Bundle Public Board Meeting 4 September 2025

Agenda
Final Agenda Public_Board_Meeting_4 September_2025

1 09:00 - Welcome, Introductions And Apologies

2 Declarations Of Interest

3 Questions From Members Of The Public

4 Minutes Of Previous Meeting Action Log And Matters Arising

4.a Minutes Of The Meetings Held On: •5 June 2025 •25 June 2025 (Extraordinary Meeting) •10 July 2025 (Extraordinary Meeting)
Item 4ai Draft Public Board Minutes 5 June 2025
Item 4aii Draft Public Board minutes extrordinary meeting 25 June 2025
Item 4aiii Draft Public Board Minutes extraordinary meeting 10 July 2025

4.b Action Log
Item 4b Public Board Action log 4 September 2025

5 09:10 - Patient's Story: Hannah House

6 09:30 - Interim Chief Executive's Report
Item 6 Chief Executive's Report - September 2025

7 09:40 - Winter Planning 2025-26 - Including Board Assurance Statement 2025/26
Item 7i Winter Plan Board Assurance Cover Sheet - September 2025
Item 7ii LCH Winter Plan - September 2025
Item 7iii Appendix Winter Plan Board Assurance Statement - September 2025

8 09:45 - Health Equity Strategy
Item 8 Board equity update Aug 2025 v3

9 10:00 - Quality Committee Chair's Assurance Report: 29 July 2025 •Including Safe Staffing Report (for information)
Item 9i Chairs assurance report - Quality Committee July 2025_Amended 4 09 2025
Item 9ii Safe staffing report

10 10:15 - Business Committee Chair's Assurance Reports: 29 May 2025, 25 June 2025 and 30 July 2025
Item 10i Business Committee Chairs assurance report 28 May 2025
Item 10ii Business Committee Chairs Assurance Report 25 June 2025
Item 10iii Business Committee Chairs Assurance Report 30 July 2025 Final

11 10:25 - Audit Committee Chair's Assurance Report: 8 July 2025
Item 11 Audit Committee Chair's Assurance Report July 2025

12 10:30 - Charitable Funds Chair's Assurance Report: 1 July 2025
Item 12 Charitable Funds Committee Chair Assurance Report July 2025

13 10:35 - Performance Report
Item 13i Cover paper - Performance Brief_Board Jul25
Item 13ii BOARD Performance Brief - Q1 & June 2025-26 (July Finance)

14 11:05 - Guardian Of Safe Working Hours: •Quarter 1 2025/26 •Annual Report 2024/25
Item 14i Cover paper - GoSWH- Quarter1 report Sep 2025 v2
Item 14ii GoSWH Annual report June 25

15 11:15 - Annual Medical Director's Report 2024/25- For Approval reviewed by Quality Committee July 2025
Item 15i Annual Medical Directors Report 24-25 Board 4th September 2025 Final

Item 15ii Annual Medical Directors Report 2024-25
Annex-A-Professional-standards-framework-for-quality-assurance-and-improvement - For QC and Board 24-25

16 11:20 - Significant Risks and Risk Assurance Report •Risk Appetite Statement
Item 16i Board Significant Risks report 040925
Item 16ii Appendix 1 Risk_Appetite_Statement_2025_26

17 11:30 - Board Assurance Framework – Quarterly Update
Item 17i Board Assurance Framework Quarterly update Sep 25 Cover
Item 17ii 2025_26_BAF_June_2025

18 11:40 - Changes To Non-Executive Director Roles and Responsibilities
Item 18 NED roles and responsibilities Sep 2025

19 11:45 - Any Other Business: Questions On Blue Box Items And Close

20 Blue Box Item: Workplan - for noting
Item 20 Public Board workplan 2024-26 v3 28 08 2025

Leeds Community Healthcare NHS Trust

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

Date 4 September 2025
Time 9.00am -11.50am
Chair Helen Thomson DL, Acting Chair

AGENDA			Paper
2025-26 1	9.00	**Welcome, Introductions and Apologies** *(Acting Chair)*	**N**
STANDING ITEMS			
2025-26 2	9.05	**Declarations Of Interest** *(Acting Chair)*	**N**
2025-26 3		**Questions From Members Of The Public**	**N**
2025-26 4		**Minutes Of Previous Meetings, Action Log And Matters Arising** *(Acting Chair)* *For approval*	
4a		Minutes of the meetings held on: • 5 June 2025 • 25 June 2025 (Extraordinary Meeting) • 10 July 2025 (Extraordinary Meeting)	**Y**
4b		Action Log	**Y**
2025-26 5	9.10	**Patient Story: Hannah House** *(Lynsey Ure)*	**N**
STRATEGY AND PARTNERSHIPS			
2025-26 6	9.30	**Interim Chief Executive's Report** *(Dr Sara Munro)*	**Y**
2025-26 7	9.40	**Winter Planning 2025-26 – Including Board Assurance Statement** *(Sam Prince)*	**Y**
2025-26 8	9.45	**Health Equity Strategy** *(Dr Ruth Burnett)*	**Y**
QUALITY AND SAFETY			
2025-26 9	10.00	**Quality Committee Chair's Assurance Report:** 29 July 2025 *(Acting Chair)* • **Including Safe Staffing Report** (for information)	**Y**
BREAK			
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2025-26 10	10.15	**Business Committee Chair's Assurance Reports:** 29 May 2025, 25 June 2025 and 30 July 2025 *(Lynne Mellor)*	**Y**
2025-26 11	10.25	**Audit Committee Chair's Assurance Report:** 8 July 2025 *(Khalil Rehman)*	**Y**
2025-26 12	10.30	**Charitable Funds Chair's Assurance Report:** 1 July 2025 *(Alison Lowe)*	**Y**
2025-26 13	10.35	**Performance Report** *(Andrea Osborne)*	**Y**

WORKFORCE			
2025-26 14	11.05	**Guardian Of Safe Working Hours:** • **Quarter 1 2025/26** • **Annual Report 2024/25** *(Dr Nallapetta Nagashree)*	**Y**
2025-26 15	11.15	**Annual Medical Director's Report 2024/25- For Approval** reviewed by Quality Committee July 2025 *(Dr Ruth Burnett)*	**Y**
GOVERNANCE AND WELL LED			
2025-26 16	11.20	**Significant Risks And Risk Assurance Report** • Risk Appetite Statement *(Lynsey Ure)*	**Y**
2025-26 17	11.30	**Board Assurance Framework – Quarterly Update** *(Dr Sara Munro)*	**Y**
2025-26 18	11.40	**Changes To Non-Executive Director Roles And Responsibilities** *(Acting Chair)*	**Y**
CLOSING BUSINESS			
2025-26 19	11.45	**Any Other Business. Questions On Blue Box Items And Close** (Acting 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 Acting Chair will invite questions on any of these items under Item 19.

***Blue Box**		
2025-26 20	**Workplan – to note**	**Y**

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (4ai)

Title of report:	Minutes Trust Board Meeting Held in Public: 5 June 2025

Meeting:	Trust Board Meeting Held in Public
Date:	4 September 2025

Presented by:	Acting 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
	Dr Sara Munro	Interim Chief Executive
	Rachel Booth (RB)	Non-Executive Director
	Dr Ruth Burnett	Executive Medical Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Alison Lowe OBE (AL)	Non-Executive Director
	Lynne Mellor (LM)	Associate Non-Executive Director
	Andrea Osborne	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Laura Smith	Director of People, Organisational Development (OD) and System Development (LS)
	Helen Thomson Deputy Lieutenant (DL) (HT)	Non-Executive Director
	Lynsey Yeomans	Executive Director of Nursing and Allied Health Professionals (AHPs)
Apologies:	Jenny Allen	Director of People, Organisational Development (OD) and System Development (JA)
	Khalil Rehman (KR)	Non-Executive Director
In attendance:	Jodie Collins	Charitable Funds Administrator (Item 37)
	Dr. Nagashree Nallapeta,	Guardian of Safe Working Hours (Item 40)
	Helen Robinson	Company Secretary
Minutes:	Liz Thornton	Board Administrator
Observers:	None present	
Members of the public:	None present	

Item 2025-26 (25)

Discussion points:

Welcome introduction, apologies, and preliminary business.

The Trust Chair opened the Board meeting and welcomed members and attendees. He particularly welcomed Dr Sara Munro to her first meeting as Interim Chief Executive of the Trust and Jodie Collins who was attending to speak about the work of the Trust's Charity.

Before formal business began the Trust Chair invited Alison Unsworth, Front of House Administrator at Seacroft Clinic to provide a brief overview of the services provided at the Clinic.

Apologies

Apologies for absence were received from Non-Executive Director (KR) and Director of People, Organisational Development (OD) and System Development (JA).

Chair's Opening Remarks

He said that this was a time of major change, and the Trust had already faced the challenge by:

- Rationalising its business to manage costs down whilst maintaining high standards of performance and delivery.
- Shaped and developed partnerships – particularly with fellow trusts and with the local authorities in order to improve the Trust's offer.
- Sustained an organisation with positive values and where patient care was the primary focus.

Next steps would be about influencing the future.

Item 2025-26 (26)

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 (27)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2025-26 (28)

Discussion points:

Minutes of the last meeting, matters arising and action log

a) Minutes of the meeting held on 1 April 2025

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

b) Action log

One action on the log: 2025-26 (6) was considered and agreed as completed for closure.

There were no other actions or matters arising to address at this meeting.

Item 2025-26 (29)

Patient Story Item

This item was withdrawn due to short notice unavailability of the patient.

2025-26 (30)

Discussion points:

Chief Executive's report

The Interim Chief Executive presented the report which focussed on:

- National and Regional NHS
- Quality and Value Programme

- Business Unit Updates
- Education Update

The Interim Chief Executive referred to the recent announcement that Richard Barker CBE would oversee the abolition of NHS England and the merger of its functions into the Department of Health and Social Care and the publication of a timescale for completion of the process.

Regionally the West Yorkshire Integrated Care Board (ICB) had submitted a proposed new structure to NHS England on 30 May 2025. A Transition Board had been established to oversee the process which would include regional and local representation. The appointment of the new ICB Chair had been paused.

The Executive Director of Finance and Resources reported that notwithstanding the improvements to financial plans that many organisations had been able to make, across the West Yorkshire system there remained a planning gap of £33million. This would require a collective system effort to deliver. Over recent weeks, Chief Financial Officers/Directors of Finance across the 11 statutory NHS organisations in West Yorkshire had been working together to agree a process for how the system improvement value could be fairly and appropriately distributed across organisations and place, which had resulted in an improvement target of £5.2million (0.3%) being allocated to Leeds place. Discussions regarding how this would be delivered across the four statutory organisations remained ongoing.

Non-Executive Director (IL) referred to the independent review by Attain on the community service offer across West Yorkshire, and queried when the report would be available and whether the outcomes would overlap with the Leeds Place Review. The Interim Chief Executive stated that a first draft of the report was expected by mid-June.

The Trust Chair suggested that a summary of the headlines from the report should be circulated to Board members.

Action: A summary of the headlines from the Attain review on the West Yorkshire Community Services offer to be circulated to Board members.

Responsible Officer: Interim Chief Executive.

Outcome: the Board
- received and noted the report.

Item 2025-26 (31)

Discussion points:

Trust Priorities 2024-25 End Of Year Report

The Executive Director of Finance and Resources presented the report which provided a year end update on progress on the Trust Priorities for 2024-25.

The Board reviewed the report and noted the progress made in 2024-25.

Non-Executive Director (IL) commented on the success of the Enhance Model in the Neighbourhood Teams with the highest levels of deprivation and encouraged directors to try and exert more influence on system partners to agree to an increase in funding to ensure further roll out.

Associate Non-Executive Director (LM) suggested that the Trust should take the opportunity to communicate the significant number of excellent achievements in the report externally via social media platforms.

Outcome: the Board
- noted the report.

Item 2025-26 (32)

Discussion points:

People Headlines and Strategy Update

The Director of People, OD, and System Development (LS) presented the paper which provided the Committee with information on the key headlines linked to the Trust's People Directorate portfolio. The paper had been reviewed by the People and Culture Committee on 21 May 2025.

The Board noted the updated focus the Directorate would consider against each of the seven pillars of the Trust's current Workforce Strategy.

Non-Executive Director (AL) referred to the Trust's priority that 18% of the workforce should be of a Black, Asian & Minority Ethnic background by 2028 and she queried whether the impact of the Quality and Value Programme was being tracked in relation to this. The Director of People, OD and System Development said that the Trust was making reasonable progress in this area and confirmed that it was a focus for monitoring within the Quality and Value data.

Non-Executive Director (IL) noted that turnover rates had dropped and asked whether there were any risks associated with this. The Director of People, OD and System Development said that turnover rates between 10% and 12% were within the tolerance level to retain stability whilst bringing in fresh talent and ideas. She said that rates were beginning to rise above 10%.

Outcome: the Board

- Noted the Workforce Headlines presented in the report.
- Noted the progress achieved in pursuit of the target measures set out in the Trust's current Workforce Strategy.
- Noted that the People and Culture Committee would receive this report prior to its presentation to the Board.

Item 2025-26 (33)

Discussion points

Quality Committee Chairs Assurance Report – 27 May 2025

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

- The Committee had reviewed and approved the 2025/26 the clinical audit plan to ensure it reflected clinical and safety priorities organisationally.
- End of year Trust priority report had been reviewed and recommended for approval by the Board on 5 June 2025.
- A draft of the Quality Account 2024/25 had been reviewed and it was agreed to make further amendments based on collective comments. Sign off would take place at the extraordinary Trust Board meeting on 25 June 2025.
- Quality & Value Programme –the Committee received the Quarter 4 report for the 2024/25 programme and plans for 2025/26.
- Safeguarding Internal Audit Sudden Unexpected Infant Death – The Committee was pleased to note an excellent level of assurance from the internal audit report and thanked the team for their hard work.

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 (34)

Discussion points:

Mortality Reports Quarter 4 and Annual Report 2024/25

The Executive Medical Director presented the reports which had been considered in detail by the Quality Committee on 27 May 2025. She provided an overview of the context in which the mortality data was currently presented, collected and recorded and highlighted plans for a city-wide

approach for reviewing and monitoring the data in future to improve the quality. This would include scrutiny of the data to identify any patterns or trends and an equity analysis.

Outcome: the Board

- Noted the contents of the Trust Q4 mortality report.
- Approved the action plan for mortality reporting.
- Endorsed a city-wide approach to equity analysis for mortality data.
- Support request to prioritise Mortality data and reporting review within Business Intelligence.

Item 2025-26 (35)

Discussion points:

Business Committee Assurance Report: April 2025

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

- The Committee was advised that the Internal Audit on Recruitment for pre-employment checks had 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 the MindMate SPA service and progress with Northpoint. The Committee sought assurance on value for money and the overall risk/reward of the business case.
- Quality and Value (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 the planned position by £0.9M. The Committee discussed the impact of the transformation on staff 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.
- The Committee received the Digital, Data and Technology strategy report update, and acknowledged the progress of the digital strategy and transformation in the last year. The Committee asked for the next update to include plan priorities and timescales.
- The Committee discussed the financial report and the year end results.

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

The Trust Chair asked when the Board would next receive an update on the Digital, Data and Technology Strategy, and the Company Secretary confirmed that the Board was scheduled to receive an update at its meeting on 4 September 2025.

Outcome: the Board

- noted the assurance provided and the matters highlighted.

Item 2025-26 (36)

Discussion points:

Audit Committee Assurance Report: April 2025

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

- External Auditors had advised the Committee that the value for money work had commenced, no risks or areas of significant weakness had been identified to date.
- A progress update on the Trust's Annual Report provided assurance that this was on track.
- A first draft of the Annual Governance Statement was well-received.
- Those Charged With Governance (TCWG) statements were approved.
- The Committee received the Draft Head of Internal Audit Opinion which was expected to be significant assurance pending the final reports on four audits.
- The Committee had asked 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.
- The Security Management Report was noted, with assurance given that effective security management structures and processes were in place in the Trust.

- The Committee reviewed two final Internal Audit reports, both were significant assurance: Recruitment: Pre–employment checks, and Board Assurance Framework and Risk Management Framework.
- The Cyber Security six monthly update was received and noted.

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 (37)

Discussion points:

Charitable Funds Update Report

The Board welcomed Jodie Collins, Charitable Funds Administrator to the meeting to support the presentation of the first six monthly update on the Trust's charitable work. Her work in this area was commended for the significant difference it was making and the notable increase in:
• The number and scale of charitable projects.
• External donations and fundraising initiatives.
• Strategic alignment of charitable activities with organisational priorities.

Non-Executive Director (AL), Chair of the Charitable Funds Committee said that the Trust was exploring options to extend the funding of the Charitable Funds Administrator role.

The Board noted the detail outlined in the report and acknowledged that this growth had highlighted the need for enhanced visibility and governance at Board level.

Non-Executive Director (RB) noted the challenges around accessing corporate funding and offered to share details of her connections at BUPA.

Action: Non-Executive (RB) to provide information about accessing corporate funding.

Responsible Officer: Non-Executive Director (RB)

Outcome: the Board
- Approved the proposal to include Charitable Funds as a standing item on the Board agenda on a six -monthly basis.
- Supported the development and launch of a dedicated social media presence to enhance visibility and engagement.
- Endorsed the continued exploration of new fundraising opportunities, with appropriate risk oversight by the Charitable Funds Committee and Steering Group.
- Recognised the contribution of staff and volunteers to the Charity's success and the positive impact on Trust services and the wider community.
- Noted the increasing scale and strategic importance of the Charity's work.

Item 2025-26 (38)

Discussion points:

Performance Report

The Executive Director of Finance and Resources presented the report which highlighted key areas of performance; including areas that were performing well, areas where improvement work was underway, and early warning of deteriorating performance. Performance was measured across six domains, using indicators selected by the Board at the start of the financial year.

The Board noted that the overall picture of performance in the organisation shown by the measures in the report has not changed significantly since the last report presented to the Board. The number of measures exceeding their target had remained the same although none were showing deterioration which indicated stability with the expectation to continue to exceed the targets.

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

Non-Executive Director (IL) said that he was disappointed with how the reporting on effectiveness was reflected in the performance report with a narrow focus and a range of issues which were not reported on including outcomes, improvement and research and development. The Executive Director of Finance and Resources provided assurance that work was in progress to improve reporting on effectiveness.

Non-Executive Director (IL) noted the data on staff appraisal rates and referred to the outcome of a recent internal audit report which had provided limited assurance on this. He asked what actions the Trust was taking to improve the situation. The Director of People, Organisational Development (OD) and System Development reported that there had been a steady and gradual improvement towards the target since August 2024, which had resulted in the highest compliance rate since 2021. She acknowledged that the recent audit had identified several actions to be implemented over the next few months which related to improving the reporting of appraisal compliance on the Electronic Staff Record (ESR) System, which would ensure more accurate data recording. A more detailed discussion on the outcome of the audit was scheduled at the Audit Committee meeting on 8 July 2025.

Non-Executive Director (AL) highlighted the compliance data with Level 1 and 2 Safety Training and referred to the concerns which had been raised with her by staff during a service visit around accessing wound care training, where new staff reported they were waiting 12 months before they were able to undertake the training. The Executive Director of Nursing and AHPs reported that there had been a slight month on month improvement, however compliance had not reached the target of 95%, and options for accessing external wound care training were under consideration.

Non-Executive Director (RB) queried the data on duty of candour which was reported as fluctuating.

The Executive Director of Nursing and AHPs agreed to review the data and provide further information at the next meeting.

Action: A review of the data on duty of candour to clarify the underlying reasons for the fluctuating data.

Responsible Officer: Executive Director of Nursing and AHPs.

Referring to the Safe Domain the Interim Chief Executive requested clarification on the reclassification of seven historic Patient Safety Incidents in April 2025 she queried how old the cases were and the implications for families and the duty of candour resulting from their reclassification.

The Executive Director of Nursing and AHPs reported that some were 12 months old. She agreed to provide a briefing note on the implications for families and the duty of candour for the Board following the meeting.

Action: A briefing note to be provided for the Board on the implications of the reclassification of the seven historic incidents for families and duty of candour.

Responsible Officer: Executive Director of Nursing and AHPs.

Non-Executive Director (IL) raised concerns about the Trust's Clinical Audit Programme. It was agreed that a further discussion would be taken forward outside this meeting.

Action: Discussions to be taken forward via an offline conversation.

Responsible Officers: Non-Executive Director (IL) and the Executive Medical Director.

The Executive Director of Finance and Resources provided a brief update on the financial position.

For April 2025, the Trust had reported a breakeven financial position, which was in line with the planned target. At this early point in the year and based on Month 1 (MO1) performance the Trust was forecasting the delivery of its overall breakeven plan for the year. The Quality & Value Programme had 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 had commenced from May 2025.

At the end of April 2025, £5.3million of the £14m savings target for 2025/26 had been identified recurrently. Work continued to bridge the gap to ensure that by the end of Quarter 1 plans were fully identified, there were no high-risk schemes and all opportunities to achieve the recurrent Cost Improvement Plan (CIP) target were maximised. She said that there remained a high risk that in-year non recurrent measures would be needed to achieve the plan.

Outcome: the Board

- received and noted the report.

Item 2025-26 (39)

Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2024/25

The Executive Director of Operations presented the report which had previously been considered by the Business Committee in April 2025.

In December 2024 the Trust had received the outcome from its second self-compliance assessment against the national EPRR core standards using the new (NHS North East & Yorkshire) scoring system. Along with other Trusts in the region, compliance scores had improved considerably, but the Trust continued to rate as non-compliant. The EPRR Improvement Plan required a number of Trust and ICS actions to be undertaken which were scheduled to be completed by September 2025 (prior to the submission date at the end of October 2025).

Internal Audit would be undertaking a review of the ratings/evidence in the summer of 2025. Other requirements such as exercises, training and partnership working had all improved the Trust's understanding/ learning of EPRR risks and had helped to improve the plans, policies and other supporting EPRR documentation.

Outcome: the Board

- received 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.

Item 2025-26 (40)

Discussion points:

Guardian for Safe Working Hours (GSWH)

The GSWH presented the report for Quarter 4 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:

- Upcoming changes to managing exception reporting system.

Outcome: The Board:

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

Item 2025-26 (41)

People and Culture Committee Terms of Reference –Draft For Approval

The Chair of the Committee Non-Executive Director (RB) presented the Terms of Reference for this new Committee for approval. They had been discussed and recommended for approval by the People and Culture Committee at its inaugural meeting on 21 May 2025.

Outcome: the Board

- reviewed and approved the draft Terms of Reference for the People and Culture Committee.

Item 2025-26 (42)

Discussion points:

People and Culture Committee Assurance Report: May 2025

- The Committee received an update on employee relations and Freedom to Speak Up Activity, noting individual cases arising since April 2025 or currently under management.
- The Committee received a paper, following up on the staff survey 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 had talked about the network activity and the Committee had discussed how to make the most of the Network Chairs' presence at People and Culture Committee meetings, including what the Networks and the Trust asked of each other. Committee agreed to explore how to ensure an effective communication flow between the Committee and the Networks and discussed the concept of having a "staff story" for future meetings.
- The Committee received a number of data sets showing aspects of people performance including health & wellbeing, equality, resourcing and development and discussed what additional data it would like to see in future meetings.
- The Committee was also given a subset of the Quality and Value (Q&V) data pack showing the human factors data flowing from the programme. It was noted that the Business Committee Chair had escalated an item to the Committee around evidence of a decline in wellbeing arising from some of the Q&V activity which had also been reflected in some of the staff survey comments. The Committee received assurance that action plans had been developed following the latest survey results.
- **Risks Discussed and New Risks Identified**

The Executive Director of Nursing and AHPs advised that the risks relevant to the People and Culture 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

Outcome: the Board

- noted the assurance report and the matters highlighted.

Item 2025-26 (43)

Discussion points

Code of Governance Compliance

The Company Secretary presented the report which set out the Trust's ongoing compliance against the requirements of the new Code of Governance which came into force on 1 April 2023 and reported the Trust's compliance against the standards.

The Company Secretary highlighted one statement marked as non-compliant, relating to the Trust having a policy on its purchase of non-audit services from its external auditor, for which an explanation had been provided. Although the Trust could evidence the process for appointing the external auditors through Auditor Panel and Board reports, work needed to be undertaken to develop this specific policy. It was noted that the external auditors had not undertaken any non-audit work during the period of their contract with the Trust. This provision had therefore been marked as non-compliant but the intent to comply confirmed and a policy would be developed during 2025/26.

Outcome: the Board

- Noted the requirements of the Code of Governance for provider trusts, and the assurance that would be provided in due course by External Audit against the publication within the Annual Report.
- Reflected 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 the Trust.
- Approved 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).

Item 2025-26 (44)

Discussion points:
Audit Committee Annual Report 2024/25
In the absence of the Committee Chair, Non-Executive Director (IL) presented the Audit Committee's Annual Report for 2024-25 which provided an overview of the workings of the Committee and demonstrated that the Committee had complied with its terms of reference.

The terms of reference for each committee required the committee's chairs submit an annual report which demonstrated how the committee had fulfilled its duties as delegated to it by the Board and as set out in the terms of reference and committee's work plan.

Outcome: the Board
- approved the Audit Committee Annual Report for 2024/25.

Item 2025-26 (45)

Discussion points:
Significant Risks Risk Assurance Report
The Executive Director of Nursing and AHPs presented 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 risk register that had a score of 15 or more (extreme).
- a total of 13 risks scoring 12 (very high).

The Board noted the changes that had taken place to risks scoring 15 (extreme) or above since the last risk register report and discussed assurance on the rationale underpinning the changes in ratings. Noting that discussions were underway to improve the format of future reports.

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 (46)

Discussion points:
Board Assurance Framework (BAF) – Update on Review Process for 2025-26
The Company Secretary presented the report which summarised the process undertaken to review the BAF in readiness for the 25/26 financial year and included the draft Strategic Risks with the Board for review and approval.

Outcome: the Board
- Noted the process for review of the strategic risks, gaps in controls and sources of assurance for 2025/26.
- Approved the Strategic Risks for 2025/26 as presented in the report.

Item 2025-26 (47)

Discussion points:
Register of Sealings March – May 2025

The Interim Chief Executive presented the report which included and extract from the 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 was presented to the Board, in line with the Trust's standing orders, for noting.

Outcome: the Board

- noted the use of the corporate seal.

Item 2025-26(48)

Discussion points:

Any other business Blue Box Items and Close.

Non-Executive Director (HT), Vice Chair of the Trust Board noted that this would be Brodie Clark's final formal meeting as Chair of the Trust Board. On behalf of the Board, she expressed gratitude for his years of dedicated service as Chair, his leadership, his contribution to the organisation and his commitment to improving the health of the people of Leeds. Board members wished him all the best for the future.

The Trust Chair closed the meeting at 12.15pm

Date and time of next meeting.
Thursday 4 September 2025 9.00am-12.30pm

2025-26 49	Quality Strategy – presented to the Quality Committee May 2025
2025-26 50	Workplan – to note

Agenda item:	2025-26 (4aii)

Title of report:	Minutes Extraordinary Trust Board Meeting 25 June 2025

Meeting:	Trust Board Meeting Held in Public
Date:	4 September 2025

Presented by:	Acting 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		
	Helen Thomson Deputy Lieutenant (DL) (HT)	Trust Vice Chair and Non-Executive Director (Via Virtual link)
	Dr Sara Munro	Interim Chief Executive (Via Virtual Link)
	Jenny Allen	Director of People, Organisational Development and System Development (JA) (Via Virtual Link)
	Rachel Booth (RB)	Non-Executive Director
	Dr Ruth Burnett	Executive Medical Director (Via Virtual Link)
	Professor Ian Lewis (IL)	Non-Executive Director (Via Virtual Link)
	Alison Lowe OBE (AL)	Non-Executive Director (Via Virtual Link)
	Lynne Mellor (LM)	Associate Non-Executive Director
	Andrea Osborne	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Khalil Rehman	Non-Executive Director (Via Virtual Link)
	Sheila Sorby	Deputy Director of Nursing & Quality and Director of Infection Prevention and Control– Deputising for Lynsey Yeomans (Via Virtual Link)
Apologies:	Brodie Clark CBE	Trust Chair
	Laura Smith	Director of People, Organisational Development (OD) and System Development (LS)
	Lynsey Yeomans	Executive Director of Nursing and Allied Health Professionals (AHPs)
In attendance:	Helen Robinson	Company Secretary
Minutes:	Liz Thornton	Board Administrator (Via virtual link)
Observers:	None	
Members of the public:	None	

Item 2025-26 (51)

Discussion points

Welcome introduction, apologies, and preliminary business

The Trust Vice Chair opened the Extraordinary Trust Board meeting.

