/A			X	X		X							X
Performance Brief	every meeting	EDFR	SR 1,2,3,4,7,8,10	X		X	X	X	X	X	X		X	X	X	X
Performance brief: High Level Performance Indicators for inclusion in the performance brief	annual	EDFR	SR 1,2,3,4,7,8,10							Taken as part of Board Workshop March 2025						
Financial Plan	annual									X						
Annual report	annual	EDFR	All		X							X				
Annual accounts	annual	EDFR	SR 5		X							X				
Letter of representation (ISA 260)	annual	EDFR	N/A		X							X				
Audit opinion (Internal)	annual	EDFR	N/A		X							X				
Green Plan	2x year (June and Dec)	EDO	SR 4,6	x				X -Blue box			Deferred			X		
WORFORCE																
Staff survey	annual	DW	SR 8							X						
Safe staffing report	2 x year (Feb and Sept)	EDN&AHPS	SR 2,8			X			X				X			X
Freedom to speak up report	2 x year (Feb and Sept)	FTSUG	SR 8			X +Annual Report			X				X Annual report			X
Guardian for safe working hours report	4 x year (April, June, Sept, Dec)	GoSWH	SR 8	X + Annual Report		X		X		X	X		X plus 2024-25 Annual Report		X	
Medical Director's annual report	annual	EMD	SR 4			X -deferred to Oct 2024	X						X			
Professional registration: Nursing and Allied Health Professions	annual	EDN&AHPS	SR 4			X							X			
WDES and WRES -annual report and action plan	annual	DW	SR 8,9				X							X		
GOVERNANCE AND WELL LED																
Well-led framework	2x year (April and Oct)	CEO	N/A							X				X		
Code of Governance Compliance	annual	CEO	N/A								X					
Audit Committee annual report inlcluding Committee terms of reference review	annual	CS	N/A	X							X					
Standing orders/standing financial instruction	annual	CS	N/A					Deferrred to be reviewed by Audit Committee prior to Board following well led review								
Going concern statement	annual	EDFR	N/A							X						
Declarations of interest/fit and proper persons test	annual	CS	N/A							X						
Register of sealings	As required (from February 2025)	CS	SR 5	X None for this meeting		X None for this meeting		X None for this meeting	X		X					
Significant risks and risk assurance report	every meeting	CS	All	X		X	X	X	X		X		X	X	X	X
Board Assurance Framework -quarterly update report	Apr, June,Sept and Dec	CS	All	X			X	X		X	X		X		X	X
Board Assurance Framework -process update (July Audit Committee)	annual	CS	All			X - Blue box item							X - Blue box item			
Risk appetite statement	annual	CS	All							Deferred to June 2025	Deferred Board Workshop July 2025					
Management of Risk Policy & Procedure (3 yearly)	(Next due for review in Oct 2025)	CS	All													
Board Members Service Visits Report	3xyear (June, October,February) from June 2024	CE	N/A	x First Report			X		Deferred		Deferred			X		X
Business Continuity Management Policy	as required	EDO	SR 2,7													
Policy for the Development and Management of Policies (3 yearly)	(Next due for review Jan 2026)	EDN&AHPS	N/A													
Health and Safety Annual Plan	annual	EDFR	SR 4			X - Blue box item							X - Blue box item			
Health & Safety Policy (3 yearly)	(Next due for review Feb 2026)	EDFR	SR 4													
Senior Information Risk Officer - Annual Report	annual	EDFR	SR 4,7							X						X
FOR INFORMATION																

Key

CE	Chief Executive
EDFR	Executive Director of Finance and Resources
EDN	Executive Director of Nursing
EDO	Executive Director of Operations
EMD	Executive Medical Director
DW	Director of Workforce
CELs	Committees' Executive Leads
CS	Company Secretary