Apologies

Apologies were received and accepted from Brodie Clark CBE, Laura Smith and Lynsey Yeomans.

Item 2025-26 (52)

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 prior to papers being distributed to Board members.

Item 2025-26 (53)

Discussion points:

Update from the Chair of the Audit Committee on end year Committee meeting on 23 June 2025

Non-Executive Director and Chair of the Audit Committee (KR) provided a verbal update on the deliberations of the Audit Committee on 23 June 2025.

He informed the Board that the Committee had given full and proper scrutiny to the Trust's accounts for 2024-25. The Committee had also reviewed the draft letter of representation and the audit completion report on the Trust's financial statements issued by the external auditors, Forvis Mazars.

He reported that he was satisfied with the opportunity the Committee had had to review the annual report and accounts and he extended his thanks to the Company Secretary, Head of Communications, the Finance Team and the External Auditors for their efforts in maintaining a robust process both throughout the year and for the year-end processes.

He added that in relation to the Head of Internal Audit Opinion for 2024/25, an overall opinion of Significant Assurance had been provided. It was noted that the Head of Internal Audit Opinion was one of the sources of assurance used by the Board to produce the annual governance statement included in the annual report. He commented on the excellent collaboration between the Trust and Internal Auditors this year.

He informed the Board that due to changes to the General Accounting Manual this year there would be a delay in the External Auditors issuing the audit certificate but this would not preclude the Board from adopting the accounts at this meeting and their submission to NHS England by noon on 30 June 2025.

The Audit Committee was recommending that the Trust Board adopt the annual report and accounts for 2024-25. This conclusion had been supported by the External Auditors' opinion on the accuracy of the financial statements.

Item 2025-26 (54 a, b, and c)

Discussion points: Annual report and accounts 2024/25

On 23 June 2025, the Audit Committee had received the Audit Completion Report and reviewed the draft letter of representation on the Trust's financial statements issued by the external auditors, Forvis Mazars.

The Executive Director of Finance and Resources confirmed that, as noted in the draft letter of representation, directors had provided written confirmation that, to the best of their knowledge, all information relevant to the financial statements had been disclosed. The External Auditors had confirmed their confidence that this had been the case.

Referring to the external auditors' opinion on the accounts, the Executive Director of Finance and Resources said she could report that the auditors would issue an unqualified opinion on the Trust's

accounts and there were no significant concerns on the value for money statements. She highlighted that some non-material further changes to the remuneration report had been suggested by the External Auditors, but she was able to confirm that the changes would not impact on the primary financial statements or the financial results and would not preclude the Trust Board signing off the annual report and accounts at this meeting.

In addition, due to some changes to the process by the National Audit Office, certification of the accounts would not be possible at this time however this would not change the auditor's overall opinion on the Trust's accounts but could potentially impact on the Value for Money commentary.

A more streamlined programme management approach this year had led to the production of a more cohesive report.

The Board placed on record its thanks to all members of the Trust's staff who had contributed to the timely completion of the annual report and accounts for 2024/25, and the External Auditors for their efforts in maintaining a robust process both throughout the year and for the year-end processes.

Outcome: the Board accepted the recommendations of the Audit Committee and:

- adopted the draft annual report and accounts (as supported by the external auditors' opinion) subject to further non-material changes
- approved the letter of representation, which, amongst other matters, required that the Trust Board considered and agreed that there are no "events after the reporting period" to include in the accounts and bring to the auditor's attention
- following the Trust Board approval, the Chief Executive and Interim Executive Director of Finance and Resources' e-signatures would be applied to relevant documents for submission to NHS England on or before noon on the 30 June 2025.

Item 2025-26 (55)

Discussion points:
Quality Account 2024/25
The Deputy Director of Nursing & Quality and Director of Infection Prevention and Control presented the final draft of the Quality Account 2024/25 for approval.

The Board noted that the final version reflected the comments and suggestions made following a review by the Quality Committee in May 2025.

The Board placed on record its thanks to all staff who had contributed to producing the Quality Account for 2024/25 which was a substantial piece of work.

Outcome: the Board

- approved the Quality Account for publication by 30 June 2025.

Item 2025-26 (56)

Discussion points:
Any other business
No matters were raised.

Item 2025-26 (57)

Discussion points:
Close of the public section of the Board
The Trust Vice Chair thanked everyone for attending and closed the Board meeting at 9.20am

Date and time of next meeting
Thursday 4 September 2025 9.00am-12.00 noon

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (4aiii)

Title of report:	Minutes of Extraordinary Trust Board Meeting Held in Public: 10 July 2025

Meeting:	Trust Board Meeting Held In Public
Date:	4 September 2025

Presented by:	Acting Chair					
Prepared by:	Company Secretary					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	√

Executive Summary:	Draft extraordinary public 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 (meeting Chair)
	Sara Munro	Interim Chief Executive
	Rachel Booth	Non-Executive Director
	Dr Ruth Burnett	Executive Medical Director
	Lynne Mellor (LM)	Associate Non-Executive Director
	Andrea Osborne	Executive Director of Finance and Resources
	Khalil Rehman (KR)	Non-Executive Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
	Lynsey Yeomans	Executive Director of Nursing and Allied Health Professionals (AHPs)
Apologies:	Helen Thomson Deputy Lieutenant (DL) (HT)	Deputy Trust Chair, Non-Executive Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Alison Lowe OBE	Executive Director of Operations
	Sam Prince	Director of Workforce, Organisational Development and System Development (LS)
	Laura Smith	
In attendance:	Helen Robinson	Company Secretary (minutes)
Observers:	Anne Ellis	Risk Manager
	Dan Barnett	Associate Director Strategy, Change, and Improvement

Item 2024-25 (58)

Discussion points:

Declarations of interest

Prior to the Trust Board meeting, the Deputy Trust Chair had considered the Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest prior to papers being distributed to Board members.

No other additional declarations were made above those on record or in respect of any business covered by the agenda.

Item 2024-25 (59)

Discussion points:

Green Plan Refresh 2025-2028

The Executive Director of Finance and Resources introduced the refreshed Green Plan on behalf of the Sustainability Manager. She explained that since the previous Green Plan 2022-2025, emissions had steadily increased and therefore the refresh was focused on projects which would result in an emissions decline to ensure the Trust was meeting the requirements set by the Greener NHS team. This would bring the net zero ambition forward to 2040, although the challenges to achieving that target were acknowledged.

The Board was informed that the plan proposed that an Adaptability and Sustainability Steering Group would be formed, in order to ensure sustainability becomes a golden thread throughout business processes and investment decisions. Wider staff engagement was essential, to support the Sustainability Manager.

Board members were invited to make a collective and personal pledge, including moving away from paper Board and Committee packs in favour of a digital format. It was acknowledged that this would also need to be applied to wider business processes, but modelling at Board level was welcomed.

Committee representatives from People and Culture, Business and Quality Committees each welcomed the plan and commented on discussions held at Committees focussing on different elements of the plan such as staff engagement and shared ownership, and clinical waste.

A brief discussion was held regarding champion roles, in general and in relation to the Green Plan, which it was felt needed more rigour and supporting principles. Further work on this would be done through the Leaders Network.

The Executive Director of Finance and Resources thanked the Sustainability Manager for their hard work in pulling the refreshed plan together.

Outcome: the Board

- Felt assured that the actions within the plan would bring about emission decline and ensure the Trust met the compulsory requirements outlined by the Greener NHS team.
- Discussed the feasibility and increased ambition of the net zero trajectory of 2040, considering the available resources, capital and staffing in the sustainability department.
- Acknowledged the limited capital for ambitious projects to decarbonise. Discussed tactics and prioritisation to maximise progress with limited resources.
- Approved the proposal to commence a Director led Sustainability and Climate Adaptability Steering Group.

Item 2024-25 (60)

Discussion points:

Any other business and Close

The Executive Director of Finance and Resources provided an update on the digital letters issue, which had been highlighted at the private Board on 5 June 2025.

The Board was informed that the clinical risk had been reviewed during June, and the EQIA for the project was also to be reviewed in light of the issues.

In the interests of full transparency, the Information Commissioner's Office had been notified of the issue, along with the Care Quality Commission.

Contractual implications were being reviewed and legal advice had been sought.

Outcome: the Board noted the update.

Date and time of next meeting
Thursday 4 September 2025 9.30am

AGENDA ITEM 2025-26 (4b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) action log: 4 September 2025

Key		Key colour code
Total actions on action log	5	
Actions on log **completed** since last Board meeting on 5 June 2025 with a **proposal to close**	5	
Actions due for completion by 4 September 2025 – for update at the meeting	0	
Actions not due for completion before 4 September 2025	0	
Actions outstanding at 4 September 2025**: not having met agreed timescales and/or requirements**	0	

Agenda Item Number	Action Agreed	Lead	Timescale/Deadline	Status
5 June 2025				
2025-26 (30)	**Interim Chief Executive Report:** a summary of the headlines from the Attain review on the West Yorkshire Community Services offer to be circulated to Board members.	Interim Chief Executive	Post meeting – when the report is available	**Propose Closure:** Final report circulated to Board Members 12 August 2025
2025-26 (37)	**Charitable Funds Update Report**: Non-Executive Director (RB) to provide information about accessing corporate funding.	Non-Executive Director (RB)	Post meeting	**Propose Closure:** Email re accessing grants and applications sent to Charitable Funds Officer
2025-26 (38)	**Performance Report - Duty of Candour:** clarification on the underlying reasons for the fluctuations in the data on the duty of candour.	Executive Director of Nursing and AHPs	Post meeting	**Propose Closure:** Variability is driven by small numbers, changes in case mix, and process timing (including multi-agency cases). Statistical Process Control reporting is in place and will continue to be monitored through the Quality, Assurance and Information Group (QAIG). Controls: weekly patient safety

				meetings in each business unit and risk profile in place to monitor progress. Paper to risk management group due at next meeting in September.
2025-26 (38)	**Performance Report Safe Domain**: a briefing note to be provided for the Board to clarify the implications for families and the duty of candour as a result of the reclassification of seven historic Patient Safety Incidents in April 2025.	Executive Director of Nursing and AHPs	Post meeting	**Propose Closure:** Harm gradings were aligned to national definitions; several incidents now meet the Duty of Candour threshold. The Trust is undertaking retrospective Duty of Candour with compassionate engagement and full documentation. Performance charts will be annotated to show the step-change associated with completion of these historic cases. A one-off closure update to the Board will be provided in October 2025.
2025-26 (38)	**Performance Report: Clinical Audits 2025-26:** an offline discussion to address concerns raised by Non-Executive Director (IL).	Non-Executive Director (IL)/Executive Medical Director	Post- meeting	**Propose Closure:** Completed July 2025

Agenda item:	2025-26 (6)

Title of report:	Interim Chief Executive's Report

Meeting:	Trust Board Held In Public
Date:	4 September 2025

Presented by:	Dr Sara Munro, Interim Chief Executive					
Prepared by:	Dr Sara Munro, Interim Chief Executive					
Purpose: (Please tick ONE box only)	Assurance	X	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:

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	X	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

The purpose of this report is to update and inform the Board of key activities and issues from the Chief Executive. Due to the timing of the board and annual leave there will be a verbal update at the Board meeting for any more recent announcements.

2 Our Services and Our People

Veteran Aware

We are delighted to announce that the Trust has received its Veteran Aware accreditation. Thanks to everyone involved in the work to achieve this which is an important signal to the work we do to value our veteran's community.

Trust Leaders Network

Shortly after commencing with the Trust, we were asked to re-launch a monthly network for leaders across the Trust to come together to receive and share key information that those in leadership roles find valuable. We have now run two sessions – the last one in August was attended by over 80 people with contributions from across different departments. We will continue to develop this as an important space for sharing national and local intelligence and internal updates. Board members are very welcome to join the network.

Industrial Action

Resident doctors took industrial action from 7am Friday 25 July to 7am Wednesday 30 July. 90% of BMA members voted in favour of taking industrial action on a 55% turnout. The mandate lasts until January 2026 and the dispute is with the government on pay and conditions. Negotiations have resumed and at the time of writing there have been no further announcements of industrial action – the BMA are required to give a minimum of two weeks' notice.

Thanks to everyone involved who managed and coordinated our response to the industrial action which resulted in minimal disruption and no patient safety incidents in the Trust.

Trust Annual General Meeting

Our trust annual reports have been laid before parliament and plans have been finalised for us to hold our annual general meeting. This will be held on the 16 September at 12.30pm, held at The Vinery in Leeds and a calendar invite will come out to board members' diaries. We look forward to seeing everyone there.

Medium Term Planning

NHS Trusts will be expected to develop medium-term plans before the end of this year that will then span 2026-2029. Guidance is being developed, and we expect to understand more on what will be required by October. We will bring further information to the November Board meeting, assuming the guidance has been published by then.

3 Leeds System Update

NHS England Chair Penny Dash visit to Leeds

The chair of NHSE Penny Dash visited Leeds on 8 July 2025. Following a tour at Leeds General Infirmary a small group of representatives from health and care in the city joined Penny for lunch to discuss the 10-year plan and the work underway in the city.

Leeds Provider Partnership Review

The Leeds Provider Partnership Review commissioned by NHS providers, Leeds City Council, and the ICB is well underway, and Dr Ruth Burnett and Dan Barnett represent the Trust on the operational steering group that meets weekly.

The first phase focused on reviewing key documentation, including organisational strategies and interviews with a range of stakeholders. The second phase is more focused on potential scenarios for how we work together – partnership governance, mutual accountability, integrated models that will support neighborhood health and address current risks and issues being experienced by statutory organisations, implications of changes to the ICB and NHSE for providers.

Now the 10-year plan for health has been published this will be explicitly considered in the blueprint we want to create for the city and what the roadmap should look like to achieve this. We have also asked that learning from work underway in other systems is included. The aim is still to have a draft report by the end of September.

Leeds Teaching Hospitals NHS Trust leadership update

The new chair of Leeds Teaching Hospitals NHS Trust (LTHT), Mr Antony Kildair has now commenced in post and is meeting with partners as part of his induction. Having met Antony, it was a good opportunity to brief him on our approach to partnership working in the city and the importance of this continuation as a priority for the new leadership team at LTHT.

Professor Phil Wood – CEO at Leeds Teaching Hospitals NHS Trust has announced his intention to retire at the end of this year. Phil will remain committed to the Leeds Provider Partnership development during this time, and this will be one of the priority areas of work for his future successor.

Deputy CEO and Chief Operating Officer Clare Smith has been successful in getting the CEO post at York and Scarborough acute trust and will soon be leaving Leeds. Interim arrangements will be put in place as permanent recruitment will not take place until a new CEO is appointed for LTHT.

National Neighbourhood Health Pilot

ICBs and places have been invited to apply to be one of 42 pilot sites to test, learn and grow models of neighbourhood health. There is no limit to the number of applications from ICBs, but they must be endorsed by all partners, the ICB and the elected mayor. Three bids have been endorsed for West Yorkshire – including a bid by Leeds which will involve a select number of PCNs as the footprint. We will update at the Board meeting on the timescales for when we hear if our application has been successful.

4 Regional and National Updates

The most notable update since our last Board meeting is the publication of the **10 year plan** for health, coinciding with the NHS 77th birthday. The Board has been sent links to the plan separately.

The plan sets out a future model of provision which has shifted significantly in the use of AI and technology to enable care delivery, service delivery, support staff etc. Some key updates to note:

- Further guidance on the implementation of the 10-year plan is being developed.
- The foundation trust model will be relaunched, and mature systems will be able to develop as an integrated health organisation where population budgets are collectively managed.
- Move to medium term financial planning and capital planning is welcomed.
- Anticipate further changes to the funding and payment mechanisms for providers.
- The development of a blueprint for NHS England regional teams has still not been published.
- The timescale for changes to Integrated Care Boards is still to be confirmed.
- The progress of the new MHA to receive royal assent is expected to now take place in the autumn.
- A new workforce strategy is expected in the autumn.
- Development of modern service frameworks will begin later in the year to set out more detailed strategy on service areas including mental health.

NHS CEOs were asked to volunteer to help with the development of detailed implementation guidance over the next few months and the following workstreams have been established:

- Neighbourhood health
- NHS app and single patient record
- Oversight model, foundation trust and model integrated health organisation
- Financial foundations and medium-term planning
- Quality
- Workforce

Having volunteered for several of these I have now been asked to join the workforce workstream.

The second phase of the review by Penny Dash into the **quality and safety regulatory** landscape for health and care was also published in July. Key headlines include abolition of Healthwatch and the National Guardian's Office. The Freedom to Speak Up Guardian role will however remain at provider level. Consolidation of different safety regulatory functions is recommended e.g. Health Services Safety Investigations Body (HSSIB) to be incorporated into the Care Quality Commission. There will be a relaunch of the national quality board and publication of a new national quality strategy for the NHS.

National Oversight Framework (NOF)

NHS England consulted on the development of a new NOF for providers and ICBs earlier this year. It is also being referred to as the provider assessment framework/score (PAF/PAS). The consultation has concluded, and all NHS providers are being assessed under the new framework and scored in segments from 1-4. The level a Trust is in determines the level of oversight/intervention that will be provided by NHSE regional teams. One is the highest/best segment – 4 is the lowest.

For Trusts in segment 3/4 they will be required to produce and agree recovery plans with NHSE, monitored against agreed milestones. For Trusts who are not able to improve as planned/expected, there may be further reviews of organisational capability. Trusts that are deemed not to have the capability to improve can be placed in a new segment of 5. Trusts currently in special measures will be placed in segment 5. Any Trust in receipt of deficit support financially cannot be higher than segment 3.

NHSE has finalised these new segments, and we are advised they will be published on 11 September 2025. Work is well underway to understand our own metrics and where we need to prioritise improvement and to prepare for publication. This will be discussed further in the private board session.

Provider Capability Assessments

At the time of writing this paper I have just received notification that NHSE is introducing a new provider capability self-assessment framework. The template is expected before the end of August and Boards will have two months to complete and return the assessment to NHSE.

The capability assessment will be based around:

- an annual self-assessment by provider boards submitted to NHS England, with supporting evidence, based on themes from last year's publication of The Insightful Board.
- a review of the self-assessment, triangulated with NHS England views of the provider and any third-party information, to provide an overall view of capability.
- across the year, NHS England will use the capability assessment to inform their relationship with the provider, including revising the capability rating should events require it.

It is intended that the capability rating will be published alongside the quarter 2 2025/26 NOF segmentation during quarter 3 and the outputs used to determine the level of oversight, support and intervention from NHSE to providers. Further detail will be shared once received and we will agree at the Board meeting our approach to completing the self-assessment and Board sign off before submission.

5 Recommendations

The Board/Committee is recommended to:

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

Dr Sara Munro
Interim Chief Executive
August 2025

Agenda item:	2025-26 (7i)

Title of report:	Leeds Community Healthcare NHS Trust Winter Plan 2025-2026

Meeting:	Trust Board Meeting Held In Public
Date:	4 September 2025

Presented by:	Sam Prince, Executive Director of Operations					
Prepared by:	Samantha Steede, Operations Business Manager					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	The LCH Winter Plan outlines how the Trust will manage seasonal pressures in 2025/26, ensuring safe and effective care delivery. It sets out service-specific risks, surge modelling, and escalation processes, alongside actions to strengthen resilience, manage sickness and absence, and maintain patient flow. Planning has been informed by learning from previous winters and engagement across all Business Units, corporate functions, and system partners. The plan provides assurance that LCH is prepared to respond flexibly to increased demand while supporting system-wide flow. The plan is still in development and will remain a live working document over winter. This year NHS England requires all Boards to understand their organisation's Winter Plan and submit a Board Assurance Statement by 30 September 2025. The timing of the Board meeting means that not all aspects of the Board Assurance checklist can be assured and further sign off will be required towards the end of the month.

Previously considered by:	SLT EPRR Group Winter Planning Working Group

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

	Yes		What does it tell us?	

Is Health Equity Data included in the report (for patient care and/or workforce)?				
	No	X	Why not/what future plans are there to include this information?	Not used specifically within the report, but is embedded within the offer from services within the plan.

Recommendation(s)	Review the draft LCH Winter Plan for 2025-2026 Review the Board Assurance Statement required for submission to the ICB by 30 September (Appendix 1) Provide details on any other information required to sign off the Assurance Statement. Discuss relevant delegation of authority.

List of Appendices:	Winter Plan Board Assurance Statement and Checklist

Leeds Community Healthcare NHS Trust Winter Plan 2025/2026

Contents

1. Introduction

Winter places significant and sustained pressure on health and care services across the system. This Winter Plan outlines how Leeds Community Healthcare NHS Trust (LCH) will prepare for and respond to these challenges to maintain safe, high-quality, and resilient services for the people of Leeds. This plan aligns with and directly feeds into the system level ICB plan. Winter pressures in the context of this plan include an increase in referrals/service demand due to increased system flow, a general increase in respiratory infections, adverse weather events and increased staff unavailability/absence.

Key priorities for this winter for LCH include:

- Strengthening community pathways to support system flow
- Balancing urgent care with waiting list management
- Enhancing workforce capacity and resilience through rota planning and wellbeing support
- Increasing utilisation of data to monitor demand and manage escalation
- Clear communication with staff, partners, and patients on service changes and pressures
- Ensuring that ongoing restructures linked to the current Quality and Value (Q&V) programme do not negatively impact service delivery
- Managing workplace sickness and absence
- Mitigating and responding to the impact of potential strike action

1.1 Services in Scope

Each service area that experiences increased demand during winter or is directly affected by system flow has contributed to this plan. Contributions are based on expected seasonal pressures, learning from previous years, and current forecasts for the upcoming winter period. The following services have been included:

ABU	Neighbourhood Teams Home Ward Frailty Transfer of Care Services (Community Discharge Assessment Team, Bed Bureau, TOC) Health Case Management Community Therapy Service (Patient Flow Services, Active Recovery) Wharfedale/Community Care Beds
CBU	Children and Young People's Mental Health Crisis Service (CYMPHS) Children's CIVAS
SBU	Home Ward Respiratory Community Stroke Rehabilitation Team Community Intravenous Administration Service (CIVAS) Homeless and Health Inclusion Team
OPS	Administration Services

Other services, including Children's Community Nursing, were engaged during the development of this Winter Plan. However, as their current pressures are not considered to be specifically seasonal, they have not been included in this iteration. For future planning, all

services should be contacted again to ensure any emerging pressures are identified and all relevant areas are appropriately reflected.

2. Risks, Capacity and Demand

Winter presents a range of operational risks and pressures that may impact the Trust's ability to maintain safe and effective service delivery. Key overarching risks include an increase in staff sickness absence, a high surge in referrals and demand across key services, and potential disruption to the Trust's physical infrastructure and external factors such as severe weather and 4x4 availability.

2.1 Key Risks by Service

The table below summarises the anticipated pressures for each service during Winter 2025/26, detailing service-specific risks, projected impacts, and the mitigation measures in place to manage demand while maintaining safe, effective care. Key demand data from Winter 2024/25, provided in Appendix 1, has informed the planning within this section.

BU	Area	Risk(s) Description	Anticipated Impact	Mitigation Plan
ABU	Neighbourhood Teams	High demand and workforce pressures in Neighbourhood Teams; increased complexity of care at home. Anticipated surges in activity along with consistently higher referral rates across winter (as demonstrated in the 2024-2025 referrals in appendix 1).	Reduced capacity for admission avoidance and discharge support	Prioritisation of discharge and urgent care; integration with HomeFirst and Active Recovery; triage hubs and joint delivery models. All prioritisation will be managed using the service's Business Continuity Plans (BCP) Applied for centrally funded 2x B6 agency nurses to support Triage Hubs with an additional 15 per day triaged (approval in principle given by Active System Leadership Executive Group).
ABU	Home Wards (Frailty)	Risk of demand out stripping capacity	High hospital admissions	Daily Multi-disciplinary Team meetings and close monitoring of staffing and capacity on home ward
ABU	Community Care Beds/Wharfedale	Risk of demand outstripping capacity, with fewer overall beds in the Leeds bed bases this year.	Increased length of stay; hospital flow disruption and community admission disrupted	Work with system partners who can impact flow out of bed bases to create capacity to ease system pressures. Central funding agreed to improve timeliness of

				Continuing Heathcare assessments (2xB6 temporary staffing to reduce wait for assessment in community care beds to 7 days (currently 28 days)
ABU	Health Case Management	Risk of increase in referrals for End of Life (Fast Track Services)	Delay in providing services	Prioritisation of referrals based on patient need and utilisation of BCP. Working closely with Continuing Health Care and neighbourhood teams.
ABU	Community Therapy Service (including Active Recovery)	Risk of increase in Referrals, demand outstripping capacity for Therapy services	Increased length of stay in acute and Community Care Beds, increasing length of stay.	Prioritisation of referrals by patient cohorting and need, whilst managing any waiting and priority patient list.
ABU	Transfer Of Care (TOC)	Risk of increase in referral and case management activity (Community Discharge Assessment Team and Assistant Case Managers)	Increased length of stay in acute setting or inappropriate admissions via Same Day Emergency Care and A&E	Prioritisation of workforce and demand in Transfer of Care and visible clinical leadership supporting in A&E and assigned wards. Applied for central funding for B5 secondment within transfer of care for supporting flow (approval TBC).
CBU	Childre and Young People Mental Health Services (CYPMHS) - crisis services	Access issues in other parts of CYPMHS creates higher demand and workforce pressures in crisis service – urgent, emergency, liaison and call line teams. Emergency crisis assessments are undertaken in LTHT emergency department. Increased footfall/bed blocking in LTHT.	Increased pressure on staff – increased capacity needed for more appointments/assessments. Demand on service to prevent hospital admission and support discharge. Increased pressure on staff. Note current work on avoiding emergency department admissions for crisis assessments which is underway.	Careful management of roster to ensure maximum staffing across 7 days. Use of bank hours as last resort but understanding availability. Efficient pathways within CYPMHS to move young people on from crisis to CORE team. Effective collaboration with LYPFT regarding admissions and access to CYPMHS inpatient beds.

CBU	Children's Community Intravenous Antibiotics Services (CIVAS)	Potential increase in referrals of children requiring IV antibiotics.	Increased pressure on staff	Utilising staff from other teams as second checkers for CIVAS appointments Clinical Coordinators to step in to deliver care
SBU	Community Stroke Rehabilitation Team	Inappropriate hospital discharges into the community. Continued high demand with seasonal peaks (flu, COVID, RSV); risk of longer waits.	Increased pressure on existing staff within service impacting morale and wellbeing. Potential issues for increased sickness, burnout, and reduced productivity. Long waits reduce patient neuroplasticity and therefore potentially impacting patients' outcomes.	Change of model to anticipate increased demand. Staff rota management with additional slots created to enable patient flow from hospital to community. Ongoing monitoring of demand to respond to need. This often is done jointly with LTHT colleagues.
SBU	CIVAS	Increased demand due to higher respiratory and infectious illness rates. Referral rates anticipated to be consistently higher across the winter months in line with 2024-2025 data (Appendix 1).	Potential delays in treatment if demand exceeds capacity leading to delays in hospital discharges.	Management of roster to ensure maximum staffing across 7 days. Inform LTHT of delays to administration of zoledronic acid to maximise slots for hospital discharges / admissions. Use of extra hours/ overtime as last resort. Liaise with OPAT (hospital based service) re use of/swap to oral antibiotics to maximise capacity. Review clinical lead / senior nurse job plans to maximise clinical capacity.
SBU	Homeless and Health Inclusion Team	Increase in hospital admissions.	Increased demand from acute trust to support hospital discharges.	Daily prioritisation meetings to triage essential activity. Support throughput of beds at St. George's Crypt to maximise availability to support hospital discharges. Use of HHIB beds where

				appropriate. Attendance at weekly Transfer of Care meetings. Reviewing working practices within the team to minimise duplication.
SBU	Home Ward Respiratory	Increase in respiratory illnesses leading to hospital admissions	Demand on service to prevent hospital admission and support discharge. Increased pressure on staff. Team undergoing Q&V throughput winter period, increasing pressure due to service development work. Potential for increase in administration requirements to book in patients.	Promote winter vaccination campaigns with patient group. Regular reviews with clinical leads looking at capacity and demand. As part of Q&V reviewing staffing in HWR to look at staffing across weekends to increase capacity. Maximising use of clinics to increase capacity.
OPS	Administration Services	Increased demand in incoming referrals and calls, appointment slot booking, E-roster/SystmOne ledger management. Potential that C3 activity needs to cease in certain areas for specified period of time	Reduced capacity for routine activity focus on C1 work	Outline and understand activity urgency Move admin staff around different services based on demand, staff working outside of usual role (requirement for additional training)

2.2 System generated risks

System risks for this coming winter have been identified in terms of inappropriate/early discharge without appropriate support in place. TOC to pilot supporting discharge flow out of Wharfedale CCB to support the delays, liaising with system partners to expedite delays and reduced no reason to reside lengths of stay. The system risks contributing to delays include the demand for Adult Social Care (ASC) colleagues for social work assessments, housing delays due to a significant shortage of housing options available in the city and delays to Decision Support Tool assessments from Continuing Healthcare

LTHT is forecasting higher bed and ward occupancy than in previous years, driven by increased planned elective surgery and elevated summer occupancy levels. This is likely to result in more referrals and greater demand for LCH services.

2.3 Surge Planning

In the event of a surge, individual services will manage flow based on patient need, applying cohorting arrangements and established escalation processes (see Section 3). The table below outlines how key services in the plan will manage patient flow in the event of surge.

Service	Average Referrals	+10%	+20%	+30%	Impact and Mitigation
Neighbourhood Teams (13 NTs)	634 (week)	697	670	824	Daily NT performance is monitored by leadership across ABU to track demand entering the triage hubs. The immediate pressure point is in the Triage Hubs, where the target is to screen referrals within 24 hours to determine priority based on patient need and cohorts. Importantly, referral volumes do not equate to all patients being directed to Neighbourhood Teams, nor are all patients medically fit for discharge at the point of referral. To manage winter surges, a proposal has been made for two additional Band 6 centrally funded triage clinicians. These roles will strengthen referral management capacity and support responsive care calls during peak demand. During surge, the triage hub escalation process is activated, and resources are mobilised to key pressure points to maintain patient flow. Demand is assessed both at the neighbourhood level and across the city to ensure targeted support for the teams most affected. For example, where one area experiences disproportionately higher demand, resources are redeployed accordingly to maintain equity of service. There is also close coordination with the TOC and the LTHT Lead Nurse for Discharge and Transfer of Care to support timely and safe patient transitions.
Community Stroke Rehabilitation Team	70 (month)	77	84	91	The team has experienced an increase in referrals, rising from an average of 61 to 70 over the past year. In response, the service has adapted its model to better anticipate and manage this increased demand. During surge periods, priority is given to urgent cases by allocating the 15 available slots accordingly. The service also retains the flexibility to create additional slots where required; however, this has a knock-on effect on overall waiting times within the professions from which these slots are drawn.
Home Ward Respiratory	50 (month)	55	60	65	HWR ‘beds’ are capped at 10. In exceptional circumstances this can be increased to 12 depending on staffing levels and acuity of patients.
CIVAS	70 (month)	77	84	91	Each admission triaged for need dependent on number of daily visits required. Zoledronic Acid patients to be temporarily ‘paused’ to allow for hospital discharges to be accommodated. Liaise with OPAT to discharge patients on / transfer patients to oral antibiotics if safe to do so to maximise capacity.

2.4 Virtual Wards Capacity

Element	Description	Capacity	Managing Demand
Community Stroke Rehabilitation Team - Urgent patients (requiring 72 hour response)	Patients with an urgent classification during referral and assessment need to be seen withing 72 hours. This is because of the potential reduction in neuroplasticity.	Initial assessment capacity slots is 15 p/w.	Referrals into the service during winter 2024/25 (Appendix 1) showed a sustained increase throughout the period, a trend that is expected to continue this winter.
Home Ward Respiratory	Home Ward Respiratory to support early discharge from hospital and more intensive support to avoid hospital admission.	10	Regular reviews with clinical leads looking at capacity and demand. Maximising use of clinics to increase capacity.
Virtual Ward - Frailty	LCH Home Ward for frailty supports patients at home with MDT input The home ward (frailty) provides support and care for people who become acutely unwell, within agreed criteria but can be safely cared for in their own home (it also supports people return home from hospital sooner if safe to do so). Consultant led service including rapid access to diagnostics and treatments that can be safely delivered at home (intravenous antibiotics or diuretics). Support can include home visits and care overnight if necessary. A citywide partnership approach also helps people being cared for to access support from the third sector and therapy services where needed. Referrals via SPUR and community teams; aligned with HomeFirst	55 beds	Figures in Appendix 1 show the ward occupancy averaged over 70% during last winter peaking at 78.5% in January. A similar or higher demand is anticipated for this year. Daily MDT's and close monitoring of staffing and capacity on home ward

2.5 Discharge to Assessment (D2A) pathways

Element	Description	Capacity (Current/Planned)	Admission/Discharge Criteria	Integration with SPA/Community
D2A Pathway 1	Discharge home with support; reablement and Active Recovery services	Majority of discharges; capacity increased via HomeFirst.	Medically optimised patients needing short-term support at home	Coordinated through triage hubs; integrated with LCH and LCC services
D2A Pathway 2/3	Short-Term Community Beds and Residential/Nursing placements	Beds expanded for winter; surge capacity planned	Patients requiring further assessment or rehabilitation in a bedded setting	Managed via Care Transfer Hub and SPA; social care and health teams collaborate

2.6 Urgent Community Response (UCR)

Service	Local Model/Approach	Interdependencies and any areas for further development prior to winter
ABU Neighbourhood Teams	- 3 UCR response hubs operational within Leeds Community Healthcare (LCH). - Multidisciplinary team (MDT) model delivering care outside hospital settings. - Focus on rapid response to prevent hospital admissions. - 2-hour response standard consistently achieved	Aiming to hit an average of 90% for 2 hour UCR. Maximising workforce to meet demand in available resources. Integration with triage hubs and SPUR.

3. Operational Management and Escalation Framework

3.1 Escalation Protocols

Business Continuity Plans (BCPs):
In the first instance, any service-level escalations will follow the service's internal BCPs. These are reviewed and updated annually and all services contributing to this winter plan have confirmed that their BCPs have been updated to ensure timely and effective escalation procedures are in place. BCPs have been Audited in August 2025.

OPEL Framework:
While currently under review and subject to future change, LCH continues to operate an internal Operational Pressures Escalation Levels (OPEL) framework, categorising service pressure from Level 1 to Level 4. Services can update their status daily, and this feeds into a daily cascade shared with relevant Trust leaders. LCH also contributes to the external

system-wide OPEL reporting process to support the monitoring of wider system pressures. Any changes to the internal framework will be reflected in an updated version of this plan.

Emergency Preparedness, Resilience and Response (EPRR):
LCH has a suite of Emergency Preparedness, Resilience and Response (EPRR) plans including pandemic planning. These should be used in conjunction with the Trust's on-call procedures and service-level BCPs to ensure a coordinated and resilient response to emerging risks or incidents. As part of this suite LCH maintains a formal Incident Response Plan, which aligns with local, regional, and national emergency planning frameworks. It is designed to be flexible and adaptable to a range of scenarios.

3.2 On Call Arrangements

The Trust maintains a 24/7 senior manager on-call function throughout the year, ensuring timely leadership support for urgent operational issues and incident response. This consists of a first and second on-call manager, operating on a weekly rota system. The first on-call manager acts as the initial point of contact for most calls and is responsible for managing operational queries and incidents as they arise. Where necessary, they will escalate to the second on-call manager for senior oversight, advice, reassurance, or the establishment of a formal command structure. The on-call manager can be contacted via the dedicated number: **0845 265 7599**.

The on-call arrangements are designed to provide an immediate out-of-hours response and ensure safe and effective service continuity until normal business hours resume. These arrangements form a key part of the Trust's EPRR infrastructure and ensure that operational decision-making and escalation can happen.

3.3 Coordination and Oversight

The operational elements set out in this framework are overseen through established Trust governance structures. During the winter period, the Trust will maintain regular oversight through its internal business unit structures, performance panels, operational command arrangements, and winter planning leads.

Issues and escalations identified through OPEL reporting, business continuity triggers, or via the on-call system will be reviewed and escalated as necessary through Bronze, Silver and Gold command structures, in line with the Trust's EPRR and Incident Response arrangements.

4. Staffing and Workforce

LCH has effective, stable Temporary Worker Bank arrangements, and has increased both the number of people on the bank, and the fill rate of bank shifts, over the past 3 years. Agency should always be a last resort, once all internal options have been explored (bank, additional hours). LCH has existing arrangements with a range of Framework providers where needed, for clinical workers. Non-clinical agency workers will not normally be approved.

There is a Staff Mobility / Workforce Sharing protocol available for use across Leeds, which could be particularly useful for urgent Mutual Aid situations. Clear rostering guidelines and protocols are in place, to enable services to plan-in-advance to ensure appropriate capacity is available, including the management of safe staffing levels and planned absences.

4.1 Service Specific Workforce Plans

Service	WTE	Average Absence (Oct/Mar – AL, sickness etc)	10%	20%	Impact and Mitigation
Neighbourhood Teams (13 NTs)	405 WTE	116 WTE based on: 36 WTE Sickness 81 WTE AL- average 20% allowance per team	127.6	139.2	Unplanned Sickness – immediate review impact on service delivery and patient care; BCP and Action Cards are actioned. If the local NT is unable to cover essential patient visits, resource will be explored on a NT area level and then subsequently at a citywide level if required. Neighbourhood Team resource is fluid and can be mobilised to key pressure points to maintain patient safety and stood down when required. Opel levels (C1, C2 and C3) action cards are in place to support with consideration of the pausing of different elements which could release capacity. Should the unplanned sickness be forecasted to become long term appropriate Service Manager escalation to Head of Service to review overall impact. Daily morning huddles take place in the triage hub and across Neighbourhood Teams to review the starting position, led by Team Managers. Any immediate capacity concerns will be escalated to service managers and managed at a local level, then area level and the citywide level if required. If the surge in demand can not be resolved this would be escalated to Head of portfolio for consideration whether Opel Level for Neighbourhood Teams needs to be changed, for example Opel 2 to Opel 3. Internal process would come into action with daily capacity and demand meetings with Head of Portfolio and Service Managers. GM updated on position daily. Consideration of Bank/CLASS workforce.
Community Stroke Rehabilitation Team	24.57 WTE	5.99	6.59	7.19	If absence rates were to increase 10–15% during a period of high demand, the service would escalate to the SBU leadership team, review OPEL levels, and consider the use of mutual aid where appropriate. The service would also enact BCP procedures.

					During 2024–25, the service did not experience a rise in absence rates over the winter period. Sickness levels remained below the 16-month average of 5.5%. This has previously been managed within existing resources, and the service has not encountered staffing shortages that prevented the handling of short-lived surges in winter demand.
Home Ward Respiratory	9.0 WTE	2.92	3.21	3.5	Reports show average absence does not increase over the winter months and is relatively static throughout the year. Where sickness impacts on ability to provide 7-day service, extra hours / over-time is offered to cover weekends utilising staff from the Respiratory core team if needed. Service BCP covers significantly reduced staffing.
CIVAS	9.51 WTE	2.0	2.2	2.4	Shift patterns / roster to be looked at to maximise capacity during busiest times of the day. Liaise with OPAT to discharge patients on / transfer patients to oral antibiotics if safe to do so to maximise capacity.Offer extra-hours / over-time if essential to prevent readmissions.

Our overarching Admin Services are preparing for staff with mutual skills to work across specific areas who experience winter pressures. A review of C1/2/3 activity is also taking place in preparation for winter to aid in moving staff to C1 activity where necessary. The Children's services aligned to this plan are also carefully managing rotas abd annual leave to ensure full coverage and have internal arrangements within the service to move staff if required due to higher rate of absences or service need.

4.2 Sickness and Absence Management

LCH is launching a focused project to strengthen sickness and absence management, ensuring optimal staffing levels throughout the winter period. Initial work has commenced through targeted *Sickness Deep Dives* with services recording the highest absence rates. Building on these insights, further actions will be implemented to minimise service disruption and maintain safe, effective care during peak seasonal pressures. Sickness data for the services covered in this plan over the last year is provided in Appendix 2.

5. Adverse Weather Preparedness

In 2024 LCH produced specific Adverse Weather Plan, which is part of a suite of Emergency Preparedness, Resilience and Response (EPRR) plans which have been developed to provide the framework by which LCH will respond to specific incidents\events.

Adverse weather planning should also feature as part of service BCPs and have been reviewed this year in line with this plan. Below is a summary of the Trust's local adverse weather preparedness arrangements.

Area	Details or Mitigation Plan	Named Lead	Partner Agencies Involved
Local adverse weather plan in place	In place as part of our EPRR arrangements	LCH - Rebecca Todd, Emergency Planning Manager	Partner Trusts ICB WY Local Resilience Forum WY 4x4 Club
Staff travel disruption plan	In place as part of our EPRR arrangements Local arrangements in service level BCPs (Loss of staff\building denial) HR policy Fuel disruption plan	LCH - Rebecca Todd, Emergency Planning Manager	Generally managed on a local level. Partner Trusts
Adverse Weather Preparedness – Service-Level Reviews	Ongoing work for the Winter Planning Group looking at reviewing options on snow socks, snow shoes and 4x4 tyres in services. Undertake a review with affected teams to confirm winter travel preparedness.	TBC – Findings to be collated and reviewed by the Winter Planning Group.	Internal piece of work
4X4 specific arrangements	Memorandum of understanding in place with WY 4x4 Club. Offer in place, not as reliable as needed so currently an area of potential **risk** for certain services. Taxis may need to be resorted to, which comes with associated costs and delays. LCH currently in negotiations with the 4x4 Club to ensure LCH Priority. Voluntary Action	LCH – Rebecca Todd, Emergency Planning Manager	MOU with WY 4x4 Club

	Leeds are also being contacted to see if they can support. Remains high risk for certain services.		
Communication with Partner organisations	In place through system partnerships	Active System Leadership – Gill Warner, Operational Head of Portfolio LCH local working arrangements	Active system leadership through Silver Group\ICB lead Exec System Leadership – Sam Prince, Executive Director of Operations
Coordination with Voluntary sector	In place through system partnerships	City Silver\ICB	Arrangements in place through Active System Leadership\ ICB LCH has relationship with VCSE through Board membership.

6. Data Monitoring

To support system flow throughout the winter period, LCH will closely monitor key data indicators to track demand, capacity, and discharge activity across services. This will enable timely interventions, support effective resource allocation, and maintain patient flow across the wider health and care system.

Indicator or Dataset	Monitoring Frequency	Used For	Responsible Lead/Team
System visibility dashboard - new release to include NT demand, response times, home ward occupancy, NT case load size	Weekly including at weekly Winter Group meeting.	Monitoring flow, capacity and demand in key services.	Business Intelligence building due for release in September – service to then manage and use data.
Leeds system visibility dashboard	Daily	System Flow	Gill Warner, Operational Head of Portfolio linking in for LCH
Responsiveness - dashboard on contacts, waiting lists and referrals	Weekly report distributed. General dashboard available for services to do deep dive	Monitoring waiting lists across Trust,	Built by Business Intelligence – individual services to respond to data
Workforce absence rates	Monthly on PIP Well Led Dashboard	Assess staffing resilience and	ESR data accessible by service managers. Well led dashboard

	Daily on ESR for services when uploaded	trigger workforce plans as applicable	built by Business Intelligence and People Directorate.
OPEL Report as per national definitions reported externally	Daily via email and on PIP	Real-time system status and escalation coordination. Covers Wharfedale Community Bed Occupancy, No longer meeting criteria to reside, UCR 2-hour response, Virtual Ward occupancy.	Sam Prince, Executive Director of Operations Gill Warner and Victoria Storton Operational Heads of Portfolio in ABU monitoring
Internal OPEL levels (currently in review) via daily LCH Managing Escalations report.	Collects OPEL service from every service each day and circulated daily.	Monitoring real-time service pressures. Can be used to begin bronze/silver/gold command levels as necessary	Distributed by Business Intelligence, services update individually.
Health Equity Data – service level data available on PIP	Available on Power BI for services to access	Referrals, missed appointments, waiting times, broken down by IMD and ethnicity.	Individual services to engage with the data regularly and act accordingly.
Winter Vaccination rates (staff only) - Casandra	Weekly	Track uptake across LCH Staff	BI Manage report. Liz Grogan, Head of Infection Prevention and Control leading for LCH.

7. Communication and Engagement Plan

The Trust has established communication routes and engagement mechanisms to ensure staff and the public are kept informed, involved, and supported throughout the winter period.

Communication Area	Key Messages	Target Audience	Delivery Method
Internal staff bulletins	- Keep staff informed of winter pressures, escalation levels, and service changes - Promote wellbeing support	LCH Staff	Into the Week, My LCH,
Urgent SMS messages to staff	- A suite of messaging to be developed for cascade to staff	Staff	Text – logistics being worked through by Winter Planning Group

	in the event of bad weather etc.		
Staff Winter Vaccination Campaign	-Revised and enhanced internal offer for Flu - Staff invited via Casandra an internal booking system to book a vaccine. -Book a session with IPC at one of the many clinics running through to Dec. Roving offer from Jan-Mar 2026 to improve in low uptake teams. -Emails with prompts will be sent until decision logged. -Addressing myths, concerns and questions. FAQ's and resources available on the Oak -Vaccines can also be had at participating community pharmacy's	LCH staff. Extra emphasis on patient facing staff.	My LCH (Intranet) Into the week and My LCH Today (Internal Trust bulletins) Leaders Network emails Screensavers Posters Email signatures.
Public messaging around NHS pressures	- Where to get urgent help -When to call 111 - Get winter vaccines to help alleviate winter pressures	General public	Social media Patient Information Hub (Website)
National Comms around 111, pharmacy, and self-care	-Use NHS 111 service, online or use the NHS App when urgent but not life-threatening medical need. -111 for mental health. -'Think pharmacy first' campaign that pharmacists can provide some prescription medicines if needed, without seeing a GP. -Stay Well This Winter resources -Looking after neighbours -Hand Hygiene to avoid spread -Cold weather warnings and what to do to keep well -Christmas/New Years pressures- where and how to get help during bank holidays, protect yourself and families during holidays	General public	Social media
Flu Campaign (public)	- Promote vaccination and wellbeing messages. -Emphasis on pregnant women, parents/carers, children and people with long term health conditions. - Includes HPV, measles, RSV and whooping cough	General public	Social media

Urgent Responses e.g. to incidents and press	Actioned as required.	Press	Emails (check with ICB and LYPFT?) for consistent messaging

8. Wellbeing Support Offers

LCH recognises the ongoing pressures staff face over winter and remains committed to supporting their physical, mental, and emotional wellbeing. A range of health and wellbeing offers are in place to help staff stay well, feel supported, and sustain high-quality care during this challenging period.

Support Initiative	Description	Access Method
Health and Wellbeing Intranet Pages	A range of support including links to financial, mental and physical wellbeing	Available on My LCH
Mental Health First Aiders and Health and Wellbeing Champions	A point of contact for an employee who is experiencing a mental health issue or emotional distress. They are not trained to be therapists or psychiatrists but can offer initial support and provide guidance on support available.	Full list available on My LCH
Occupational Health	Occupational Health Services provided by South West Yorkshire Partnership Foundation Trust (SWYPFT)	https://swy.cohort.hosting/Cohort10/logon.aspx
Employee Assistance Programme (EAP)	A range of support and guidance is available from Health Assured for our staff, including self-help guides, top tips and counselling sessions (6 sessions free).	https://healthassuredeap.co.uk/ Username: Leeds Password: NHS - Phone Service: 0800 030 5182
Staff Wellbeing Clinical Pshychologist	A clinical psychologist whose role in LCH is focused on supporting the psychological wellbeing of the people who work in the Trust.	Jen Gardner can be contacted on: Jennifer.Gardner11@nhs.net
Freedom To Speak Guardian at LCH	An independent and impartial service. offering a confidential and supportive space to explore what is happening and what you might like to say about this to the organisation. Concerns can be raised locally or to Chief Executive and/or board level, concerns can be in a person's name or non identifiable.	John Walsh can be contacted on: john.walsh@nhs.net - 07949102354

9. Vaccination Strategy

Plans are in place for the Winter Flu Staff Vaccination Programme in line with Criterion 10 of the Health and Social Care Act Code of Practice (2008, updated 2022). During winter 2024/2025, LCH achieved a 49% staff flu vaccination rate. For 2025/2026, the target is 54%,

as outlined in the National Flu Immunisation Programme Letter from NHS England, aiming for a 5% increase on last year's figures.

Collaboration with colleagues from the Organisational Development and Inclusion (ODI) team will be central to driving uptake. Working together, we aim to influence attitudes and behaviours by addressing misconceptions, building confidence, and promoting the benefits of vaccination for both staff and patients. Through tailored messaging, inclusive communication strategies, and targeted engagement activities, the campaign seeks to change hearts and minds across the workforce. This partnership ensures that messaging is accessible, supportive, and resonates with diverse staff groups, ultimately supporting higher vaccine uptake across the Trust.

Flu vaccinations have been ordered via Moorhouse Medicines Management at LTHT and are scheduled for delivery in mid-September to Chapeltown Health Centre, with a proposed campaign start date of early October 2025. A detailed GANTT/Project Plan is in place, outlining a week-by-week schedule to track campaign progress. The IPC Team will engage bank staff in August to support vaccine delivery and begin planning rotas and any required training.

Staff will be invited to book vaccination appointments via the Casandra internal booking system, where all campaign data will also be recorded and monitored in real time. Work is underway to identify Flu Champions across each business unit to promote the campaign locally, with a specific focus on hard-to-reach teams such as Night Services and Custody Suite staff. Engagement with the Executive Team is ongoing to encourage leadership support and visibility. A combination of existing campaign materials and videos will be reused, supplemented by new resources where possible.

Consideration is also being given to the use of incentives to encourage uptake; however, evidence suggests these are most effective when combined with clear communication and strong leadership endorsement.

Finally, system-wide collaboration continues, with benchmarking of innovative ideas and best practice across partner organisations. A weekly collaborative system meeting will monitor progress, share insights, and review uptake figures across the region.

10. Fit Testing

To ensure the health, safety, and wellbeing of staff and to maintain full compliance with Infection Prevention and Control (IPC) standards, as stipulated in the *Health and Social Care Act: Code of Practice* (2008, updated 2022) and the Health and Safety Executive (HSE) INDG479 guidance, LCH operates a comprehensive fit testing programme for relevant clinical and frontline staff. This programme ensures that respiratory protective equipment (RPE) is both suitable and correctly fitted, thereby safeguarding staff during periods of heightened clinical risk.

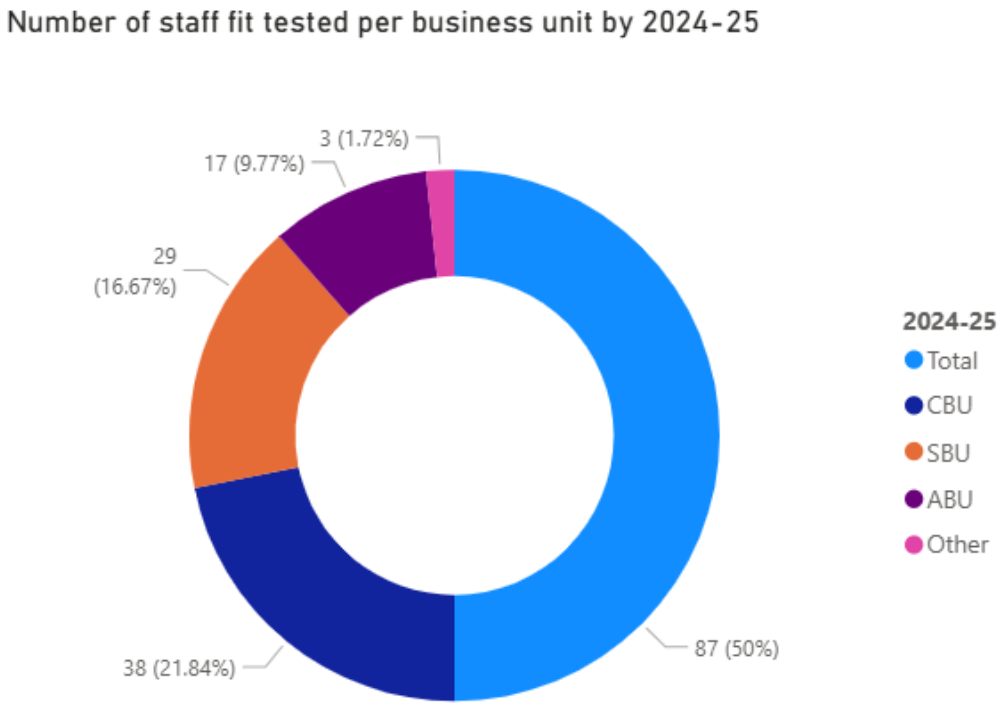
The fit testing process is currently transitioning to a fully digital, in-house platform, developed by Coreshare, with a phased rollout commencing in September 2025. The platform will be accessible via the Power BI application and has been designed to streamline and strengthen governance around fit testing by incorporating:

- A mandatory risk assessment for all clinical and frontline staff to determine individual fit testing requirements.

- An integrated booking system enabling staff to schedule fit testing appointments directly.
- Delivery of quantitative fit testing undertaken in-house by appropriately trained personnel.

Initial trials of the system are currently underway within the Dental and LSH services ahead of wider implementation. The platform will feature an automated daily data import from ESR, ensuring that staffing information — including starters and leavers — remains accurate and up to date. Furthermore, the system's integrated data reporting functionality via Power BI will enhance monitoring, enable efficient oversight, and ensure ongoing compliance with statutory and regulatory requirements.

The Pie Chart below shows the number of staff fit tested per business unit by 2024-25.



11. Outbreak Management and System Response

LCH has established robust procedures for the early identification, management, and containment of outbreaks across all services. These procedures are fully aligned with national guidance, including the *UK Health Security Agency (UKHSA)* framework, and are supported by the Infection Prevention and Control (IPC) team's expertise to minimise disruption, protect patients and staff, and ensure the continuity of safe, effective care.

In addition, LCH works in close partnership with Leeds City Council (LCC) and wider system partners through a formal Cooperation Agreement to ensure a coordinated, system-wide response to outbreaks. This collaborative approach enables:

- Real-time information sharing across system partners to facilitate rapid action.

- Joint decision-making regarding outbreak control measures and resource deployment.
- Consistent communication of public health messages and guidance.
- Integration of outbreak response plans across LCH, LCC, and other system stakeholders.

This coordinated system response strengthens resilience across health and care services, ensuring that outbreak management remains timely, effective, and aligned with both local and national requirements.

A specific outbreak management plan for LCH has been developed along with the Roles and Responsibilities matrix for the system response to outbreaks.

12. Bank Holiday and Christmas period planning

A full list of festive building and service opening hours will be circulated to On Call Managers in early December by the Facilities Team.

Any specific arrangements will be shared with staff that have on-call responsibilities over the Christmas and New Year Holiday Period. Christmas on-call arrangements are now split between on call managers with additional changeovers to ensure that the responsibilities are shared fairly. The Trust's arrangements will also be shared with the system through circulation of the ICB System Christmas and New Year Bank Holiday Plan.

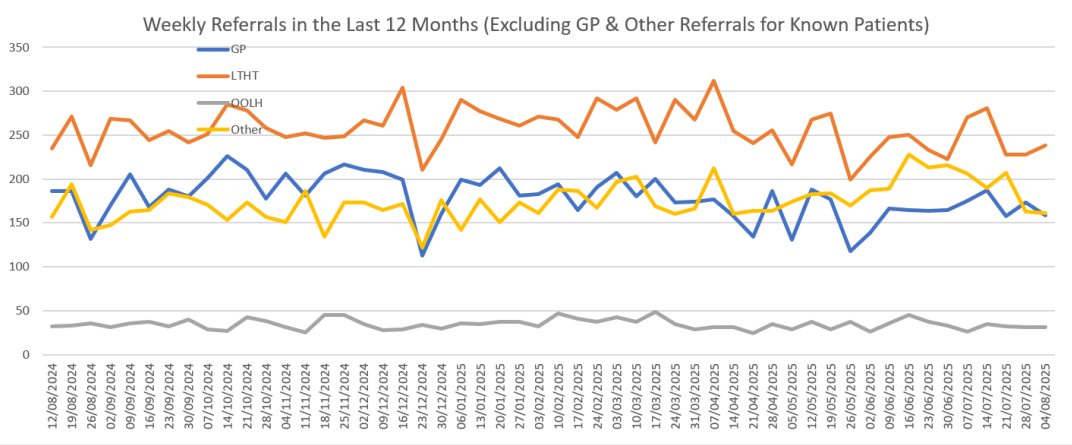
13. Evaluation plan

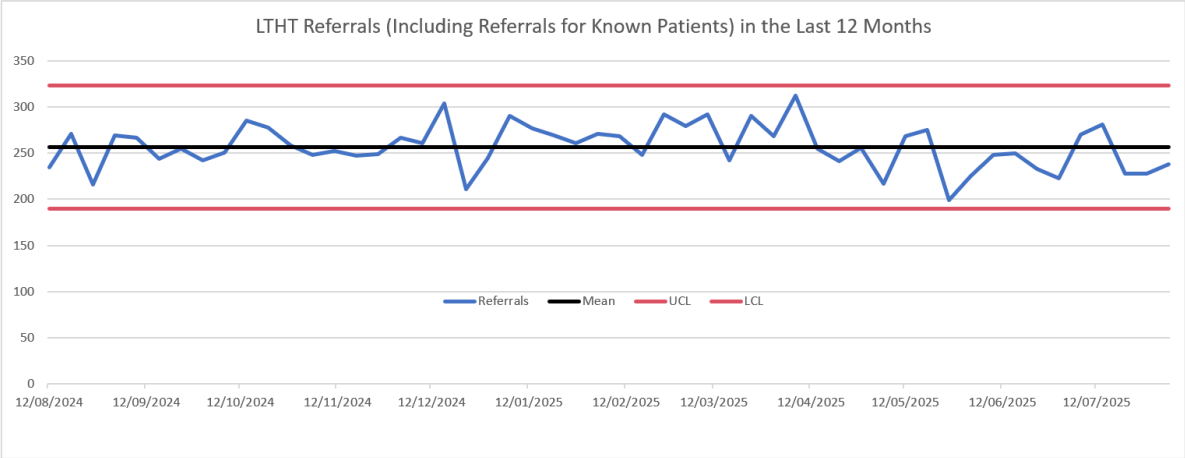
LCH will monitor the effectiveness of the Winter Plan through weekly 30-minute huddles with each of the three business units, providing a structured forum to identify emerging pressures, escalations, and support needs in real time. Insights from these huddles will feed into wider system planning and enable responsive decision-making. At the end of the winter period, a debrief workshop will be held with representation from across the Trust to review what worked well, identify areas for improvement, and inform future seasonal planning. This will be held in late April to allow information to be fed into the wider system evaluation workshops in May.

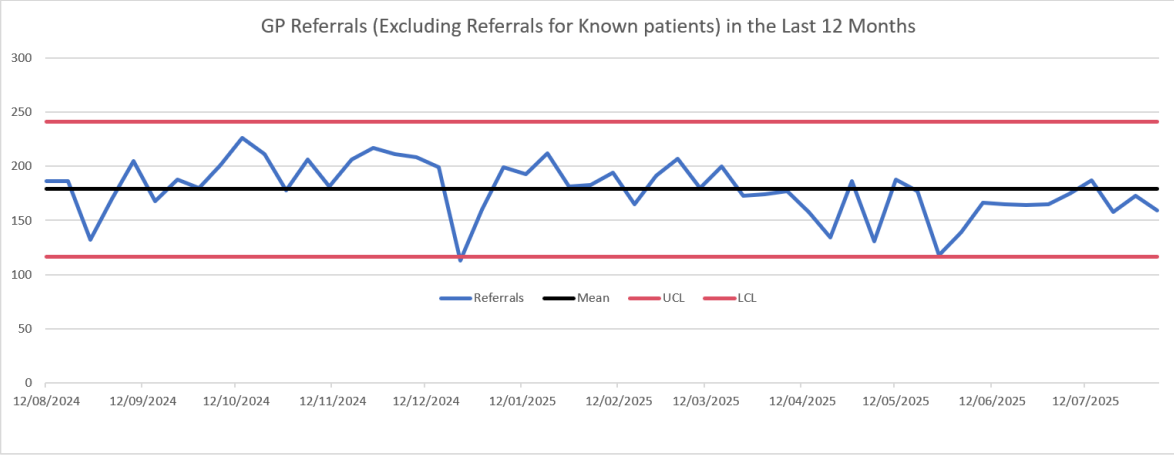
Appendix 1 – Winter 2024-2025 Demand

Neighbourhood Team Referrals

The three charts below demonstrate the peaks/surges in demand for the NT over the winter period, with demand consistently above the Mean average throughout the winter period.







Demand Winter 2024-2025 – Virtual Wards

		Oct	Nov	Dec	Jan	Feb	Mar	Average/Notes
Community Stroke Rehabilitation Team	Number of Referrals	65	54	63	74	78	81	61 (monthly average the over year)

Home Ward Frailty	Percentage Occupancy	Unav	Unav	Unav	78.5%	69.2%	73.8%	67.6% (Over first 7 months of 2025, higher than average in the avail winter months)
Home Ward Respiratory	Percentage Occupancy	97%	82%	70%	80%	58%	68%	69.5%
	Referrals	59	52	56	56	52	44	50 (monthly average the over year)
CIVAS	Number of Referrals	75	69	73	83	81	72	70 (monthly average over the year)

Appendix 2 – Sickness Rates Above 2024-2025 by Service

Services below with an average rate of sickness above 10%

Service	Team	2025-05	2025-06	AVERAGE
Respiratory, Cardiac, CIVAS, TB, HHIT	Home Ward (Respiratory)	17.40%	23.50%	13.49%
Admin Adults	Admin Nights	11.00%	11.60%	12.76%
Neighbourhood Services	Night Nursing	10.40%	11.00%	11.71%
Neighbourhood Services	Pudsey Neighbourhood Services	8.60%	11.50%	11.66%
Neighbourhood Services	Self-Management Team	15.60%	20.00%	11.02%
Neighbourhood Services	Neighbourhoods South Triage Hub	13.70%	23.00%	10.57%
CAMHS	CAMHS Outreach Service	13.70%	24.10%	10.39%
CAMHS	Crisis Helpline	6.90%	15.00%	10.27%
Patient Flow	Community Discharge Assessment Team	15.00%	12.50%	10.02%

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Double click on the template header to add details

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.		Initial draft considered by the Board on 4.9.25 Final sign off by ……
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.		In production and to be further informed by workshop 3 September.
The Trust's plan was developed with appropriate input from and engagement with all system partners.		Trust planning feeds directly into ICB level planning.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.		Takes place 3 September.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.		Executive Director of Operations
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.		
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.		
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.		Not applicable but note that robust plans in community services support system performance in these areas

Provider CEO name	Date	Provider Chair name	Date
Sara Munro		Helen Thomson	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.		
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.		
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.		
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	NA	
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	NA	
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.		
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.		
8. A patient cohorting plan including risk-based escalation is in place and		

	understood by site management teams, ready to be activated as needed.		
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.		
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.		
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	NA	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	NA	

Agenda item:	2025-26 (8)

Title of report:	Health Equity Strategy

Meeting:	Trust Board Held In Public
Date:	4 September 2025

Presented by:	Ruth Burnett, Medical Director					
Prepared by:	Anna Ray, Public Health Consultant Em Campbell, Health Equity Lead					
Purpose:	Assurance		Discussion		Approval	✓

Executive Summary:	Through the approach of a SWOT analysis, this paper provides an update on the progress against our strategic goal of equity and our statutory obligations, and considers how they are contributing to value as well as quality agenda.

Previously considered by:	None

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?	There is inequity in waiting times and in the pace of improvements for people in IMD1.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	• Chair and Committee Chairs to agree the continuation of the equity data question in Board and Committee paper cover sheets and plan, in discussion with the Exec Lead for Health Equity and Equity Lead, how this could be most effectively utilised going forwards. • Ensure the inclusion of equity measures in the Integrated Performance Report

Health Equity Strategy

1 Introduction

As an NHS Trust, LCH has statutory requirements to address inequity. Alongside this, the trust has made an ongoing commitment to identifying and addressing inequity in its care and pathways that contribute to wider inequity in health. Through the approach of a SWOT analysis, this paper provides an update on the progress against our strategic goal of equity and our statutory obligations, and considers how they are contributing to value as well as quality agenda.

2 Current position

2.1 Strengths

- **Implementation of Internal Audit recommendations**
  Following the Internal Audit in December 2024, the improvement actions have been delivered, namely: the revised Health Equity Leadership Group has senior leader representation from all Business Units; training has been delivered on the use of equity dashboards; resourcing for the delivery of the health equity action plan has been increased and; population health management data is now available to LCH staff and training has been delivered. This has supported renewed momentum and the funding of additional capacity. The EQIA process has been rigorously embedded within the quality and value programme; EQIA training continues to be delivered with increased familiarity with the processes across the organisation. Review of EQIA processes in line with audit recommendations have further strengthened processes and governance with further work underway to align with workforce impacts and processes. LCH EQIA processes are looked to as a strong example in the city.

- **Armed forces covenant**
  A year ago, LCH signed the Armed Forces Covenant, pledging our commitment to addressing disadvantage that members of the Armed Forces community (those currently serving, reservists, veterans and family members) may face when using our services or working for LCH. We have passed our one-year accreditation review, being recognised by the national team for the work of the Armed Forces Steering Group to bring together subject specialists and people with lived experience to drive forward our work.

- **Racial equity in care**
  The Racial Equity in Care Group is co-chaired by the Director of Nursing, AHPs and Quality and a member of the staff Race Equality Network. It enables us to deliver our statutory requirements under the Patient and Carer Race Equality Framework (PCREF) for our mental health services and expand learning and improvements in racial equity in our other services. The first three areas of focus where there is nationally- and locally-recognised racial inequity are: Black men's mental health; sexual health and; maternity. This established group will also contribute to associated improvement work such as Interpreting and Translation.

- **Leeds Healthcare Inequalities Oversight Group**
  A priority that has consistently emerged from the Trust Board in relation to health equity is for LCH to increase partnership working and strengthen its alignment with citywide initiatives. In February 2025, the Leeds Healthcare Inequalities Oversight Group was established. This group comprises of senior leaders and inequalities experts from across

the city, its purpose being to ensure tackling healthcare inequalities is embedded within every aspect of decision-making, resource allocation and service delivery across healthcare in Leeds. It is ultimately about making equity core business within healthcare. LCH has been pivotal in establishing the group and contributing to its progress. The group will be considering how we align and strengthen EQIA processes across the city to examine impacts on communities at risk of poor health outcomes.

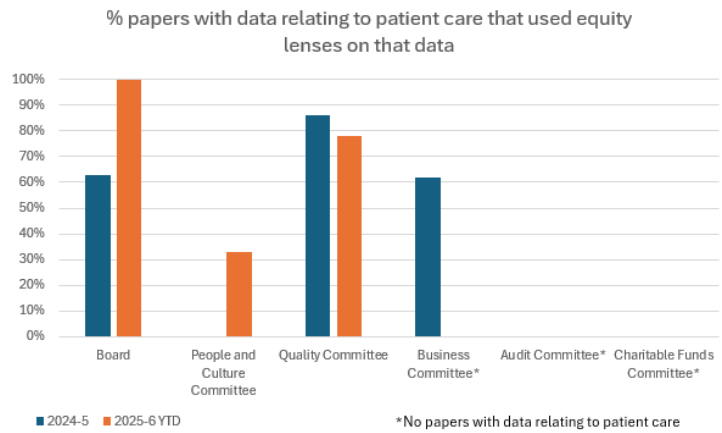
- **Improvement examples**
  LCH's new Information Hub makes information about our services and managing health conditions more accessible and inclusive. This includes a redesign of information, increased focus on self-management materials, expansion of Easy read resources and a suite of accessibility tools. This is vital when in Leeds, 42% of working-age adults are unable to understand or make use of everyday health information, rising to 62% when numeracy skills are also required for comprehension. This work goes alongside a digital inclusion programme of training for staff, EPR screening tool and partnership working with 100% Digital Leeds. It supports services to signpost to a greater range of resources that can meet wide variety of communication and literacy needs, acting as an enabler for service redesigns that meet our equity ambitions.

  When Podiatry made changes to the service, they had a focus on ensuring communication was clear, widely-shared and accessible. This included two different methods of direct communication with patients as well as sharing information about the change itself with patients, stakeholders and key sources of support / advocacy. Alongside this, they signposted to self-management guidance as well as sources of practical and financial support.

2.2 Weaknesses

- **Inequity in waiting lists**
  Recent publication of equity lenses on national waiting list data identifies that patients in the poorest communities and those from an Asian or Asian British background are more likely to be waiting longer than 18 weeks than any other group. We see inequity in LCH waiting lists too:
  - People from IMD 1 are waiting longer for services in consultant led and non-consultant led lists
  - In the evaluation of the Access LCH initiative to reduce waiting list sizes, there had been an 8% reduction in IMD2-10, but 5% in IMD1 (most deprived)
  - In some services, patients in our most deprived communities are currently waiting over 2 weeks longer on average for a first appointment

- **Data quality and use**



An equity data question was added to the Board and committee cover paper template to support chairs to monitor their committee performance and content against equity. The chart shows the inclusion of equity lenses in Board and Committee reports for the last 2 years, where data relating to patients was provided. Where there is equity data missing in papers, this is often raised by NEDs, but we are not aware of any reference to this section of the cover

paper within meetings, indicating that the cover sheet question has not yet driven committee change relating to equity.

Recommendation: Chair and Committee Chairs to agree the continuation of the equity data question in Board and Committee paper cover sheets and plan, in discussion with the Exec Lead for Health Equity and Equity Lead, how this could be most effectively utilised going forwards.

- **Permeation of messages throughout the organisation**
  Recent engagement and surveys identified limited recognition and use of equity resources such as the newly added IMD data to waiting list validation, PIP equity data and missed appointment guidance. Despite equity being better understood, there is an enormous task still to make equity part of usual business/practice. This involves defined roles and responsibilities across the organisations but also training and development.

2.3 Opportunities

- **Equity as a means to improve productivity**
  The focus on value and productivity provides an additional way to view the benefits of addressing inequity. In addition to the positive impact on individual access, experience and outcomes and on population health, addressing inequity also provides opportunities to address inefficiencies for example in waiting lists, missed appointments, adverse care incidents and lapses in communication. Equity improvement priorities are therefore focussed on these areas, for example supporting the Access LCH and Quality and Value programmes through missed appointments processes, principles for opt-in, opt-out and Patient Initiated Follow Up (PIFU), 'About Me' template and digital patient questionnaire, patient information on supporting attendance at appointments and the development of new waiting list events and resources.

- **Capacity**
  The new Equity and Learning Disability Improvement Manager and Equity Project Support are now in post, supporting delivery and implementation of key equity priorities. This will provide additional capacity to work directly with services and communities. Alongside this increased specialist capacity, the continued development of additional Health Equity Fellows provides increased expertise elsewhere in the trust.

- **Health Equity Development Programme**
  Through the Leeds Health and Care Academy, over the next two years, Leeds is embarking on a development programme on Health Equity. In its initial design and delivery, it will be predominantly focussed on nurses, midwives and AHPs, with ambition to expand the programme to other roles in the coming years. The programme aims to be a practical, action-orientated scheme, that provides staff with the ability and motivation to act on health equity within their day-to-day roles. This will include embedding equity into clinical practise, examining how health improvement and communication can improve access and experience for patients. It will also include clinical leadership levels, focussing more on embedding equity within quality improvement, performance and management. The team development level will provide opportunities for deep engagement with teams, including at LCH, to work together to address priority inequality issues.

- **Measurement of equity**
  The establishment of the Healthcare Inequalities Oversight Group has provided the opportunity to develop a health equity index that will line up how we measure equity across the city. This in turn will enable LCH to use this methodology in the Integrated Performance

Report as a metric for the success of its equity improvements. It will also provide a consistent approach that can be utilised to understand and measure the impact of service changes.

Recommendation: To ensure the inclusion of equity measures in the Integrated Performance Report

2.4 Threats

The huge system change that is underway risks equity being deprioritised. This, alongside the erosion of health equity and population health responsibilities in the ICB, has the potential for disproportionate impacts on groups at risk of worse health outcomes. Within LCH, the Consultant in Public Health has recently gone on extended leave. A 16-hour post to cover the citywide work that they lead has been agreed, but this will not provide cover for the specialist public health input into the provider trusts. While the equity work will continue, additional input into on the wider prevention agenda will be paused. The changes are significant, but the strengths, capacity and commitment in LCH to identifying and addressing inequity in LCH put us in good stead to take advantage of the opportunities, particularly by focussing on the value as well as quality benefits of equity improvements.

3 Risk and assurance

BAF risk 9 describes the risk of 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. Delivering the trust's commitment to embed equity in everything we do ensures that inequity in access, experience, safety and outcomes is identified and addressed.

4 Next steps

- Increased engagement with communities and services to develop and promote proactive approaches and mitigations for inequity, with a particular focus on barriers that arise through service change, cultural awareness and competency, communication and reasonable adjustments.
- Resources, citywide and internal workshops on equity in waiting lists
- Recruit cover for Public Health Consultant

5 Recommendations

The Board is recommended to:

- ensure the inclusion of equity measures in the Integrated Performance Report.

Chair and Committee Chairs are recommended to

- agree the continuation of the equity data question in Board and Committee paper cover sheets and plan, in discussion with the Exec Lead for Health Equity and Equity Lead, how this could be most effectively utilised going forwards.

Anna Ray and Em Campbell
Consultant in Public Health and Health Equity Lead
21 August 2025

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	**Report to:**	Trust Board 4 September 2025
Date of Meeting:	27th July 2025	**Date of next meeting:**	23rd September 2025

Introduction

Quorate meeting with a full agenda and good debate on key topics in relation to Quality Assurance in LCH.

Alert	Action
(1) Digital Letters – Jan-2025 migration; printer spooler fault blocked output. Queue cleared by deleting letters. **Scale:407/67k** letters deleted; **~250** identified so far. Mostly appointment letters; SMS reminders sent.	**Recovery:** Interim controls in place; report built to find affected patients; reissue underway. **Status:** TLT agreed to continue HCC print & post for **4 weeks** while investigating. **Board:** Note incident; receive update at 4-week point on root cause, recovery, and contract position.
(2) PSIRP Internal Audit - The Committee expressed concern that although work had been done to develop the process, the report had come back with Limited assurance. It was agreed that a robust plan was required to respond to the recommendations.	EDON to report progress to Audit committee and assurance given that the report will be reviewed and changes being made with full brief back to Quality Committee.

Advise

- QAIG Paper for 25/26 Presented and proposed changes in achieving effective assurance from QAIG to Quality Committee
- Performance Brief – This was a review for data in June 2025. All elements were discussed in Safe, Caring, Effective and Responsive. Discussion points around.

Committee Escalation and Assurance Report

- Quality & Value Programme – In regard to EQIAs, the Executive Director of Nursing and AHPs stated that reporting had been quieter in the period. A Non-Executive Director (AL) expressed concern that staffing was not a part of the EQIA end to end process. The Executive Director of Nursing and AHPs agreed to investigate this and an action was taken.
- R&I - The Clinical Head of Research set out a new Research Long Term Plan, replacing the five-year strategy and aligning with the Trust and the wider 10-year plan. Next steps are to build partnerships and confirm readiness. Funding will need Director of Finance sign-off with a clearer ask; LSH is out of scope as research isn't contracted. Including Research in the innovation pot was recommended, and the Committee expressed strong support subject to these follow-ups.

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Assurance

Safeguarding AAA provided assurance of compliance in this statutory committee and reporting good assurance to Quality Committee

IPCG AAA provided assurance of compliance in this statutory committee and reporting good assurance to Quality Committee

Risks Discussed and New Risks Identified

- 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

Committee Escalation and Assurance Report

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 care and exacerbating inequalities in health outcomes within some cohorts of patients.	12 (high)	Reasonable	N/A

Author:	Lynsey Ure/Helen Thomson
Role:	Executive Director of Nursing and AHPS/Committee Chair
Date:	26/08/2025

Agenda item:	2025-26 (9ii)

Title of report:	Safe Staffing Report – for information

Meeting:	Trust Board Held In Public
Date:	4 September 2025

Presented by:	Lynsey Yeomans, Executive Director of Nursing and AHPs					
Prepared by:	Lynsey Yeomans, Executive Director of Nursing and AHPs Caroline McNamara, Clinical Lead ABU Ram Krishnamurthy, Clinical Lead CBU					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	The paper describes the background to the expectations of boards in relation to safe staffing, outlining where the Trust is meeting the requirements and highlighting if there is further work to be undertaken. The report sets out progress in relation to maintaining safe staffing over the last six months. It covers the mandated in-patient areas only and for LCH these are Hannah House and Wharfedale Recovery Hub. Safe staffing has been maintained across both inpatient units for the time period.

Previously considered by:	Quality Committee 29 July 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?	N/A

Recommendation(s)	• Receive the report • Agree the level of assurance provided

List of Appendices:	

Safe Staffing Report

1 Introduction

In line with the NHS England requirements and the National Quality Board (NQB) recommendations, this paper presents the six-monthly nursing establishment's workforce review, alongside other staffing data.

This report will just report on the two in-patient areas which is what is mandated by the NQB for the last 6 months 1 January 2025 to 30 June 2025.

We continue to use a set of principles to monitor safe staffing in our in-patient beds.

2 Current position/main body of the report

Children's Business Unit (CBU)

Hannah House is the inpatient unit in the CBU. There are currently 3 vacancies (1 x Band 4 and 2 x B5) in the team only and there has been increased usage of bank staffing during this period. The bank hours utilised in the last 6 month are outlined below. Safe staffing levels have been maintained at all times.

Band 3 = 984 hours (101 shifts)
Band 4 = 34.5 hours (3 shifts)
Band 5 = 22.5 hours (4 shifts)
Band 6 = 4.25 hours (1 shift)

Total Bank = 1045.25 hours

Increased bank hours were due to sickness (both short term and long term) and maternity leave in addition to the vacancies. One member of staff left the Trust, however, decided to return and utilised bank hours (250 hours) until her substantive position was commenced. Also, we have had new families accessing Hannah House and subsequent increases in bed occupancy.

There have been no complaints. Once staff incident was reported but no harm was caused.

Forty-five nights were cancelled in total during the 6-month period and 91% of the cancellations were due to weather conditions, child illness, hospital admission, parent cancellations and children not ready for admissions.

Four nights (9%) were cancelled due to not having safe levels of staffing and these nights were re-offered immediately for the children in question.

Adult Business Unit (ABU)

Wharfedale recovery hub is a 24/7 bed-based service within the ABU. There are currently 5 vacancies (3 x Band 2, 1 x B5 and 1XB6) in the team. All Allied Health Professional (AHP) vacancies have been filled and are now in post.

There has been increased usage of bank/agency staffing during this period due to short and long term sickness, maternity leave and vacancies.

Safe staffing levels have been maintained at all times by using bank/agency. The bank hours utilised in the last 6 month are outlined below:

- Non-registered nursing staffing = 9,914 hours. This includes additional care for patients requiring 1:1 enhanced care, which totalled 862 shifts.

- Registered nursing staffing
  Band 5 = 456 hours (39 shifts)
  Band 6 = 23 hours (2 shifts)
  Band 6 AHP = 240 hours (32 shifts)

Total Bank hours = 10,633.25 hours

Wharfedale are now participating in the Enhanced Therapeutic Observation of Care (ETOC) NHSE improvement work that links to the 1:1 staffing requirements of patients requiring ETOC.

Staff turnover remains stable and staff that have left Wharfedale have been successful in securing higher banding roles.

There have been no complaints during this period with regards to staffing issues.

➢ 3 Next steps

This paper provides assurance to Trust Board in relation to safe staffing levels and that these have been maintained in the inpatient units during the last 6 months.

➢ 4 Recommendations

Trust Board are asked to receive this report and agree the level of assurance provided.

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 4 September 2025
Date of Meeting:	28 May 2025	**Date of next meeting:**	25 June 2025

Introduction

Quorate meeting. Very good debate with challenging conversations and constructive feedback provided on papers requiring comment. This Committee included a presentation of the Green Plan, the MindMate SPA Business case for approval and the Leeds sexual health online HSJ awards presentation.

Alert	Action

Advise

- The Committee welcomed and discussed the Green plan and the important contribution the Trust is making to net zero. The Committee discussed the challenges and issues in achieving the plan and were informed that relatively low-cost improvements could contribute to the reduction in carbon emissions in the next few years such as the introduction of solar panels. The Committee asked for a future update of the low-cost improvement plans. The Committee agreed, subject to some suggested improvements, the Green plan would be submitted to Board in July.
- The Committee received the business case proposal to sub-contract delivery of the MindMate SPA service to Northpoint. The Committee discussed the business case including its associated risks and were assured that the Trust had addressed the key risks; for example, patient waiting list volumes, staff issues and financials. The Committee requested that benefits were monitored during the life of the contract so that the Trust could reap the rewards from improvements made e.g. a reduction in costs due to efficiencies made during the current in-life contract. The Committee also discussed the digital solution and agreed it would be beneficial for closer interworking between all parties on the digital improvement plans. The Committee approved the business case submission to Board for final approval.
- The Corporate Savings Target Submission for NHS England was discussed and approved for submission.

Assurance

- Q&V – The Committee discussed the summary of the report with a focus on programme RAG trends and risk. The Committee welcomed the CIP approach recommended by NHS England and noted that work is underway to assess how it can be applied to the current Q&V programme. The alignment of programme risk and financial risk was also discussed for future reporting improvements.
- The Committee noted the verbal update on the Neighbourhood model with LCH involvement in the Leeds City Council's 'Sounding Board Group' and the continued 'Home First' Programme improvements such as the commissioning of a piece of work to review e.g. earlier interventions. The Committee noted and applauded the achievement of the launch of the Single Care Record which has gone live and requested an update/demonstration at a future Committee.

Committee Escalation and Assurance Report

- The Committee discussed the NHS Provider Strategic Review with the launch event on May 30 and noted the importance of LCH's continued involvement alongside all system partners.
- The Committee received a summary of the organisation strategy development plans with Health Watch and discussed the benefits of feedback loops into the NHS Provider Strategic Review and the Neighbourhood Health model.
- The Committee noted the updates on the Tenders/Contracts/Commissioners intention including the early notification for the 0-19 service tender in 2026.
- The Committee discussed the 'End of Year Trust Priority report', noted the achievements, and discussed communication improvements of the report for assurance including more on outcomes and presentation style for easier assimilation of the results.
- The Committee discussed the Performance Management updates including financials. The Committee discussed the HSJ Digital Innovation Award presentation for the Leeds Sexual Health System. It noted the benefit for patients and the community with an innovative digital approach and collaborative use of partners. The Committee discussed the significant efficiencies e.g. 2698 requests since July saved 1058 clinical hours to date. The Committee also suggested reviewing the sustainability benefits e.g. net zero emission savings. The Committee wished the team luck at the awards ceremony!
- The Committee noted the progress on Waiting Lists and welcomed the new breakdown in statistics for further assurance on activities, with a request to include these in future reports.

Risks Discussed and New Risks Identified

- The Committee agreed that it had received reasonable assurance against all relevant strategic risks. 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	MindMate SPA business case was approved for submission to the Board supporting children and young people in Leeds with emotional well-being and mental health needs.

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	Leeds Sexual Health presentation for HSJ Awards provided assurance of innovative investment with digital enablers.
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 discussion included: - the pay award settlement emerging. - The wider system has a stretch target of £5.2M and it is not yet known what LCH's 'fair share' contribution may be. - Q&V recurring benefits for Year 2. - The Corporate Savings Target Submission for NHS England was discussed and approved for submission.
Risk 6 Failure to have sufficient resource to transformation programmes: If there is insufficient resource across the Trust to deliver the Trust's priorities and targeted major change programmes and their associated projects then it will fail to effectively transform services and the positive impact on quality and financial benefit may not be realised.	9 (high)	Reasonable	
Risk 7 Failure to maintain business continuity (including response to cyber security): If the Trust does not have suitable and sufficient staff capacity, capability and leadership capacity and expertise, within an engaged and inclusive workforce then the impact will be a reduction in quality of care	12 (high)	Reasonable	

Committee Escalation and Assurance Report

and staff wellbeing and a possible misalignment with the objectives of the Q&V programme.			
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	

Author:	Lynne Mellor
Role:	Committee Chair
Date:	29/05/25

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 4 September 2025
Date of Meeting:	25 June 2025	**Date of next meeting:**	30 July 2025

Introduction

Quorate meeting. Challenging conversations and constructive feedback provided on papers requiring comment. This Committee included a presentation of the Procurement Strategy, a redrafted Green Plan, and the Neighbourhood model/Community collaborative.

Alert	Action

Advise

- The Committee welcomed the refresh of the Green plan including the reinvigoration of the Sustainability Pledge campaign and the first pledges to be made by the Trust's Board Members in July. The Committee applauded the team for being nominated for a national staff benefit award given the Trust's plans e.g. on 'green vehicles' as part of staff benefits and wished the team good luck! The Committee were assured by the actions and improvements and approved the plan.
- The Committee discussed the National Cost Collection 2024/5 pre-submission planning report and were assured the report meets the expected requirements. The Committee delegated authority to the Director of Finance to submit the costing submission on 4 July 2025.

Assurance

- Q&V – The Committee applauded the significant assurance given by internal audit. It also welcomed the improvements to reporting including RAG trends and the planned forthcoming updates to address the recommendations from Audit, and NHS England on transformation plans. The Committee noted the achievements in month two. It discussed the risk around achieving the recurring benefit target for the year (e.g. Corporate and digital programmes) particularly as significant benefit is forecasted for delivery towards the latter half of the year. The Committee discussed the need for more insight into key outcomes from initiatives including digital. The Committee also discussed the need for a review of the medium-term transformation strategy to set the Trust on a continued positive trajectory. The Committee discussed the cultural engagement of the workforce to move to a business-as-usual modus operandi for transformation. The Committee also noted the requirement for a continued focus on the mitigation of risks arising from transformation 'fatigue' and lack of engagement.
- The Committee received the Procurement Update in support of the Trust's procurement strategy, working in tandem with Leeds York Partnership Foundation Trust. The Committee were assured that the plan is on track including reviewing system level improvements, and the resourcing to manage the review of twelve strategic projects. The Committee did discuss the benefits realisation and wondered if plans could be accelerated to address the gap. The Committee noted the significant ongoing work by all teams involved to improve procurement with a clear cultural shift and approach.

Committee Escalation and Assurance Report

- The Committee discussed the update on the Neighbourhood model/Community Collaborative. The Committee were assured that the programme of work is progressing with four key focus areas for this fiscal: i) Home First Phase 2, ii) Community Mental health transformation, iii) Children and Young People with particularly complex needs and iv) Early identification of Cardiovascular Disease. The initial focus will be on 2-4% of the population with complex health needs in Leeds.
- The Committee noted the Provider Partnership review initiative has held workshops to engage with initial stakeholders.
- The Committee noted the update on the White Rose Park Office lease – discussions are ongoing.
- The Committee discussed the Finance Report which outlined the year-to-date breakeven position, and the full year forecasted break even position. The Committee noted the Trust's strong cash position. A focussed discussion centred on recurrent savings and plans to mitigate the risk with the ask for regular updates as the plans develop.
- The Committee noted an update on Waiting Lists will be presented in July.
- The Committee noted the Internal Advisory Audit Report for Procurement, and noted there were plans in place to address the improvement advice (e.g. via the procurement strategy and plans).
- The Committee discussed the Internal Q&V Audit report, welcomed the significant findings, and recognised there is more work to do to make improvements and were assured plans were in place to address.
- Risks to escalate to other committees – Given the discussion around potential transformation fatigue in some parts of the organisation, the Business Committee agreed it would raise again to the People and Culture Committee (P&CC) with a suggestion for the P&CC to have a 'deeper dive' into the root causes and determine actions to address any impacts on culture and engagement.

Risks Discussed and New Risks Identified

- The Committee agreed that it had received reasonable assurance against all relevant strategic risks. 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

Committee Escalation and Assurance Report

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.	16 (extreme)	Reasonable	The Committee discussed contributions from the Q&V workstreams. The Neighbourhood Model programme was reviewed including the 6 key components of the overall plan and 4 key focus areas for this fiscal.
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.	9 (high)	Reasonable	The National Cost Collection Pre-submission report provided assurance
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.	16 (high)	Reasonable	Risk discussion included: Q&V, procurement, and finance reports Risk discussed around culture and the consequences of ongoing transformation including the perception and presentation of 'transformation fatigue.' BC agreed to reinforce risk identified previously and flag to People and Culture Committee for further investigation/mitigation.
Risk 5 Failure to maintain business continuity: If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.	12 (high)	Reasonable	The Procurement strategy outlined plans to adhere to the February 2025 act, particularly on supply chain, cyber security, and business continuity linkages.
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, within an engaged and inclusive workforce then the impact will be a	12 (high)	Reasonable	Collaboration and partnership discussed during in particular, but not exclusive to, Q&V, Procurement strategy, Green Plan, Neighbourhood model and the Provider Partnership review.

Committee Escalation and Assurance Report

reduction in quality of care and staff wellbeing and a possible misalignment with the objectives of the Q&V programme.			

Author:	Lynne Mellor
Role:	Committee Chair
Date:	26 June 2025

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 4 September 2025
Date of Meeting:	30 July 2025	**Date of next meeting:**	24 September 2025

Introduction

Quorate meeting. Robust discussions and constructive feedback provided during the Committee. This Committee included a presentation of the Medium-Term Plan, the Trust's plan to address the National Oversight Framework, as well as papers covering for example Digital, Third Sector Strategy, Organisational Strategy Development and Risks

Alert	Action
• Digital Letters – The Committee is concerned about the unknown risk to patient safety. This was also flagged at the Quality Committee. • The Committee discussed a need for urgent action including resolution of the technology issues which will help with any future legal negotiations if needed. Benchmarking with other Trusts who can already do digital printing (phase 1 and 2) was discussed with current and alternative suppliers who can provide viable solutions. Gaining assurance from Technology partners in writing as to their understanding of the problem and their view of next steps to reach a solution.	A clear prioritised plan to reach resolution, covering potential options for mitigating risks to patient safety, business case impact and any feedback from ICO. Technology resolution needed – consideration of a credible external independent review with technical expertise.

Advise

- The Committee welcomed the Medium-Term plan and noted the national shift to a 3-year revenue and 4-year capital spend review. The Committee discussed the pace required over the next few months to firm up this full-scale operational plan.
- New BAF strategic risks – these were discussed and noted.

Assurance

- Q&V – The Committee welcomed the further improvements to reporting including the addition of the NHSE financial RAG status and YTD versus Forecast. The Committee were given some assurance that the programme was on track to breakeven despite the £1.1M slippage YTD. The Committee discussed the need to understand the disproportionate effects the programme could have on staff and what plans are in place to mitigate any risks.
- Neighbourhood model/Community Collaborative - The Committee were assured that the programme is now starting to see avenues of funding such as the National Neighbourhood Health implementation programme has asked for bids by the 8 August. The Leeds bid focuses on the city's 6 priority neighbourhood areas plus Chapeltown with a focus on supporting people with long term health conditions in those neighbourhoods. Assurance was given that there is broad boundary alignment between the priority areas (based on electoral wards) and Primary Care Networks. Other funding opportunities included the Delivering

Committee Escalation and Assurance Report

100-day missions initiative, and Community Growth and Development Funding. The Committee also discussed the work with Newton on early prevention. The Committee suggested it would be good to see a mapping of all the initiatives and plans

- Provider Partnership review – Committee noted the update on the first phase following stakeholder feedback, resulting in some positive key findings and reflections such as acknowledgement that the system governance needs to be simpler and more joined up; and Clinical outcomes need to be better, being actively led and prioritised in our partnership programmes. The second phase of the programme will result in a 12-month roadmap. The Committee was given some reassurance that the recommendations from the programme should aim to make a difference to Leeds citizens and not just recommendations around organisational form.
- The Digital Data and Technology Strategy Quarterly update was noted. Committee applauded the successful roll outs, and wondered if the next update could show key milestone plans and direct financial benefit attributable to the updates, aligning where possible with Q&V programmes.
- The Third Sector Strategy Report was noted and welcomed. The Committee echoed the disappointment in the loss of a long-standing partner - The Market Place
- The Organisational Strategy development report was noted, with more detail to be provided at the next planned meeting.
- Performance Report - the Committee requested more detail on deteriorating waiting lists position, and requested not just to focus on 52 week waits. The Committee also discussed the need for waiting list expertise in the organisation and suggested lessons could be learned from Acute Trusts.
- Finance Report - outlined the year-to-date breakeven position, and the full year forecasted break even position. The Committee noted the ICS is forecasting full delivery of plan thus should receive £49.2M deficit support funding.
- The National Oversight Framework – Committee welcomed the discussion, noting that LCH was currently in Segment 4. The Committee noted the key drivers for LCH segmentation at present are 52 week waits, staff engagement and sickness absence. The Committee requested if the Trust could obtain more detail from the national team to inform the knowledge gaps around comparator organisations.
- The Waiting List update was discussed as part of the Oversight plans. The Committee discussed Domain 1. It noted that with Access to Services waits for Neurodevelopment Assessments in CAMHS (for children over 5) and dental waits are currently not included in the current framework, but it is expected these will be included in future. In SBU the Committee discussed areas of concern including those services with over a 65 week wait – for example, the Adult speech and language service despite having increased their capacity are having to prioritise and focus on emergency cases i.e. those patients with swallowing difficulties are seen within 2 weeks. The Committee was given some assurance that current models are being reviewed to see if things can be done differently. The Committee also discussed in this Domain CAMHS long waits for children with Neuro Developmental issues, and the need to review pathways in conjunction with the wider Leeds area. The Committee noted additional investment of c£700k would be needed to help resolve the PND (Neurodevelopment Assessment for under 5s) waiting list. Domain 2 – 2-hour access was above designated target of 70% but ambition was 85-90%. The Committee was given assurance this can be sorted quite quickly with Virtual Ward tweaks to the recording process. Domain 4 - It was noted a more in-depth review would be led by the People and Culture Committee. The Committee noted the plan re sickness rates looking at service deep dives, policy and procedures, and targeted cause analysis. It also noted Staff engagement plans including further data analysis and communications. The Committee noted Domain 5 – with work

Committee Escalation and Assurance Report

underway to review the finance and productivity measures and any actions needed. Overall, the Committee discussed the Domains and the need for an Audit review of all patient pathways.

- Safe Staffing Report was noted, and Committee questioned the need to for it to be received in future at the Business Committee
- The Committee noted the PAM report, and the HSG minutes.
- The Committee requested the Service Focus presentation is moved to September to provide more time to discuss the achievements.

Risks Discussed and New Risks Identified

- The Committee agreed that it had received reasonable assurance against all relevant strategic risks. 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 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.	16 (extreme)	Reasonable	Waiting Lists were discussed in conjunction with the NOF. Safe Staffing report.
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.	9 (high)	Reasonable	NOF discussion and Digital Letters
Risk 4 Failure to deliver financial sustainability: If the Trust cannot manage its resources effectively, ensuring that	16 (high)	Reasonable	Emerging risk on cash related to interest receivable.

Committee Escalation and Assurance Report

spending does not exceed available funding, then this could jeopardise delivery of our strategic goals and priorities.			
Risk 5 Failure to maintain business continuity: If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.	12 (high)	Reasonable	Digital Letters was discussed in detail including mitigation of risks to patient safety and business continuity.
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, 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	Neighbourhood Health Model, Provider Partnership review, and Third Sector Strategy update were covered in detail with LCH collaboration.

Author:	Lynne Mellor
Role:	Committee Chair
Date:	30 July 2025

Committee Escalation and Assurance Report

Name of Committee:	Audit Committee	**Report to:**	Trust Board 4 September 2025
Date of Meeting:	8 July 2025	**Date of next meeting:**	14 October 2025

Introduction

Quorate meeting with a full agenda and good debate on key topics – good challenging conversations, particularly around internal audit outcomes, and considered useful to have director presence for further discussion around low/limited internal audit outcomes.

Alert	Action
• N/A	

Advise

- External Audit – Committee received the Annual Report summarising the work of Forvis Mazars during 2024/25. No material changes to previous update. Delay to issuing of the audit completion certificate noted, but the GAM had been updated to allow Annual Reports and Accounts to be published and AGMs to be held.
- Appraisals Internal Audit Report (low assurance) – Director of People attended to discuss the outcome. Reassurance provided that since the report had been issued, validation had proved that the gaps identified in the report were not evidenced in practice, and all actions and recommendations had been progressed. Appraisal compliance was discussed at monthly meetings in business units. Committee noted that further work was required on quality issues and compliance levels, and an action plan should be produced. Further discussion would be held at People & Culture Committee in September.
- PSIRF Internal Audit Report (limited assurance) – weaknesses found in the application of PSIRF within Datix. To be discussed in more depth at the Quality Committee in July, and the Executive Director of Nursing to be invited to October's Audit Committee to provide an update on progress against recommendations.
- Internal Audit plans – Committee advised that the 2024/25 plan had been delivered in full, and the delivery of the 2025/26 plan had commenced. Further consideration to be given to the scheduling of financial sustainability audits in 2025/26 as concerns raised that they were late into the financial year. Some concerns around the closed recommendations on the Mortality Rates and Learning from Deaths audit without evidence of implementation, and further evidence to be sought.
- Board Assurance Framework – process report received, with Committee agreeing it had received significant assurance around the effectiveness of the BAF process. Trust risk appetite to be held on 10 July. Committee reviewed the adequacy of the sources of assurance for strategic risk 5 (failure to maintain business continuity), and agreed more evidence and assurance around the testing of controls was required. To be included in the next quarterly review.

Committee Escalation and Assurance Report

- Cyber security update – report noted. Discussion around recent phishing exercise and lack of uptake on Audit Yorkshire training offered as a follow up. Further training to be offered but was not mandatory.
- Information Governance and Data Security Update – six monthly report received. Concerns raised around 155 out of compliance mobile phones with outdated operating systems, leading to inability to achieve Cyber Essentials +. Noted as a risk on the corporate risk register. A further update to be included in the next report to Committee. Backlog of responding to Freedom of Information requests noted, along with actions to reduce the backlog.
- Data Security Protection Toolkit – independent assessment rated the Trust's overall risk environment for data security and information governance as high, and confidence in the DSPT self-assessment was medium. Implementation plan against the recommendations to be reported back to Committee, and an update report to be received in October.

Assurance

- Counter Fraud – 2024/25 annual report received and full compliance against the Counter Fraud Functional Standard Return noted.
- Committee received and noted the Tenders and Quotations waiver report, Losses and Special Payments report, and Gifts, Hospitality and Sponsorship report for 2024/25.

Risks Discussed and New Risks Identified

- Out of compliance mobile phones

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 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.	12 (high)	Reasonable	N/A

Author:	Helen Robinson/Khalil Rehman

Committee Escalation and Assurance Report

Role:	Company Secretary/Committee Chair
Date:	05/8/2025

Committee Escalation and Assurance Report

Name of Committee:	Charitable Funds Committee	**Report to:**	4 September 2025
Date of Meeting:	1 July 2025	**Date of next meeting:**	9 September 2025
Chair:	Alison Lowe	**Parent Committee:**	Trust Board

Introduction

This report identifies the key issues for the Board from the Charitable Funds Committee held on 1 July 2025 Quorate meeting with good debate on key topics

Alert	Action
No alerts	

Advise

- A CPR-a-thon would take place on 16 October 2025 – planning was underway for the event.
- The Yorkshire Three Peaks Walk would take place on 6 September 2025; this was being promoted via internal and external comms. Six walkers had been secured so far.
- One runner had been confirmed for the London Marathon. Applications were open for the second runner. A £100 contribution was required to secure the place with a minimum fundraising target of £2000. The Charitable Funds Officer explained the rationale behind the application process.
- The Giving Voice Choir joined the SBU Celebration Event in June. The latest donation from members was £716.28.

Assurance

- The charitable funds officer presented to proposed 3 year plan for the charity.
- Finance report covering December –June 2025 received and accepted
- Discussion on progression of the Chariatable funds officer role. Paper coming to BoD 4th September

Risks Discussed and New Risks Identified

No new risks identified

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

Committee Escalation and Assurance Report

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

Author:	Lynsey Ure
Role:	Director of Nursing and Allied Health Professionals
Date:	1 July 2025

Agenda item:	2025-26 (13i)

Title of report:	Performance Brief

Meeting:	Trust Board Held In Public
Date:	4 September 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:	Business Committee Quality Committee Senior Leadership Team NB July's finance data has not been through committees

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

Is Health Equity Data included in the report (for patient care	Yes	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

and/or workforce)?	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 – Data Pack Appendix 2 – HLI development update

LCH Performance Brief

June 2025 and Q1 2025/26

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 remains broadly similar. One more measure NHS talking therapies DQMI score is now consistently passing its target.

Good progress continues to be made in the Trust' appraisal rate and training compliance as performance continues at its improved level.

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

Audit Yorkshire continue to support on a fundamental review of the Trusts performance and accountability systems and processes. The National Oversight Framework (NOF) has been released by NHS England within the last month, which will also impact how Trust performance will be assessed and measured. Throughout the remained of this financial year the Performance Brief will be revised to reflect the NOF and the review from Audit Yorkshire.

Alongside a proposal for a new IPR format, a draft Performance and Accountability Framework to link the Trust vision to measurable outcomes is in the process of being developed. Underpinning this is:

- Proposed revised Terms of Reference for performance management processes to strengthen oversight and learning
- A Governance Summary Template to define roles and escalation routes
- Standardised reporting templates
- a KPI Master Data File mapping each indicator to strategic goals and owners

The work is due to conclude at the end of September.

Table 1a – Summary of SPC Indicator Performance and Assurance

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

Table 1b – Non-SPC Indicator Summary

No Concern	Concern
cDiff Infections	CAS Alerts Outstanding
E.Coli Infections	Deteriorating Patient Incidents
MRSA Infections	Eating Disorders 1-week Urgent Target
MSA Breaches	Fall Incidents
NCAPOP Audits	Meatal Tear Incidents
Never Events	Medicines Code Assurance Checks
NICE implemented from 2019	NT Clinical Triage Incidents
NICE implemented from 2020	Overdue PSII Actions
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
Positive Patient Feedback	Inconsistent, Improving	Inconsistent, No change	The percentage of patients and service users that would recommend the service is above average in recent months; however, we have only met our target twice in the reporting period.
18-week waiting list target (non-RTT)	Failing, Deteriorating	Failing, Improving	Despite performance remaining significantly below the required target, the Trust has now achieved 6months consecutively of month-on-month improvement, which confirms that statistically significant improvement is taking place
NHS Talking Therapies 18-week treatment target	Passing, No significant change	Passing, Improving	Following recent improvements, good performance continues at a consistent level.
NHS Talking Therapies Screening within 2 weeks	No change, No target	Deteriorating, No target	There is consistent level of lower than usual performance.
Pressure Ulcers Incidents	No Concern	Concern	1 of 9 incidents closed in June related to LCH care which met the criteria for statutory Duty of Candour.
Fall Incidents	No Concern	Concern	Data for incidents closed within the reporting period suggests upward trend in this area, however no falls incidents in June were identified as related to LCH care.
Deteriorating Patient Incidents	No Concern	Concern	2 of 3 incidents closed in June were identified as related to LCH care and met the criteria for statutory duty of candour.

Indicator	Previous Report	This Report	Narrative
Meatal Tear Incidents	No Concern	Concern	1 of 2 incidents closed in June identified as related to LCH care which met the criteria for statutory duty of candour.
NT Clinical Triage Incidents	No Concern	Concern	Historically this has been 0 each month, however 3 incidents were closed in May and June. None of the incidents closed in June related to LCH care.
DQMI – IAPT	Inconsistent, Improving	Passing, Improving	Performance has improved and remains above the target.
BME Staff Proportion	Failing, Deteriorating	Failing, No change	Following 5 months of deteriorating performance, this measure has stabilised over the previous 2 months but is below target at the end of June.
RIDDOR incidents	No Concern	Concern	1 RIDDOR incident occurred in May
Medicines Assurance Checks	No Concern	Concern	The Trust failed to meet the 100% in Q1, and a number of services remain with outstanding checks to complete. Further narrative is given below.

Safe

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

Summary

The Compliance with Level 1 and 2 Patient Safety Training continues to improve month on month, a request for the inclusion of monitoring this measure specifically via performance is for consideration to ensure teams with lower compliance protect the time for this to be completed.

The new Patient Incident Management Policy which is due to Clinical and Corporate Policy Group in July, once launched, will include processes for additional monitoring and assurance around actions from Patient Safety Incident Investigations. This will include actions being added as a risk to the risk register. PSII actions should be monitored to ensure these do not go overdue and evidence that the action taken meets the requirement of the action with evidence of implementation. Actions will be audited to close the loop and provide assurance that learning has been embedded before the risk is closed.

Following the review of the Patient Safety Incident Response Plan for 2025/26 Pressure Ulcers, Falls Meatal Tears and Clinical Triage Incident have been removed from the PSIRP priorities it is therefore proposed that this KPI is removed from Performance Reporting for 2025/26 as previously agreed. The Trust has been compliant with all statutory duty of candour in this reporting period.

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?

The data continues to show an improving picture over the last 10 months between September 2024-June 2025 however this remains below the 95% target.

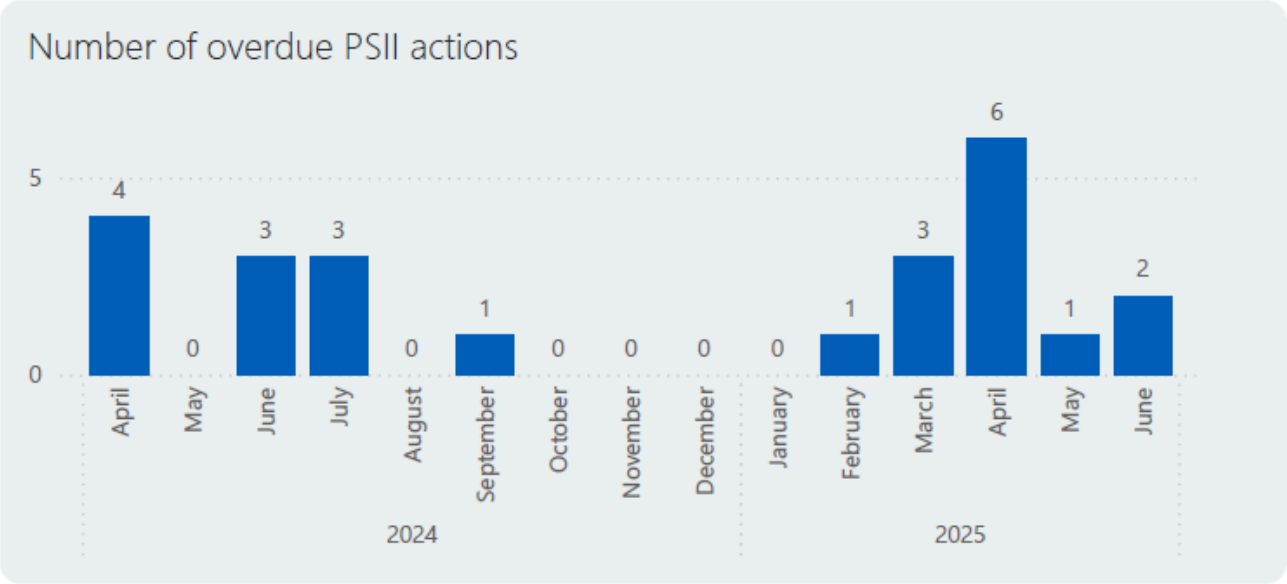
What is being done about it?

This should be monitored via the performance panels in teams as part of the statutory and mandatory training. On review of the performance template all statutory and mandatory training is grouped together with subject compliance not reported on individually. This will need to be considered to ensure monitoring and prioritisation for teams/staff who have not completed this. Request from this report for this to be considered for future performance reporting.

When do we expect to see improvement?

When the above has been considered and implemented. Proposed timeframes will be considered with Business Unit colleagues.

Number of overdue PSII actions



What is the trend that we see?

Patient safety incident investigation actions are not being completed within the allocated timescale and are becoming overdue without escalation or request for extensions as per the established process in advance of the due date. There are currently six overdue PSII actions (one March, one April and four June), all linked to incidents for the Adult Business Unit.

Three of the actions relate to deteriorating patient and sepsis- two pending launch of the deteriorating patient policy which is due to SLT week commencing 21st July to be ratified and one action relates to the introduction of the Restore 2 soft signs of sepsis tool which is being trialled in practice for end user feedback before going live on SystmOne. The remaining three actions will require an update on progress.

What is being done about it?

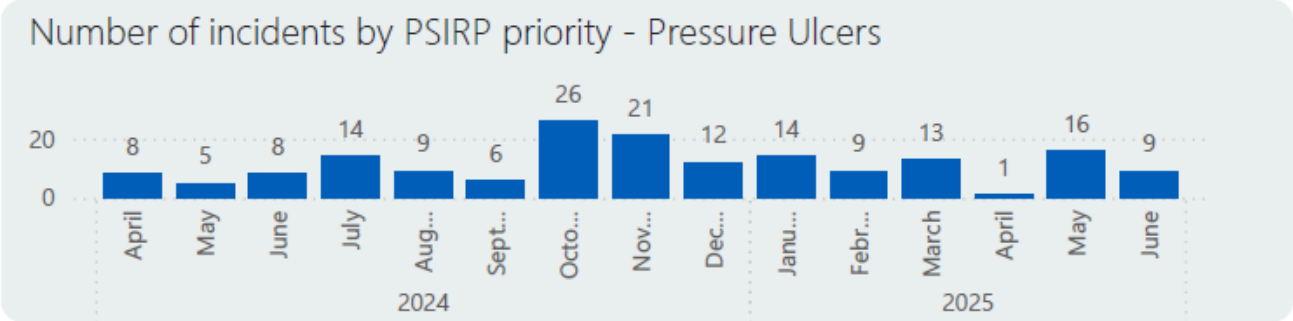
Overdue PSII actions are included in the monthly business unit reports completed by the Quality Leads to escalate when they are overdue for the business unit to action, this will continue to be monitored and highlighted. The new Patient Incident Management Policy which is due to CCPG in July 2025 includes a process whereby PSII actions will be entered as a risk on the risk register until they are complete and assigned to the Clinical Lead for the business unit with responsibility for oversight. These should be monitored and reviewed regularly to ensure they do not go overdue and where a timescale cannot be met the process for escalation and extension is followed prior to the action becoming overdue.

All overdue PSII actions have been shared with the Quality Lead for the Adult Business Unit to follow the escalation/extension process.

When do we expect to see improvement?

When the above process is implemented. Timeframes will be discussed and agreed with Business Unit colleagues.

Number of incidents by PSIRP priority - Pressure Ulcers



What is the trend that we see?

This KPI provides the number of Pressure Ulcer Incidents which have been closed within the reporting period, the data varies month on month. The data does not give an indication of how many incidents of this type have been reported within that time or those which have been investigated and confirmed that LCH care has contributed to or caused the incident.

On review, one of the incidents closed in June was identified as related to LCH care which met the criteria for statutory Duty of Candour.

What is being done about it?

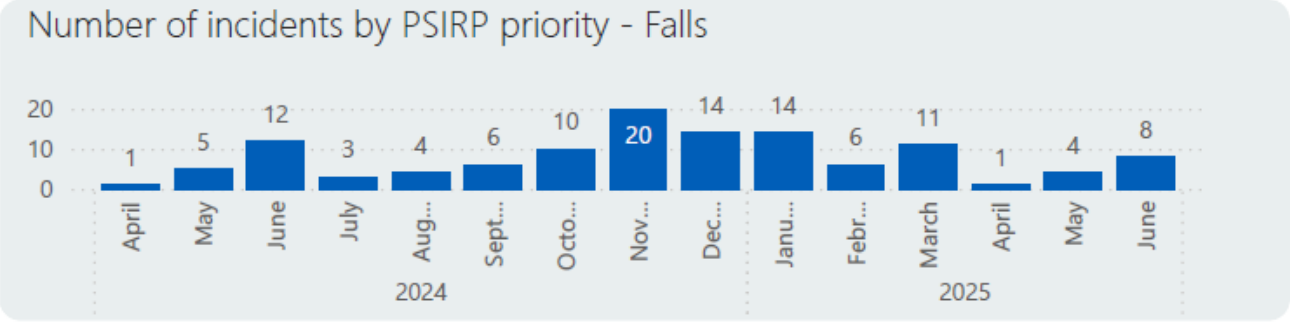
Pressure ulcer incidents are reviewed and included in a 6 monthly pressure ulcer report to QAIG as outlined in the Patient Safety Incident Response Plan (PSIRP) and any significant incidents for pressure ulcers which have progressed to a Patient Safety Incident Investigation are included in the Patient Safety 6 monthly report.

Following review of the PSIRP pressure ulcers have been removed from the LCH priorities for 2025/26.

When do we expect to see improvement?

Due to a pause on the revised KPI's for this financial year due to the ongoing Well Led Review and the new Audit of Performance from Audit Yorkshire it is proposed that this KPI is removed for future Performance Brief reporting as was the plan for 2025/26.

Number of incidents by PSIRP priority - Falls



What is the trend that we see?

This KPI provides the number of Falls Incidents which have been closed within the reporting period, the data varies month on month. The data does not give an indication of how many incidents of this type have been reported within that time or those which have been investigated and confirmed that LCH care has contributed to or caused the incident.

On review, there were no falls incidents identified as related to LCH care.

What is being done about it?

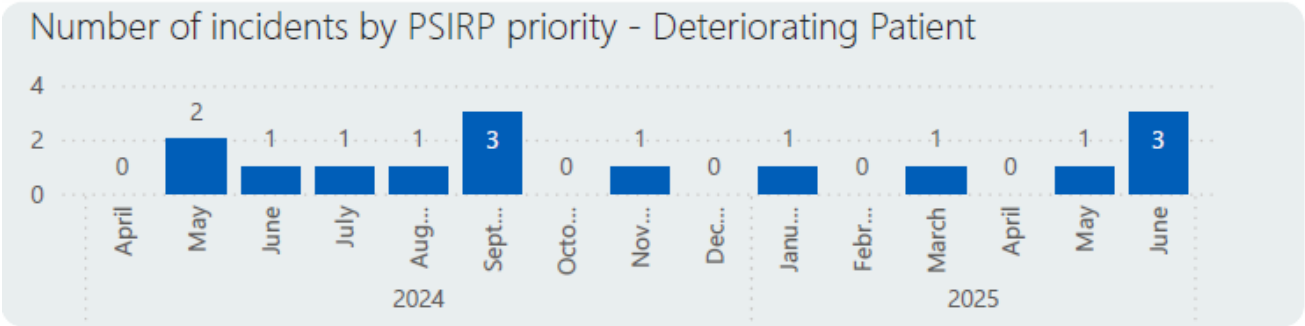
Falls incidents are reviewed and included in a 6 monthly falls report to QAIG as outlined in the Patient Safety Incident Response Plan (PSIRP) and any significant incidents for falls which have progressed to a Patient Safety Incident Investigation are included in the Patient Safety 6 monthly report.

Following review of the PSIRP falls have been removed from the LCH priorities for 2025/26.

When do we expect to see improvement?

Due to a pause on the revised KPI's for this financial year due to the ongoing Well Led Review and the new Audit of Performance from Audit Yorkshire it is proposed that this KPI is removed for future Performance Brief reporting as was the plan for 2025/26.

Number of incidents by PSIRP priority - Deteriorating Patient



What is the trend that we see?

This KPI provides the number of Deteriorating Patient/Sepsis Incidents which have been closed within the reporting period, this data varies month on month. The data does not give an indication of how many incidents of this type have been reported within that time or those which have been investigated and confirmed that LCH care has contributed to or caused the incident.

On review, there were two incidents identified as related to LCH care which met the criteria for statutory duty of candour.

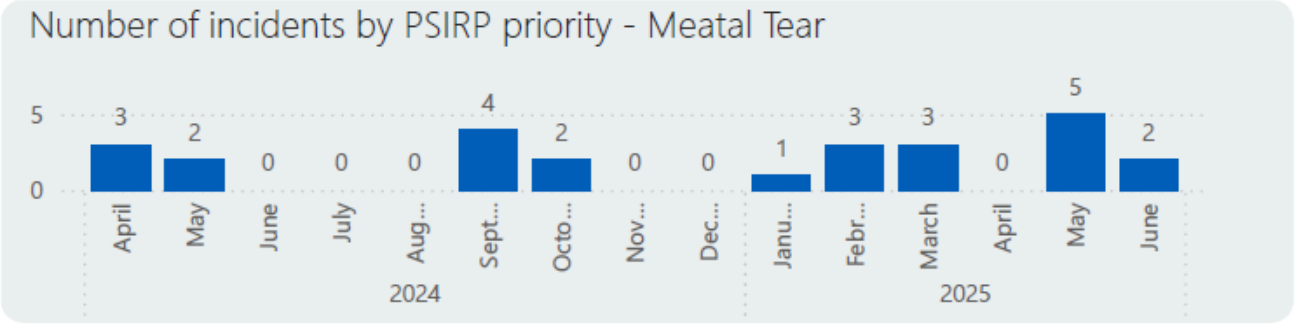
What is being done about it?

Deteriorating patient incidents will be included in a 6 monthly report to QAIG as outlined in the Patient Safety Incident Response Plan (PSIRP) and any significant incidents which have progressed to a Patient Safety Incident Investigation are included in the Patient Safety 6 monthly report.

When do we expect to see improvement?

Due to a pause on the revised KPI's for this financial year due to the ongoing Well Led Review and the new Audit of Performance from Audit Yorkshire it is proposed that this KPI is removed for future Performance Brief reporting as was the plan for 2025/26.

Number of incidents by PSIRP priority - Meatal Tear



What is the trend that we see?

This KPI provides the number of Meatal Tear Incidents which have been closed within the reporting period, this data varies month on month. The data does not give an indication of how many incidents of this type have been reported within that time or those which have been investigated and confirmed that LCH care has contributed to or caused the incident.

On review there was one incident identified as related to LCH care which met the criteria for statutory duty of candour.

What is being done about it?

Following review of the Patient Safety Incident Response Plan (PSIRP) Meatal Tears have been removed from the LCH priorities for 2025/26. This was a service led improvement plan and was expected to be short-term. As there were no recurrent themes and trends on review of the data this was not required to be included for 2025-26.

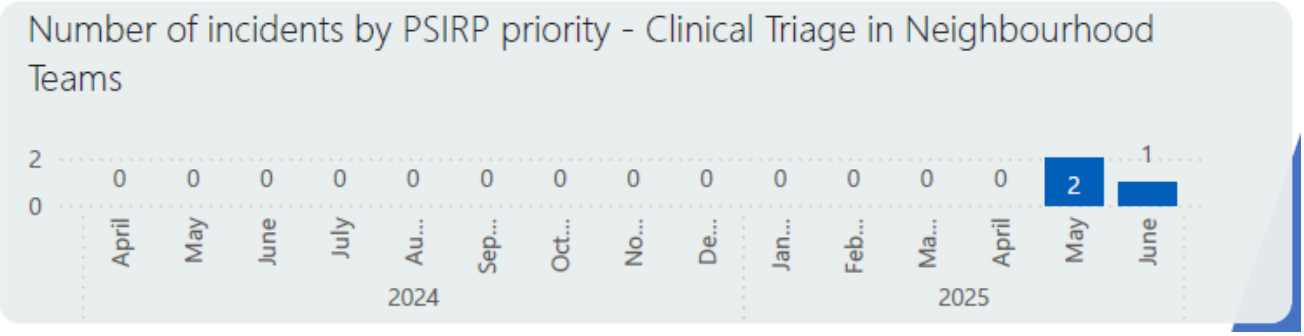
A potential reemerging theme has been identified in the Q1 data for 2025/26. A task and finish group has been established within ABU. A risk will be added to the risk register in relation to current delays in meeting the requirement of the catheter pathway to review patients discharged with a catheter within 48 hours. Any incidents reported where this delay in assessment and education has contributed to or caused a meatal tear will be linked. Incidents related to meatal tears will continue to be monitored and reported in the Adult Business Unit Report to QAIG.

Any significant incidents which have progressed to a Patient Safety Incident Investigation are included in the Patient Safety 6 monthly report.

When do we expect to see improvement?

Due to a pause on the revised KPI's for this financial year due to the ongoing Well Led Review and the new Audit of Performance from Audit Yorkshire it is proposed that this KPI is removed for future Performance Brief reporting as was the plan for 2025/26.

Clinical Triage in Neighbourhood Teams



What is the trend that we see?

This KPI provides the number of Clinical Triage Incidents which have been closed within the reporting period, this data varies month on month. The data does not give an indication of how many incidents of this type have been reported within that time or those which have been investigated and confirmed that LCH care has contributed to or caused the incident.

There were no incidents identified as related to LCH care

What is being done about it?

Following review of the Patient Safety Incident Response Plan (PSIRP) Clinical Triage has been removed from the LCH priorities for 2025/26. As there were no recurrent themes and trends on review of the data this was not required to be included for 2025-26.

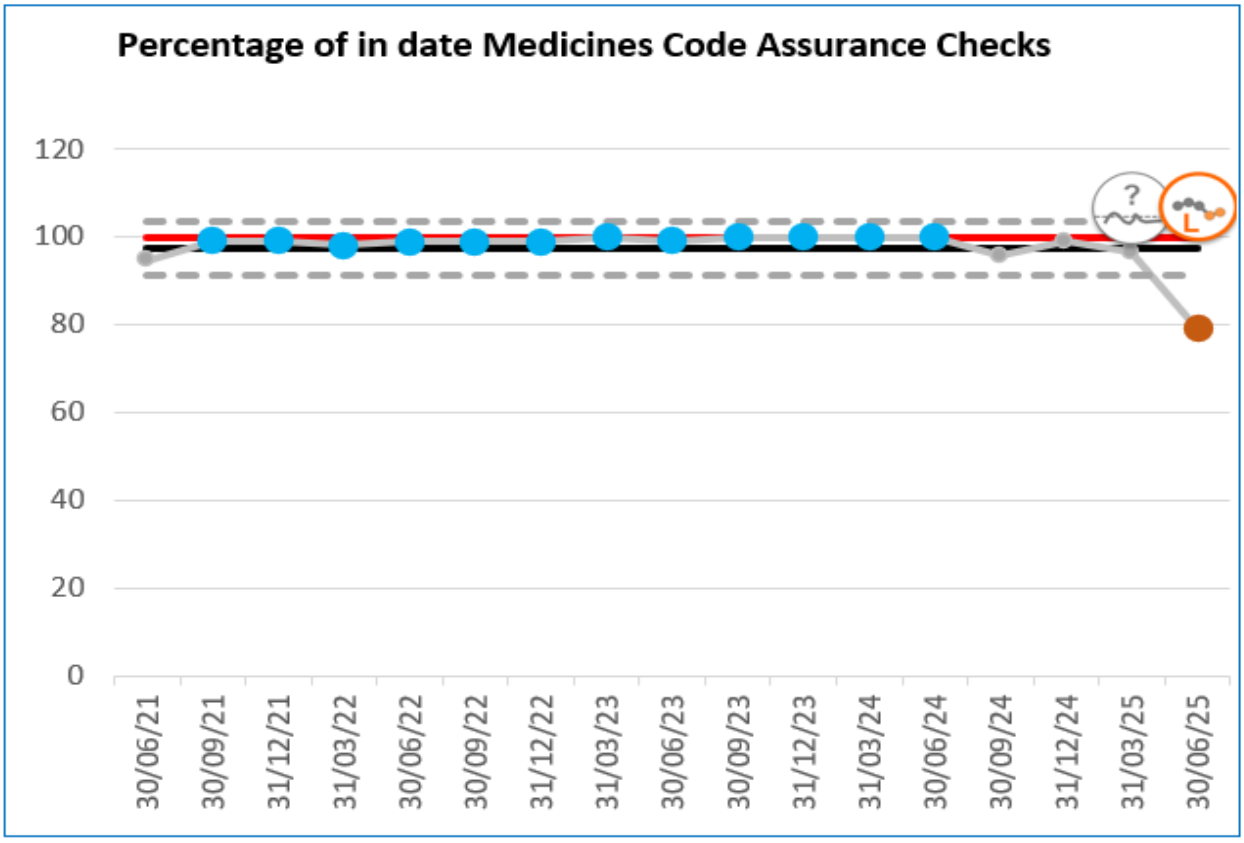
There is a risk held on the risk register ID 1307 and any patient specific incidents related to triage are linked to this so this can continue to be monitored. This will continue to be reported in the Adult Business Unit Report to QAIG.

Any significant incidents which have progressed to a Patient Safety Incident Investigation are included in the Patient Safety 6 monthly report.

When do we expect to see improvement?

Due to a pause on the revised KPI's for this financial year due to the ongoing Well Led Review and the new Audit of Performance from Audit Yorkshire it is proposed that this KPI is removed for future Performance Brief reporting as was the plan for 2025/26.

Number of Medicines Code Assurance Checks completed in last 24 months



What is the trend that we see?

Special cause concern in the June 2025 data.

Twenty-four (out of 116) teams who handle medicines have not completed a self-assessment Medicines Code Assurance Check in the last 24 months.

What is being done about it?

There are twenty-one checks overdue. A series of service visits are planned, and the Medicines Optimisation Team will complete the checks with the teams to gain assurance (rather than reassurance from the self-assessment):

- CUCS – 9 months overdue; changed base in July 2024 (check expected to be completed within three months of change of location); awaiting feedback from service for date to complete check
- Neighbourhood Night Nursing Service – 6 months overdue; changed base in September 2024; awaiting feedback from service for date to complete check
- Cardiac Team – 3 months overdue; will be completed by end of Q2
- Children's Community Nursing – 2 months overdue; will be completed by end of July 2025
- 6 x CYPMHS locations – 1 month overdue; agreed to delay checks until Q2 pending outcome of Quality & Value programme and review of team bases/merger of teams completed
- Infection Prevention & Control team – 1 month overdue; agreed to move check to September 2025 in line with start of annual staff influenza vaccination campaign as this is the only medicine the service handles
- Yeadon Neighbourhood Team - 1 month overdue; awaiting feedback from service for date to complete check
- 0-19 PHINs – 1 month overdue; will be completed by end of July 2025
- 8 x Podiatry Service locations – 1 month overdue; all checks will be completed by end of July 2025

In Q1 2025/26 the Medicines Optimisation Team reviewed the list of services who are required to undertake a Medicines Code Assurance Check every two years and identified three teams (Falls Service, Tier 3 Weight Management and Nutrition and Dietetics) who had previously indicated that a check was not required, but the service offer had changed, and medicines related activities were being delivered. They are now included in the dataset for reporting. Support will be provided by the Medicines Optimisation Team as required.

When do we expect to see improvement?

An improved position will be seen in the September 2025 dataset.

Caring

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

Summary

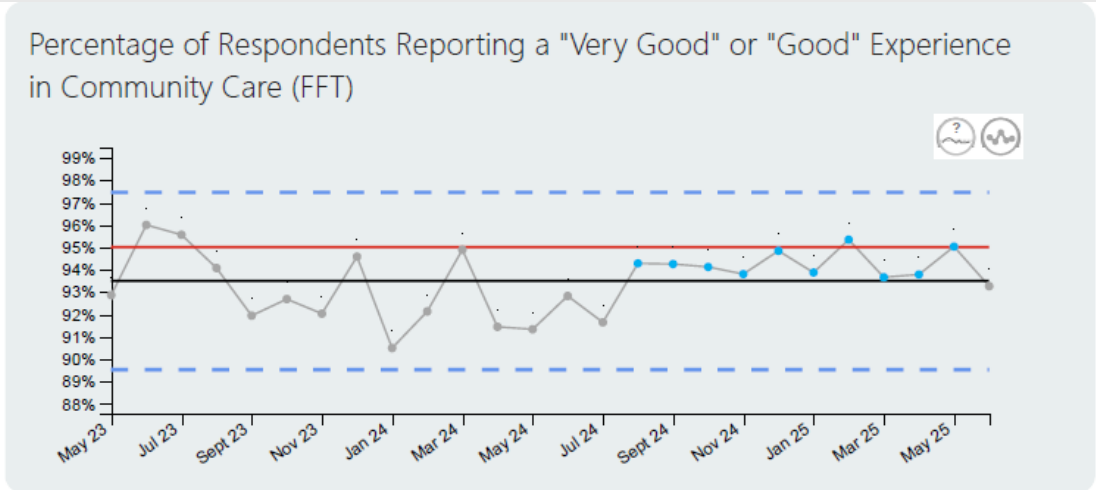
The organisation aims to uphold a strong commitment to caring by ensuring staff engage with individuals compassionately and respectfully. Staff are expected to treat people with kindness, uphold their dignity, and involve them in decisions about their care. While there are examples of positive interactions 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 although we are above average, we have only met our target twice in the reporting period. We are reviewing this on a regular basis, and we are committed to ensuring quality of care is not impacted. The Patient Experience team are currently leading a piece of work around PSHO standards to ensure robust application into the organisation, this will result in more timely, appropriate and proportionate responses to patient feedback.

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?

The data shows to be stable and consistent from last year to date. Data has remained within the upper and lower control limits, with no special cause variation.

What is being done about it?

We have recently recruited to the Patient Engagement Manager, and Engagement Officer posts. Both are currently in the early stages of their induction. As part of their induction both have received training and support from Civica (FFT platform).

When do we expect to see improvement?

Once they are through the induction phase, they will be able to understand the system and monitor trends more effectively and feedback further on the trend.

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

Clinical audit

Engagement with the clinical audit program has reduced, with work underway to understand whether this is reduction in compliance and completion of audits within services or lack of capacity to send the required returns to the Audit & effectiveness manager in order to complete the data submission. Quality Committee have the Clinical Audit Overview for 24.25 on the agenda for July 25 and work is underway to review both the Trust annual audit plan approach and the effectiveness measures for clinical audit compliance.

National audit

Although this is reported as cause for no concern there are currently 8 national audits relevant to LCHT (shown in table below). We are registered for all audits but cannot submit data to 3 of them, which are the National Audit of Cardiac Rehabilitation (NACR), Sentinel Stroke Audit Programme (SNAPP) and National Obesity Audit. More detail is included below and in the paper to Quality Committee.

NICE

There are 19 open guidance currently in the organisation with assessment pending or action plans in place.

Two 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:

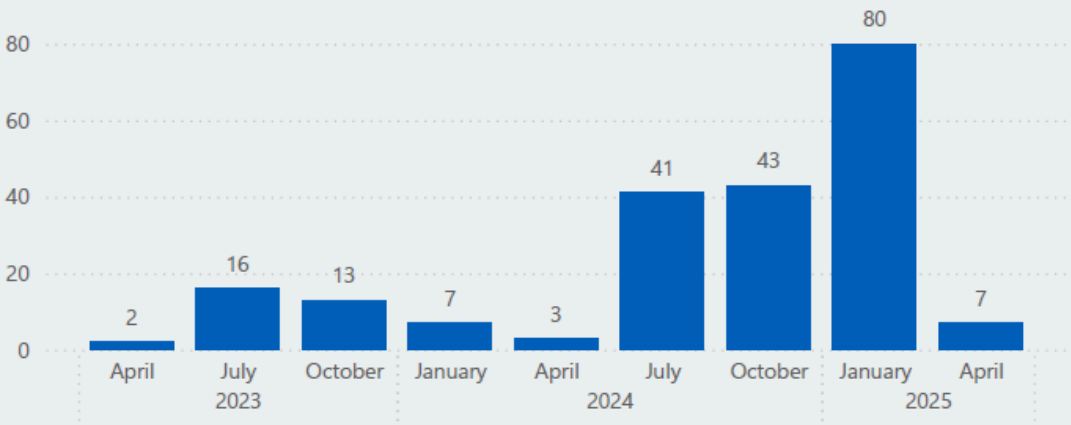
- NG197 Shared Decision Making
- NG212 Mental Wellbeing at Work
- NG236 Stroke rehabilitation in adults (becomes overdue in quarter 3).

All guidance has been risk assessed as low or minor risk.

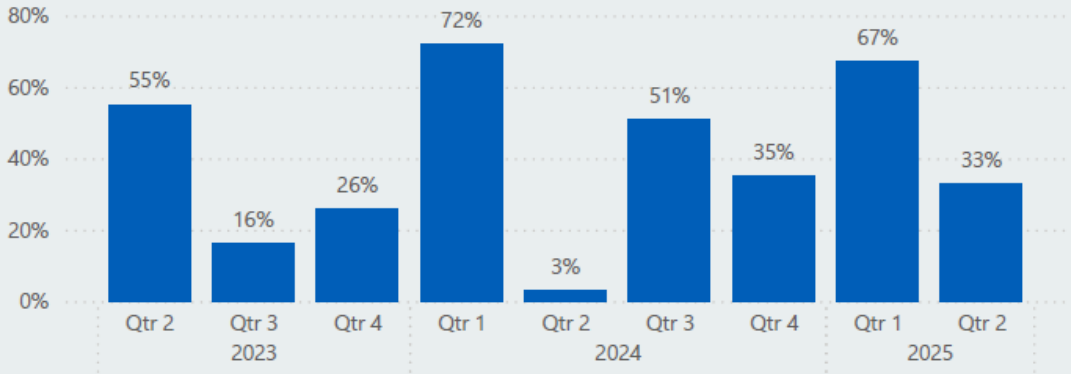
Seven guidance was proactively reopened in 2024-2025 to check for compliance against service redesign and developments.

Audit & Effectiveness

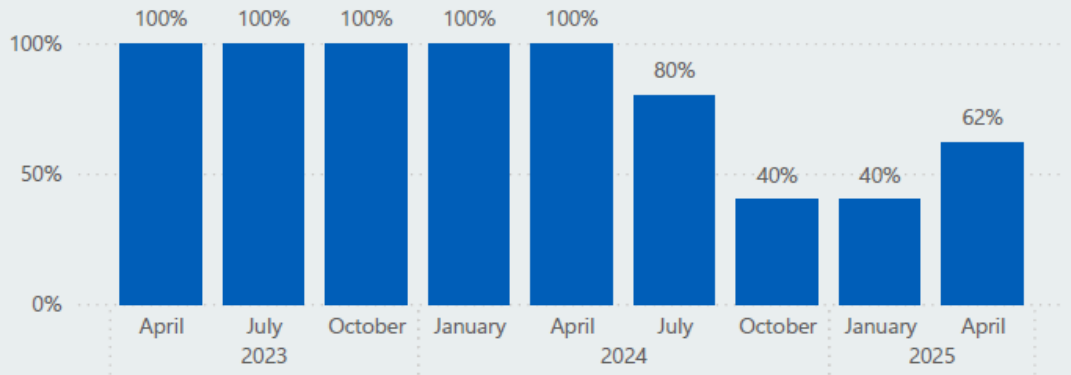
Total number of audits completed in quarter



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



What is the trend that we see?

Local Audits

97 audits have been registered to date for the 2025-26 Annual Audit Plan. 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.

At the end of Q1, the Clinical Effectiveness Team is still receiving updates for audit status throughout services, however, 6 audits have already been completed.

National Audits:

There are 8 national audits relevant to LCHT, and we are currently registered for all of them.
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. We cannot submit data to the National Obesity Audit as this has only recently been identified as relevant to LCHT, with data requirements still under review. Support from Clinical Systems and Business Intelligence is likely to be needed.

National Adult Diabetes Audit (NDA) – HQIP	SBU	Podiatry	Yes	Yes
National Epilepsy 12 Audit – HQIP	CBU	ICAN	Yes	Yes
National Respiratory Audit Programme (NRAP) – HQIP	SBU	Respiratory	Yes	Yes
Sentinel Stroke National Audit Programme (SSNAP) – HQIP	SBU	Neurology	Yes	No
National Audit of Cardiac Rehabilitation - NHS England Digital	SBU	Cardiac	Yes	No
National Adult Diabetes Audit (NDA) – HQIP	SBU	Diabetes	Yes	Yes
National Audit of Eating Disorders (NAED) – HQIP	CBU	CYPMHS	Yes	Yes
National Obesity Audit – HQIP	SBU	Tier 3 Weight Management	Yes	No

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.

We cannot submit data for the National Obesity Audit, as we have only registered recently and this will potentially require input from Clinical Systems and Business Intelligence.

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) and work is underway to transform the approach and alignment of this for 26.27.
Drop-in sessions will be delivered quarterly to help improve submission of audit information to the CET.
Development of a new registration and progress template with a move to automation to support information and learning being shared.
Monthly reviews of national audit activity via MS Forms, led by the Clinical Effectiveness and Compliance Manager.
Annual audit of the Audit Policy to ensure ongoing relevance and effectiveness.

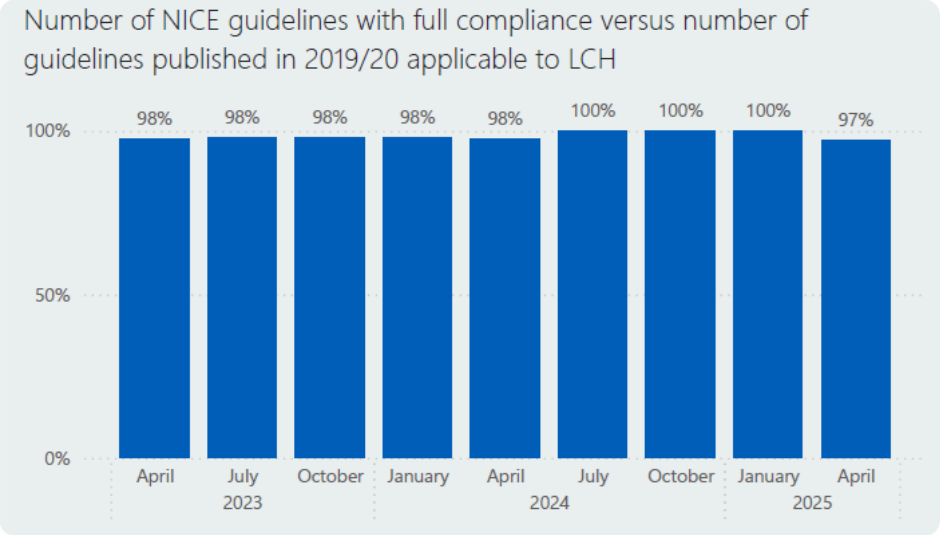
National audit (NCAPOP)

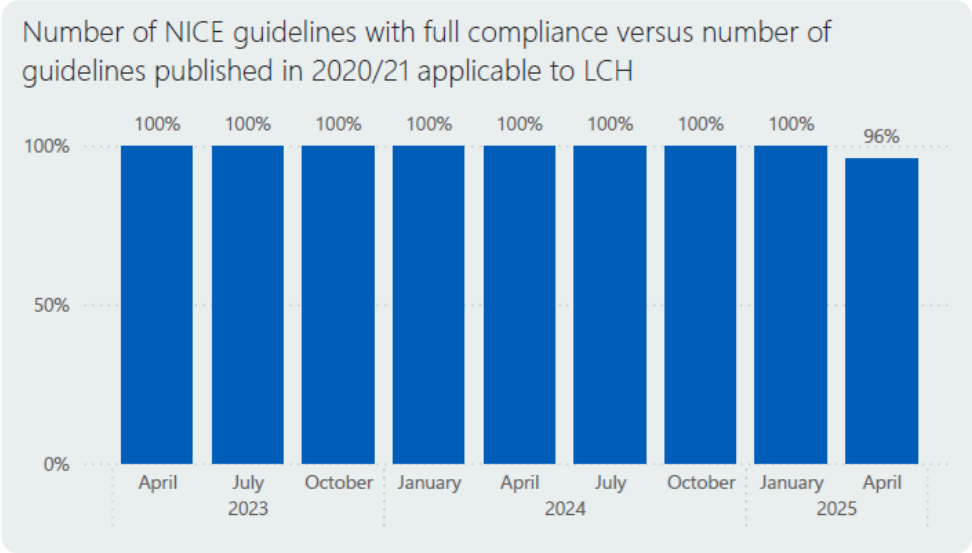
Monthly review of National Audits by Clinical Effectiveness and Compliance Manager including updates from services via the Business Unit Clinical Lead now in place.
CET review national audits monthly and send any that are potentially relevant to appropriate services for review.

When do we expect to see improvement?

We expect to see some improvement in Q2 in registration and updates sent to the CET. Further improvement will not be seen until the latter part of the year when services plan to complete audits in Q3 and Q4 and the new registration and progress template is completed.
There is already an improvement in reporting on and engagement with national audits. Submission of data to the 3 national audits outstanding is dependent on capacity within Business Intelligence and Clinical Systems to support ongoing work required.

NICE





What is the trend that we see?

Two 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.

What is being done about it?

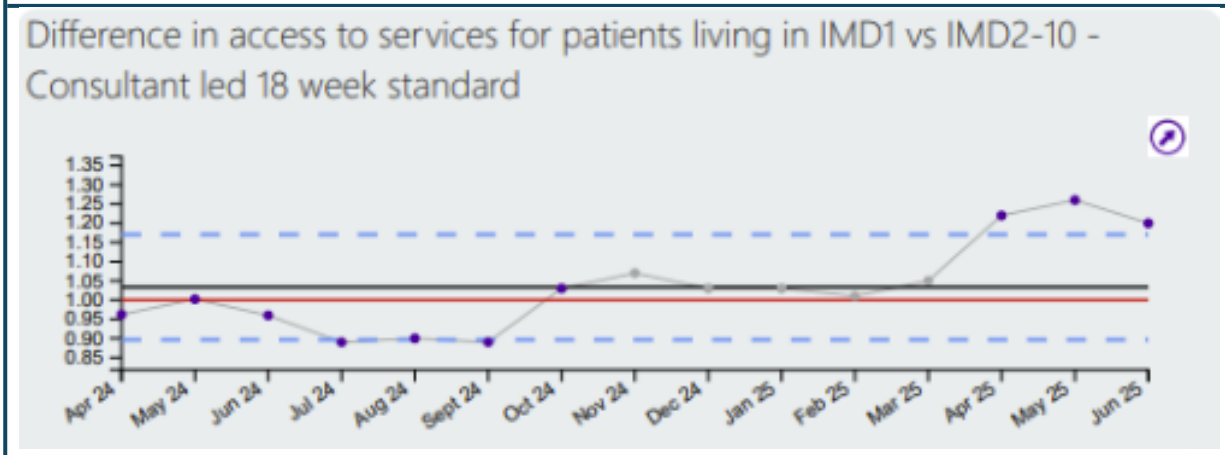
All guidance has been risk assessed as low or minor risk. Actions to achieve full concordance with NICE guidance have been escalated to Business Unit Clinical and Quality Leads.

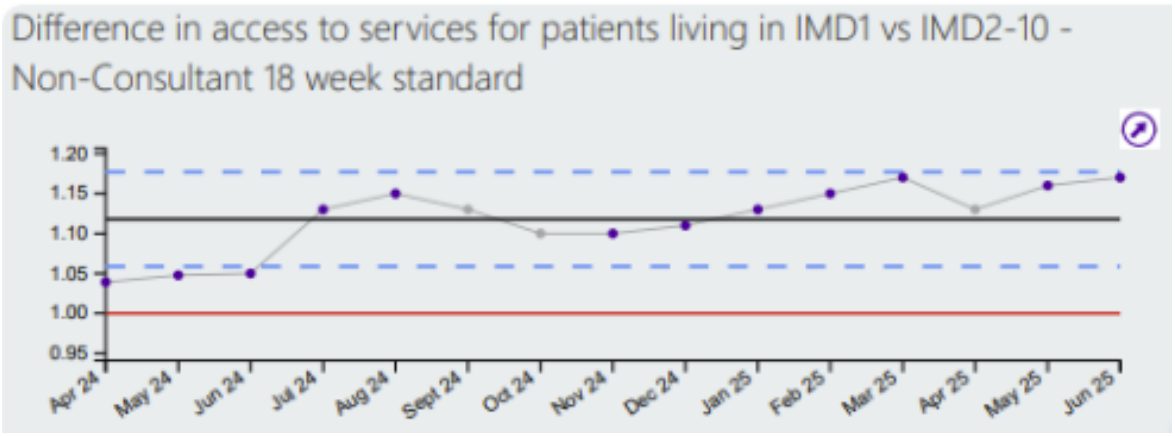
Seven guidance was reopened in 2024-2025 to check for compliance against service redesign and developments.

When do we expect to see improvement?

The number of open NICE Guidance fluctuates depending on new guidance issued. There is an improvement in overdue NICE guidance, as 1 has been closed, with a further 1 pending closure.

Equity





What is the trend that we see?

People from IMD 1 are waiting longer for services in consultant led and non-consultant led lists. We can see that the difference in waiting times between IMD 1 (most deprived) and IMD 2-10 has continued to grow. In consultant led waits, patients in the most deprived areas have gone from waiting the same or less time, to significantly longer since March 2025. In non-consultant led waits, patients from the most deprived areas are seeing progressively longer waits, a pattern that has been generally worsening since June 2024.

This pattern 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. Subsequent analysis has identified that this is due to higher rates of cancellation and non-attendance by people in IMD1 rather than a difference in rates of invitations to appointments. Cancellation and non-attendance can be for a variety of different reasons, but those living in areas of deprivation can face multiple barriers such as access to transport, financial challenges, caring responsibilities, managing multiple medical appointments and insecure employment making it more likely they won't attend appointments.

Waiting impacts patients differently. Evidence shows that those in IMD 1 often seek help at a later stage in their health condition, meaning they often enter the waiting list in a poorer state of health. This can lead to more rapid deterioration in health whilst waiting for care and poorer health outcomes. People living in IMD 1 are also at higher risk from adverse outcomes from long waits due to social disadvantage such as loss of income or employment whilst waiting for medical treatment.

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 new resource on the Information Hub is being developed to signpost patients to sources of support to attend appointments.

A review of the Access policy, incorporating missed appointments and discharges is underway, to bring it in line with the new national elective access policy, NHSE principles for good communication with patients waiting for care, and embed consistency in equitable approaches to managing missed appointments. Embedding the revised Accessible Information Standards is also expected to support a reduction in missed appointments.

When do we expect to see improvement?

Completion of the Access policy is due in Quarter 2 and implementation of a new 'About Me' template incorporating communication needs and wider reasonable adjustments is due to start in Quarter 3. A working group has been started to consider the resource requirements needed to continue the telephone call support to patients at greatest risk of missing appointments and therefore timescale for this to continue.

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 Podiatry, Children's Occupational Therapy and Cardiac Services.

The total number of people waiting for care to start has stabilised, with a total of 27,732 people waiting for care to start at the end of June 2025, compared to 30,154 at the start of the calendar year. The total number of patients waiting more than 52 weeks continues to decrease, apart from Neurodevelopmental Assessment Services, falling to 3,828 at the end of June 2025, from 4,139 at the end of April.

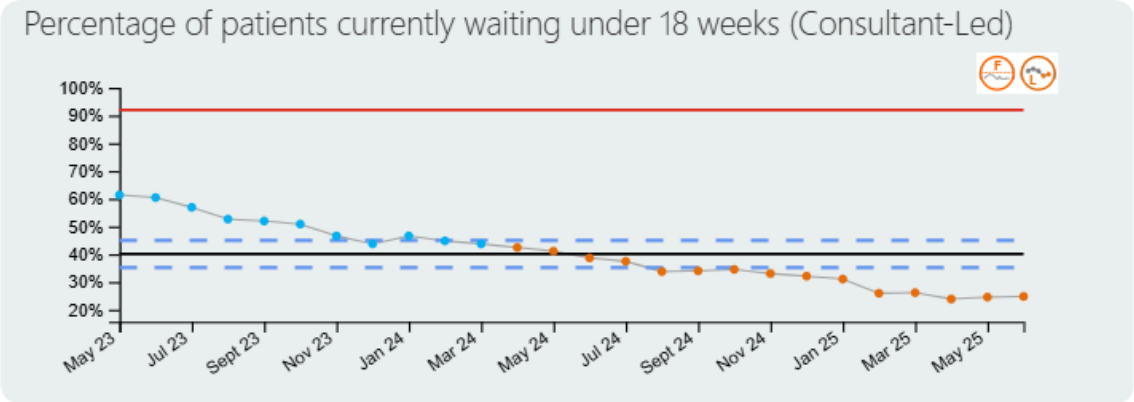
Our Children's Audiology Service met the target for 99% of patients seen within 6-weeks, achieving 100% in April 2024.

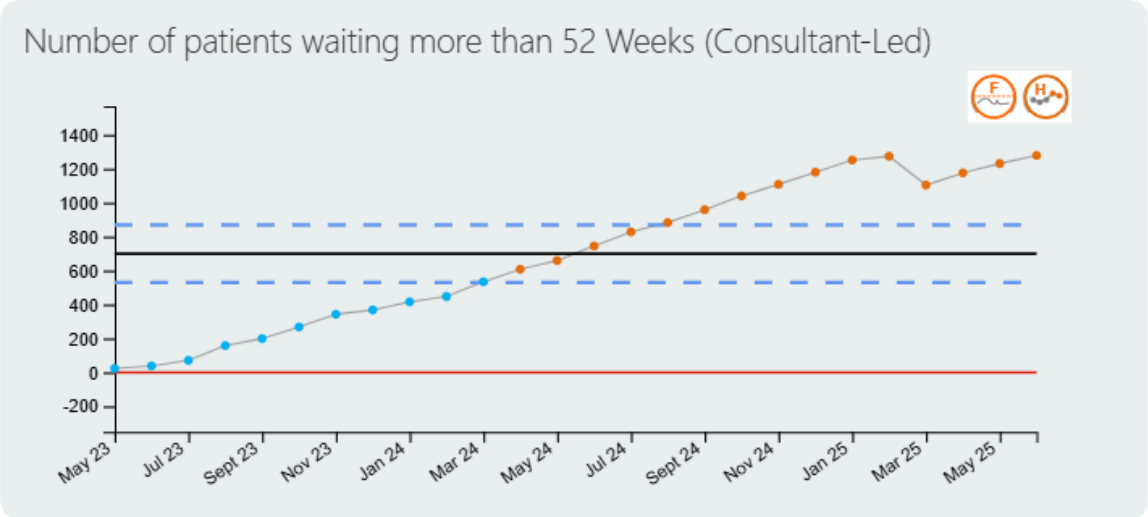
Key areas of risk are highlighted in this report, including services with the greatest concerns relating to 52-week waiting times.

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?

The long term declines we have seen in Performance have begun to hold steady in the percentage of patients waiting less than 18 weeks, at 24.8% in June 2025, however the number of people waiting more than 52 weeks continues to grow, with 1,279 patients waiting more than a year on an RTT pathway.

Now that Community Gynaecology is no longer classified as an RTT service, these indicators only include our Community Paediatric pathways and clinics within the Children's ICAN Service. PND continues to be the primary influence, where high demand for pre-school neurodevelopmental (autism) diagnosis continues. At the end of June 2025, there were 2,505 people waiting on a consultant-led RTT pathway, and 2,160 of these (86%) were waiting for a PND appointment.

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. This will be implemented alongside changes to the referral acceptance criteria for the service, which could lead to approximately 50% reductions in the number of children being offered a full assessment.

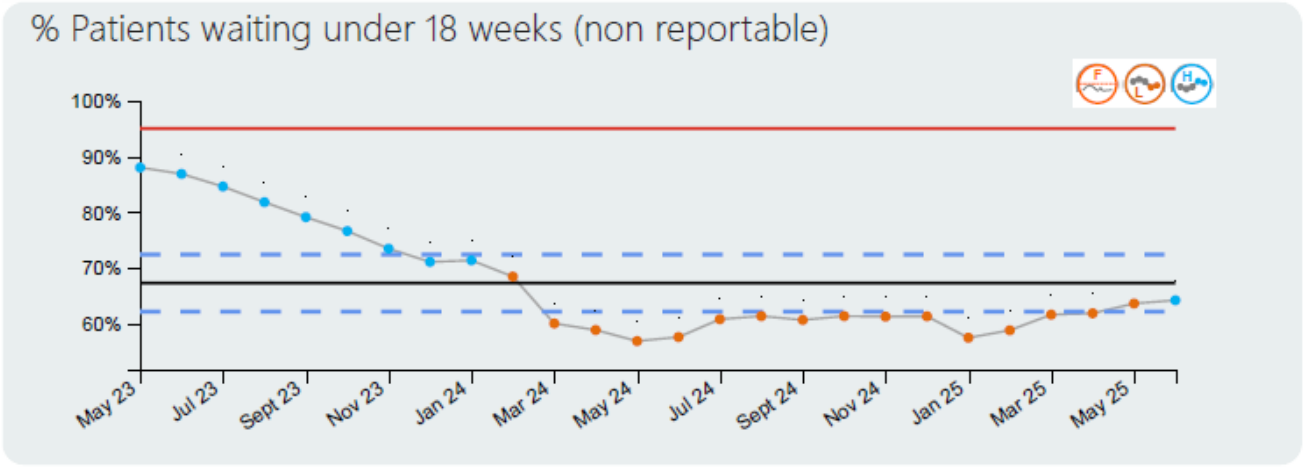
The pathway for diagnosis is also being redesigned to focus on assessments being conducted and led by Paediatricians, supported by effective information gathering from other disciplines and leveraging capacity in other CBU services. The proposed pathways have been modelled to help understand the capacity 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.

Locum Paediatricians continue to offer diagnostic assessments.

When do we expect to see improvement?

Current plans to implement the change in referral criteria are due to be implemented by Q3 this year, which should lead to some reductions in the waiting times, but modelling suggests that this would still take more than 3 years to reduce the current waiting list without additional investment alongside.

% of patients waiting under 18 weeks (non reportable)



What is the trend that we see?

A long-term trend of statistically significant improvement is now visible, showing that services have been making sustained improvements since January 2025. Performance against the 18-week standard, however, remains significantly below the target of 95%. These performance improvements coincide with the additional scrutiny and focus given to waiting list performance through the Access LCH governance structures.

There are several areas of good improvement and recovery for some services, including:

- Podiatry have achieved a 14% reduction in their total waiting list size in the last 3 months, specifically reducing the number of people waiting more than 40 weeks from 712 at the end of April, to 322 at the end of June
- The Cardiac Service have reduced the number of people waiting by 17% in last 3 months
- Tier 3 Weight Management Service has now reopened to new referrals, and is managing waiting times effectively with validations and appointments focussed on those who have waited longest
- Our CAMHS Services have achieved overall waiting list reductions of 44% in last 12 months, but increases in waiting times overall are heavily influenced by the waiting times at Mind Mate SPA and the long waiting times for Autism and ADHD assessments.

52-Week Waiting Times

The total number of patients now waiting more than 52 weeks (including RTT and non-RTT pathways) has reduced throughout the quarter, falling to 3,828 at the end of June 2025 from 4,640 at the end of March 2025. At the time of writing, 51% (1,957 out of 3,828) of these were children awaiting ND assessments in both our Pre-School and School Age assessment teams. A further 28% of these patients are waiting for our Community Dental Service.

At the time of writing, the services with patients waiting more than a year are:

Service	Patients waiting more than 52 weeks
Pre-School and School Age ND	1957
CAMHS Medication Clinics	421
CAMHS other	3
Children's SLT	2
Community Paediatric Clinics	1
Growth and Nutrition Clinic	1
Children's Nutrition and Dietetics	12*
Community Gynaecology	88**
Community Neurological Rehab	1*
Adult SLT	174
Continence, Urology and Colorectal	25
Looked after children	3*
MSK	11
Podiatry	53
Dental	1,076
Total	3828

** These patients have been reviewed by services are not true patients waiting, services are working to correct records this month*

*** As we are no longer responsible for the RTT pathway for these patients, the service is working to amend patient records this month to no longer reflect the time that patients have waited on LTHT waiting lists before transferring to ourselves*

What is being done about it?

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

CAMHS

The service continues to develop a Business Case to understand what long-term investment is required to rebalance capacity with demand, both for ND Assessments and for the Medication Clinics. The Medication Team has successfully recruited to further Nurse Medical Prescriber roles, and the increased capacity should lead to some reductions or waiting times throughout the year

Dental

Waiting Times for Community Dental remain a national and regional problem, and these challenges are replicated in LCH. However, our service is beginning to show positive improvements in waiting times for patients, with the total number of people waiting falling to 2,659 by the end of June 2025, from 2,914 at the end of March 2025. The total number of people waiting more than 52 weeks fell to 1,076 from 1,382 over the same period.

The service continues with recruitment, but longer-term risks remain 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 be delivered being mindful of maintaining balance in reducing waiting times for routine assessment against delivery of targets to deliver full courses of treatment.

Adult SLT

A long-term gap is evident between capacity and demand, driven particularly by increases in the number of urgent and complex referrals coming from acute wards. As a result, the service has limited remaining capacity to see routine patients, and waiting times are continuing to grow. The service also has long standing capacity gaps due to long term sickness. 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 currently has 858 people waiting, which has reduced from 986 in January 2025. A total of 169 people have waited more than 52 weeks, which has increased from 113 in April 2025. It is expected that these numbers will continue to grow.

Children's SLT

These patients are waiting for Parent Training Classes. There is only a limited number of these offered per year, and these patients have missed several previous opportunities leading to long waiting times. Parents are being offered a further chance to accept the offer of training if still required.

MSK

All patients waiting more than 40 weeks have been reviewed and are classified as "out-of-woodwork" patients. These are patients that were referred using the Choose and Book System but didn't take up the offer of care at the time, but then subsequently decide to request support using the original referral. All these patients have appointments booked in.

CUCS

Longer term problems exist for the service with sickness rates and capacity to see bladder and bowel patients. The service is currently working with MSK to consider joint clinics for some patients.

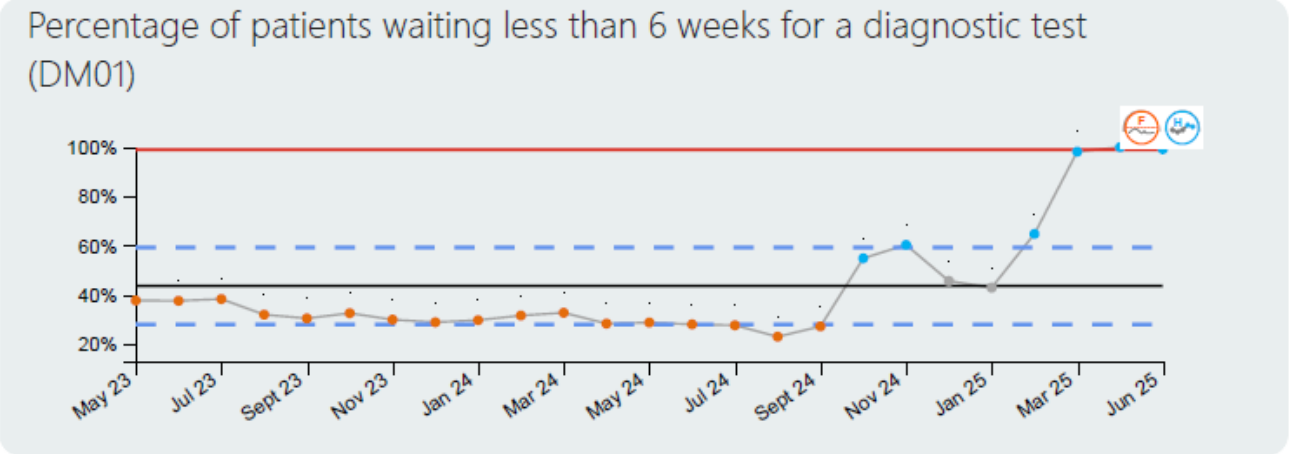
ICAN Medical Clinics (Growth and Nutrition and Community Paediatrics)

This service shares clinical capacity with the other ICAN Clinics such as PND and Child Protection Medical, which limits the availability of clinical time. The service is arranging appointments between geographical hubs where possible.

When do we expect to see improvement?

We expect to see continued improvement through the rest of the financial year, but it is unlikely that the Trust will meet the target in this time frame.

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



What is the trend that we see?

Performance continues at stable levels above the target

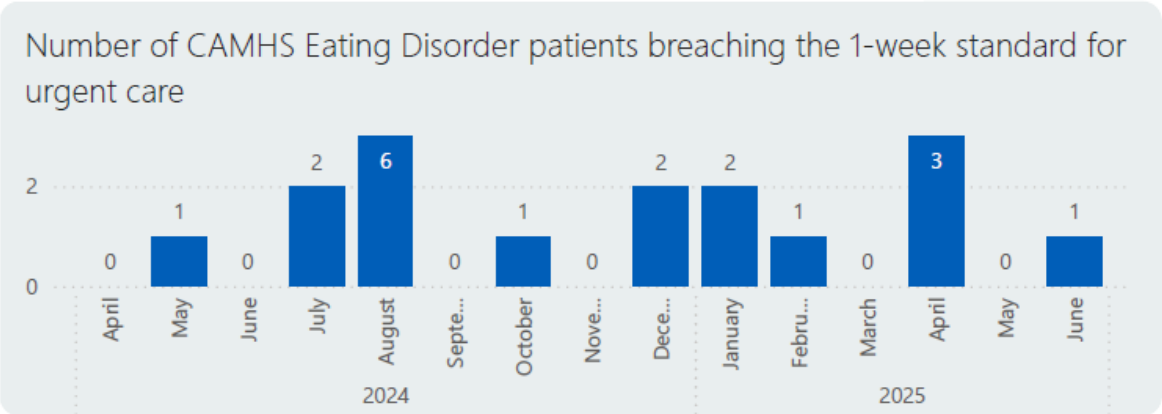
What is being done about it?

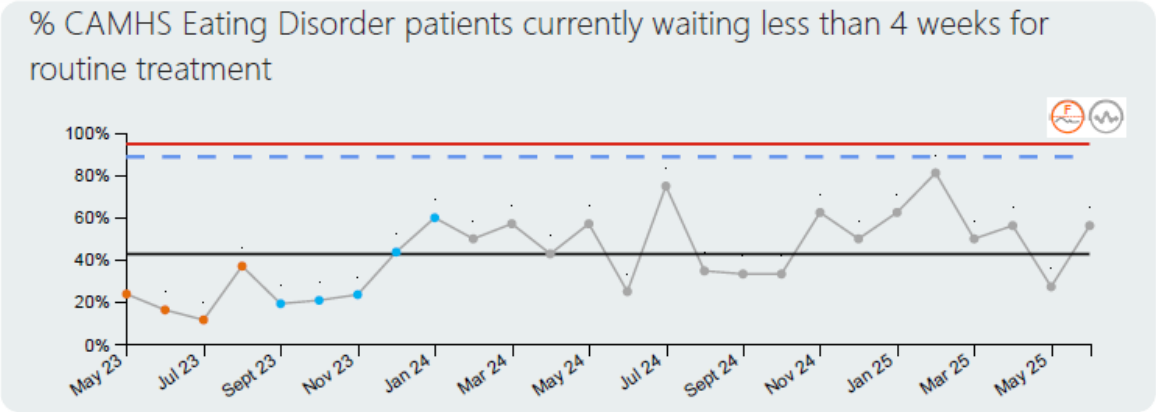
No further action required

When do we expect to see improvement?

Updates will be provided if performance deteriorates from the current position.

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 has a number of gaps in roles that are sufficiently qualified to offer initial assessment appointments.

The service has also seen a dramatic increase in the complexity of patients over the last 4 years. In 2022, patients would an average of 8 appointments from referral to discharge, but this has now increased to 18 per patient. Patients are also staying longer on the caseload and requiring a higher frequency of contact to manage their risk and provide effective treatment.

What is being done about it?

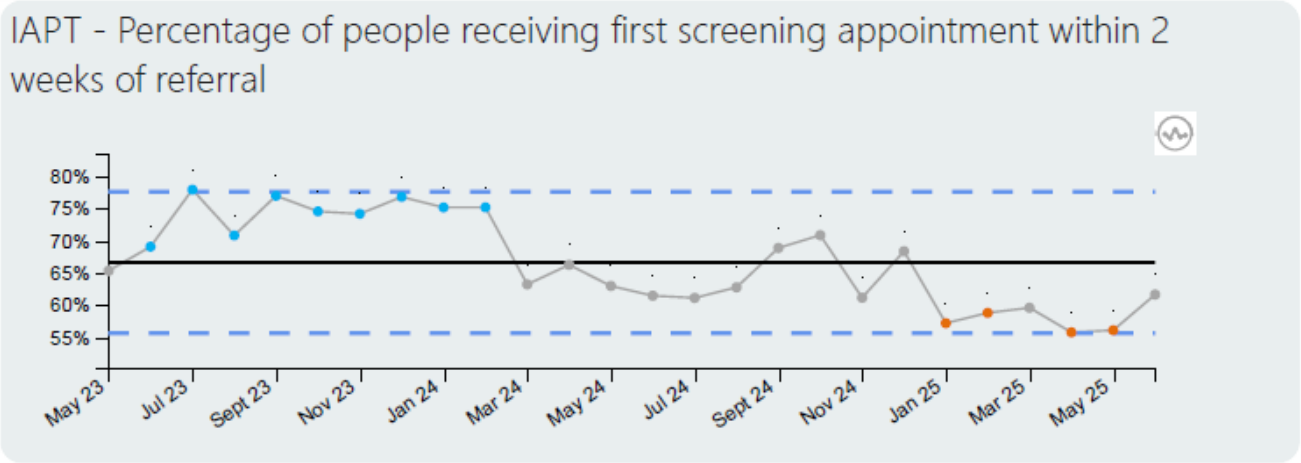
The ICB has recently provided additional funding to increase capacity for assessment appointments. Increasing the availability of the more skilled clinicians in the team will support both the capacity for assessing new patients, and the capability of the service to manage the increased risk and complexity of patients.

The service is also working with the Performance Team to assess the weekly number of assessment and treatment slots that are required to meet weekly referral demand patterns.

When do we expect to see improvement?

The service aims to have filled posts by Q4 this year, but improvements may be visible sooner if changes to the weekly assessment slot structure can be staffed from existing capacity.

LMWS



What is the trend that we see?

Performance against this measure continues to hover close to the lower control limit, suggesting a statistically significant deterioration, but performance in June began a potential return towards average levels. However, performance is still some way below the levels achieved in 2023/24.

What is being done about it?

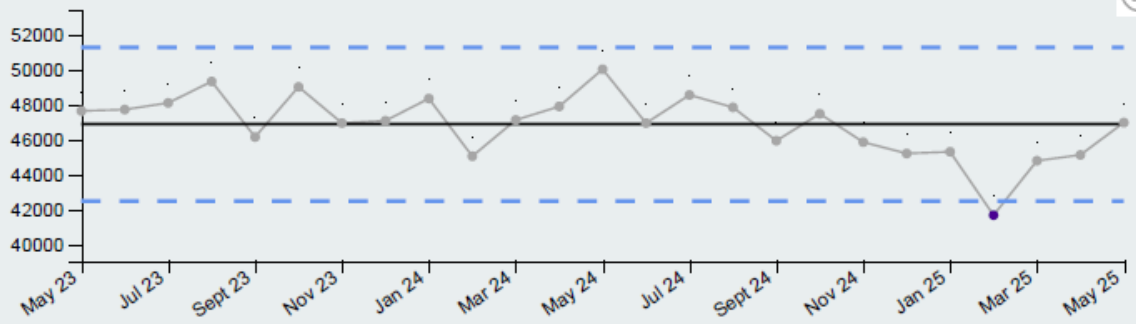
The service has reported capacity pressures in consistently achieving this target but has begun to allocate dedicated staff to offer screening appointments each week.

When do we expect to see improvement?

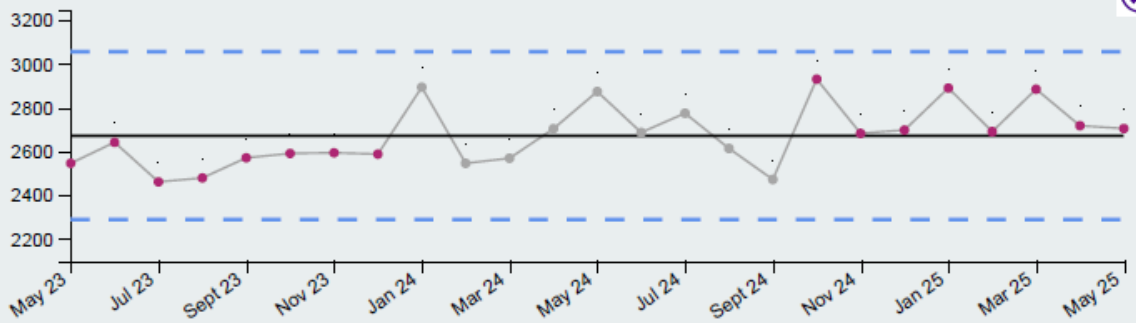
Some improvements are already visible, and these patterns will be monitored going forwards.

Neighbourhood Teams

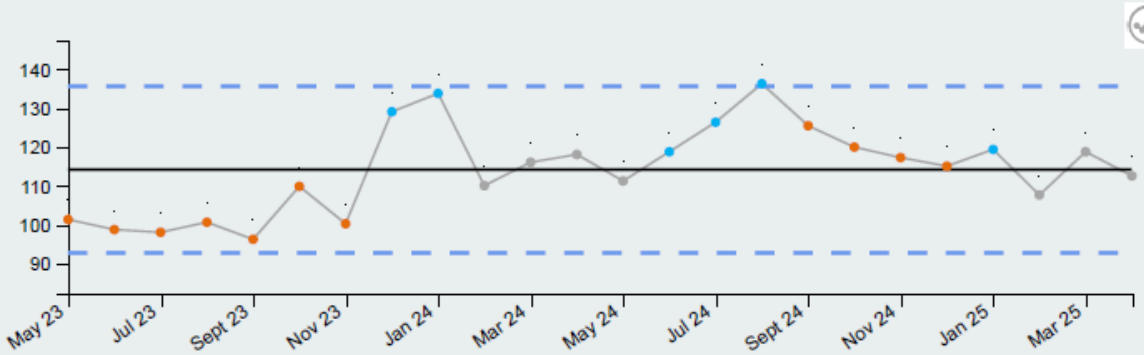
Neighbourhood Team Face to Face Contacts



Neighbourhood Team Referrals (SystmOne only)



Neighbourhood Team Productivity (Contacts per Utilised WTE)



What is the trend that we see?

A statistically significant pattern of high levels of referrals has now emerged, with 8 consecutive months of higher-than-average volumes. The number of contacts completed by the teams have also shown early signs of increasing, reaching similar levels to those achieved in 2023/24. Productivity remains at average levels.

What is being done about it?

There are several pieces of ongoing work that we expect to generate a reduction in demand for NTs – this includes the triage improvement plan and streamlining processes which will reduce unwarranted referrals. Self-referrals have been introduced for our Neighbourhood Clinics which will direct referrals directly to clinics instead of via the NTs. We are also undertaking significant work in the Q&V service redesign on our criteria and offer across both nursing and therapy which has and will be shared with system partners.

When do we expect to see improvement?

Unfortunately, we are not in full control of the referrals we receive (which is impacted by many factors) however by Q3 we expect to see an increase in the number of rejected referrals due to not meeting criteria as part of the work outlined above – this will help inform further guidance and comms to system providers to reduce unwarranted referrals in Q4 and ensure patients are directed to the right place. There are also various pieces of work in train which will allow for better granularity of data so we can drill down into the demand for specific sub-teams/functions rather than just NTs as a whole – we expect this improved data to be available from Q3 onwards.

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

Sickness absence levels have improved to below the target level, following a recent period of high sickness. Focused support continues for “hot spot” areas, and we can expect further scrutiny around sickness absence, as one of the workforce metrics within the National Oversight Framework.

The deteriorating position with the overall percentage of staff who have identified as BME (including exec. Board), was found to be due to a non-mandatory field within the new recruitment system. This enabled candidates to by-pass this declaration route. This has now been resolved, and we expect to see improvements over the next 3 months

Turnover has been flagged within the summary table of the main report as Deteriorating/Passing, however, an increase in this metric is not a concern, in line with organisational context.

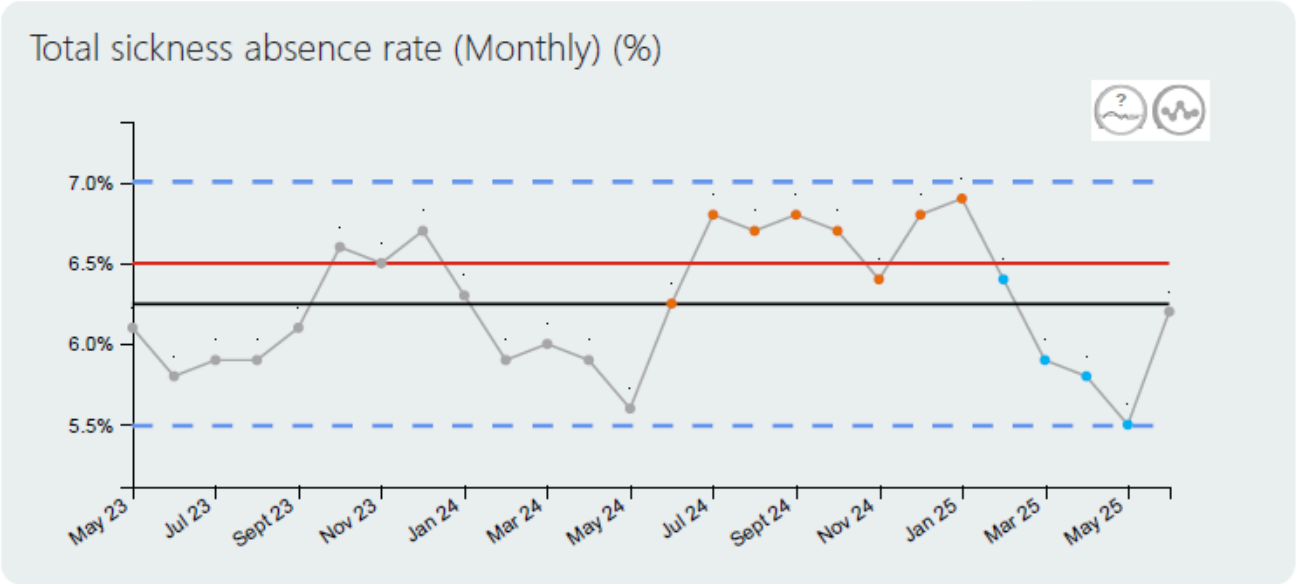
Statutory and Mandatory Training continues to hover just below 90% target.

Appraisal compliance continues to fluctuate but remains above higher limits/threshold.

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?

Performance has 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.

What is being done about it?

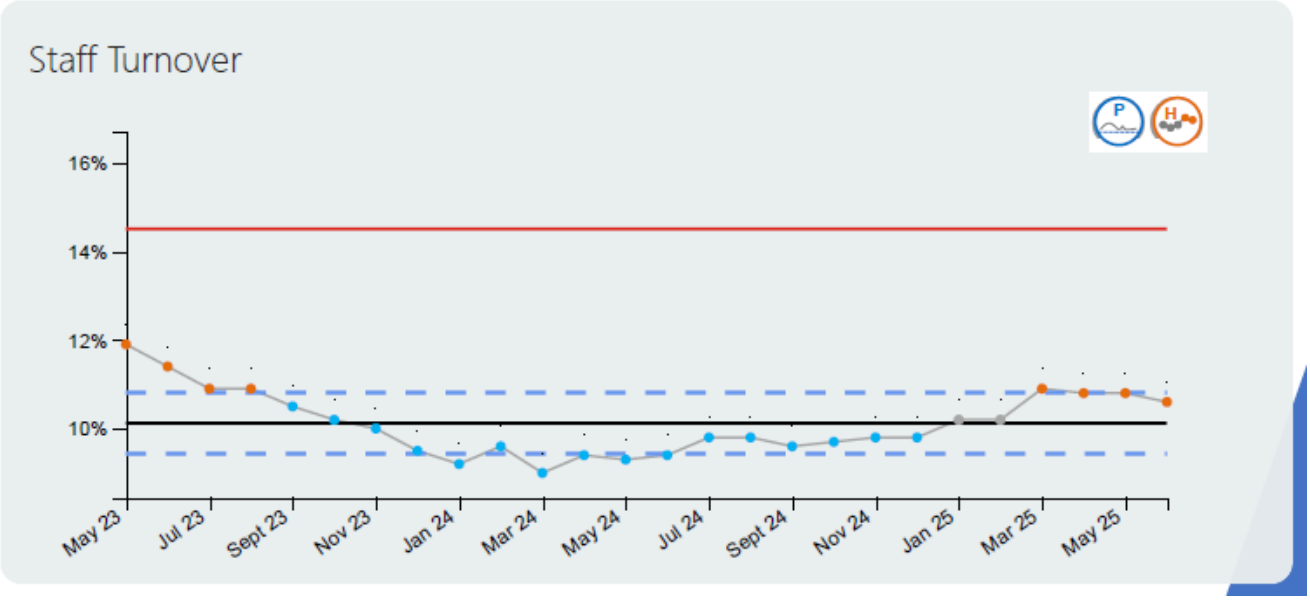
The People Directorate continue to work with managers and provide additional support where “hot spot” areas are identified. Recent focused work within the Adult Business Unit in supporting managers with absence management has led to a reduction in sickness within the Adults Night Service from, 21.4% to 11%.

When do we expect to see improvement?

One of the delivery metrics contained within the National Oversight Framework, due out in the coming months, is around sickness absence rate. We therefore expect to see more focus on this with operations and people partnering input.

In the meantime, sickness absence continues to fluctuate often due to seasonal variations, which is closely monitored and corrective interventions taken as appropriate. Supporting staff's health and wellbeing remains a Trust priority, and we regularly promote a wide range of health and wellbeing support staff can access, to help keep them well and in work.

Staff Turnover



What is the trend that we see?

Whilst there have been two months of higher than usual turnover, with both March and April appearing above the upper control limit, this is not a cause for concern.

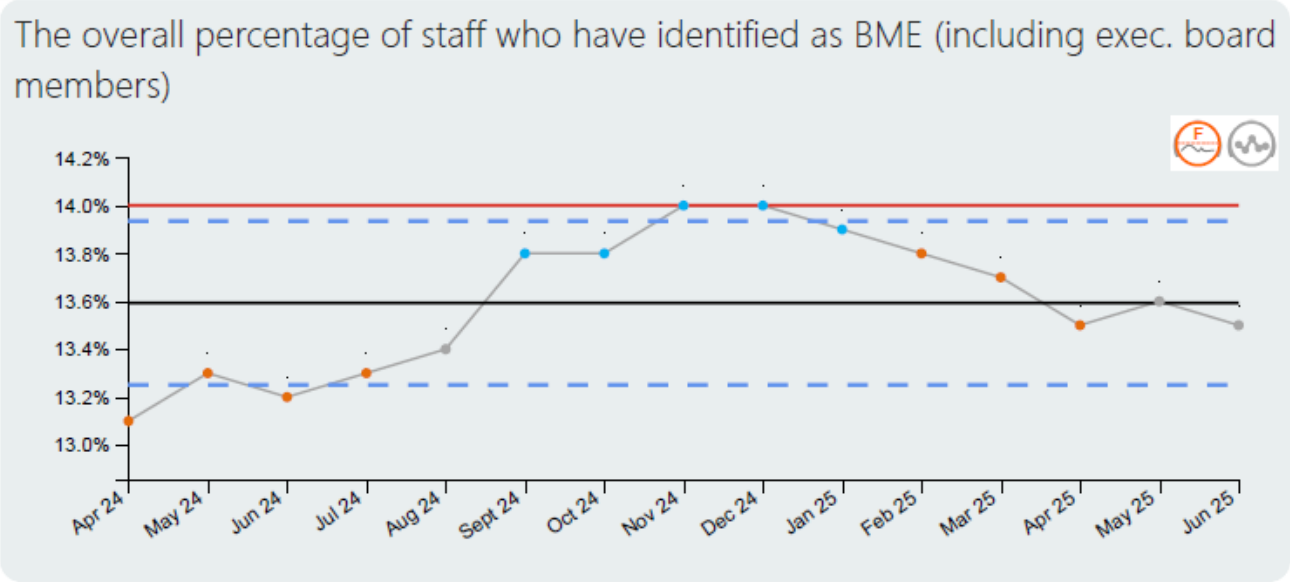
What is being done about it?

A slight increase in turnover rates is not a cause for concern, as it continues to be within limits and in line with external benchmarking data. Turnover will continue to be monitored in line with organisational context.

When do we expect to see improvement?

This is not a cause for concern – if we see a spike in turnover within a particular staff group or service area, this would be explored in more detail.

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



What is the trend that we see?

A statistically significant change is now occurring, with 5 consecutive months of decline in a row leading to deteriorating performance.

What is being done about it?

Following an investigation the People Operations and Recruitment team identified that new candidates could bypass the Equality, Diversity, and Inclusion (EDI) questions in the Applicant Tracking System (ATS) because the fields were not mandatory. We have now resolved this issue with the software provider.

From August, all new applicants will be required to complete the EDI questions. They will still have the option to select "Prefer not to say," but they will no longer be able to skip the section entirely.

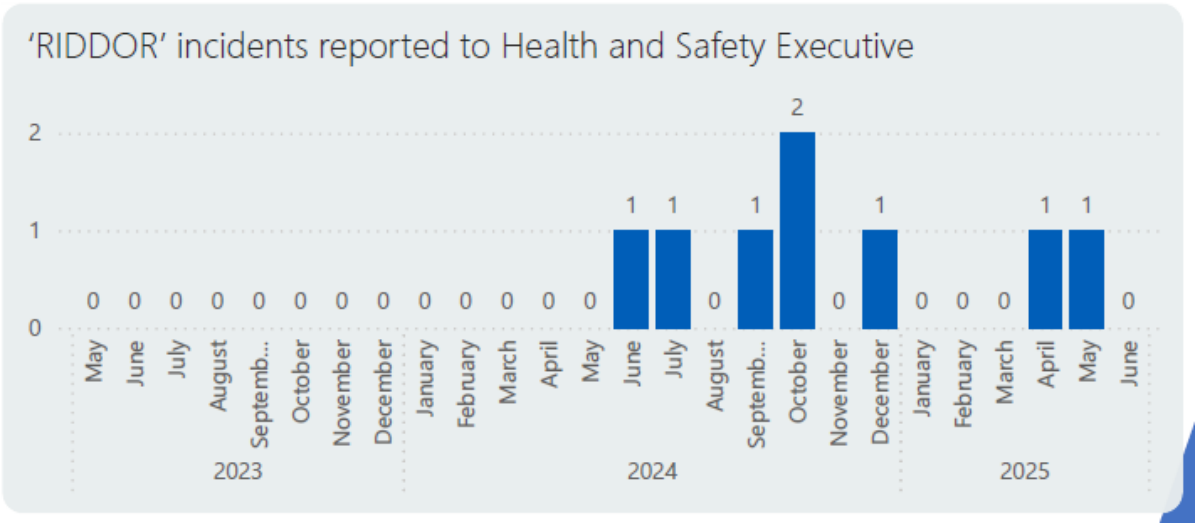
We will also send targeted emails to previous candidates, asking them to update their EDI information in the Electronic Staff Record (ESR) system.

These actions will help us collect more complete and accurate EDI data.

When do we expect to see improvement?

We expect to see improvement over the next 3 months.

‘RIDDOR’ incidents reported to Health and Safety Executive



What is the trend that we see?

Two RIDDOR incidents have been reported. A staff back injury due to leg bandaging and a patient fall at a health centre and sustained a head injury

What is being done about it?

The investigation into the staff back injury is ongoing.

Investigation into the patient fall incident identified additional warning signs were needed.

When do we expect to see improvement?

The staff back injury investigation is ongoing.

The warning signage was implemented immediately after the incident.

Finance

Summary

Prior Year	Key Financial Indicators	YTD Plan	YTD Actuals	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
(1,943)	Adjusted (Surplus)/Deficit	-	107	(107)	-	-	-
50,908	Closing Cash Balance	47,549	43,929	**3,620**	43,426	43,426	**-**
(7,628)	Capital Expenditure (CDEL)	5,328	2,513	**(2,815)**	9,711	9,711	**-**
	Quality & Value Programme						
9,130	Recurrent Savings	4,668	3,393	**1,275**	14,000	10,083	**3,917**
6,648	Non Recurrent Savings	-	1,382	**(1,382)**	-	4,024	**(4,024)**
15,778	**Total Savings**	**4,668**	**4,775**	**(107)**	**14,000**	**14,107**	**(107)**
	Temporary Staffing						
2,408	Agency	659	558	**(101)**	1,977	1,699	**(278)**
5,334	Bank	1,784	1,758	**(26)**	5,357	4,930	**(427)**
7,742	**Total Temporary Staffing**	**2,443**	**2,316**	**(127)**	**7,334**	**6,629**	**(705)**
168,716	**Total Gross staff Costs**	**54,778**	**54,214**	**(564)**	**164,499**	**162,992**	**(1,507)**
4.6%	**Temp Staffing Costs as a % of gross staff costs**	**4.5%**	**4.3%**	**(0.2%)**	**4.5%**	**4.1%**	**(0.4%)**

Income & Expenditure

As at the end of July 2025, the Trust reported a year-to-date (YTD) surplus of £0.1m, which is £0.1m favourable to its break-even plan. The Trust is on track to deliver its full-year break-even position. Progress on the Quality & Value Programme has secured £3.5m in recurrent savings to date. These results have been formally submitted to the West Yorkshire Integrated Care Board (WYICB) and NHS England.

Cash

The Trust's cash position remains strong, with a year-to-date closing balance of £43.9m, but lower than the planned figure by £3.6m. This variance is mainly due to an increase in receivables and is expected to be a timing issue only. The cash operating days, that is to pay short-term liabilities, is 70 days.

Capital Expenditure

The Trust's 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. At the end of July 2025, the Trust has reported a spend of £0.58m on owned assets and £1.94m on ROU assets. The underspend against plan as at Month 4 is related to lower than planned lease remeasurements (£0.6m) and finalisation of two property leases (£2.5m). These are partly offset by the operational capital plan being phased to the end of the year, resulting in a £0.4m year-to-date overspend which will be recovered during the year.

Quality & Value Programme

By the end of July, the Trust had identified £10.1m of its £14m recurrent savings target for 2025/26. This represents an increase of £0.4m compared with the £9.7m reported in June. The remaining £3.9m will be

delivered through non-recurrent measures enabled by strengthened grip and control. These non-recurrent elements are assessed as low risk, with active work underway to transition them into sustainable, recurrent savings via the Quality & Value (Q&V) Programme. The Trust continues to forecast full in-year delivery of the £14m target. Of the £10.1m recurrent plans identified, £9.8m is fully developed and in delivery, with £3.4m delivered YTD.

Temporary Staffing

As of July, the Trust is employing fewer temporary staff than originally planned. Further reductions are expected as the transformation programme advances, supported by the introduction of more sustainable staffing models such as the new Forensic Medical Examiners model within Police Custody and the "fair day's work" approach within CBU.

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

	P	?	F	
H	**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.
L	**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.
H	**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** — **Investigateand 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.
L	**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** — **Investigateand 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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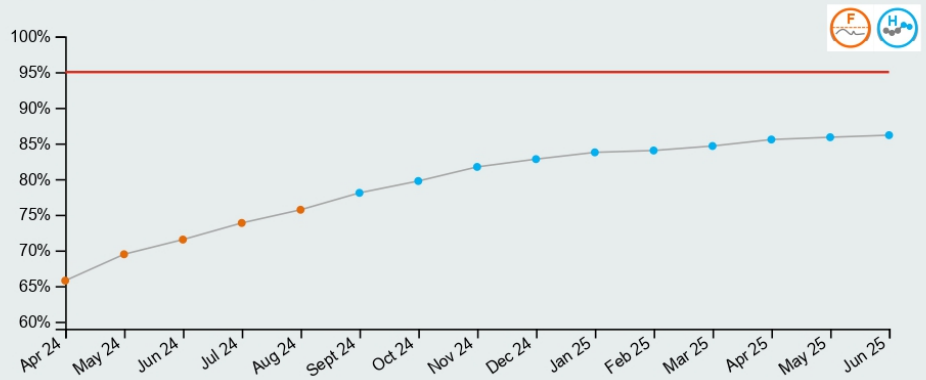
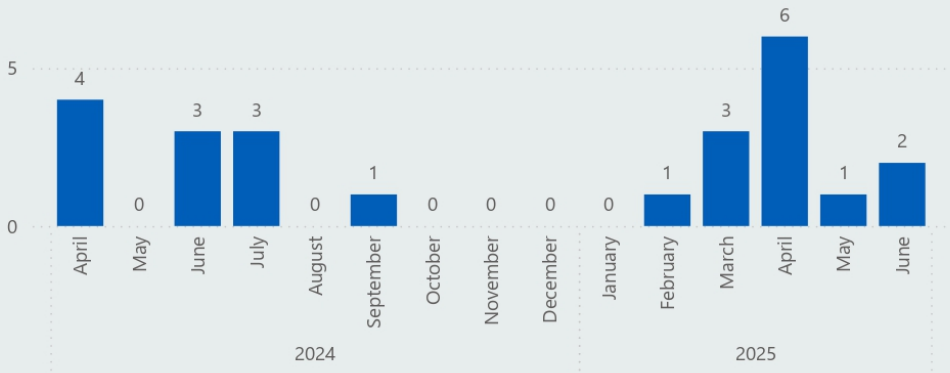
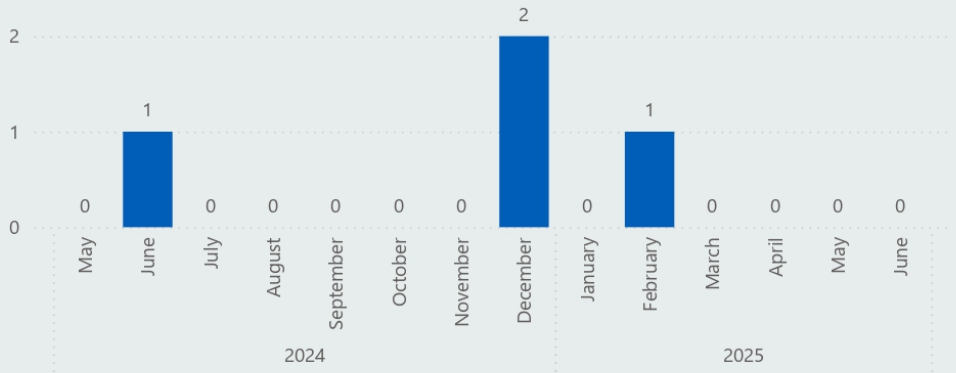
Compliance in Level 1 and 2 Patient Safety Training



Number of overdue PSII actions



Number of Patient Safety Incident Investigations (PSII)



Safe - Patient Safety

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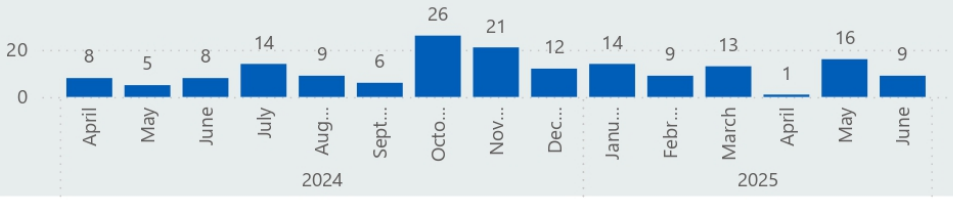
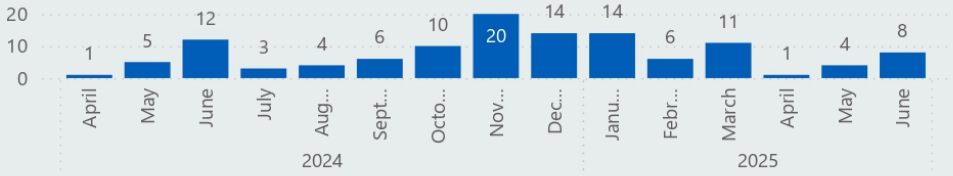
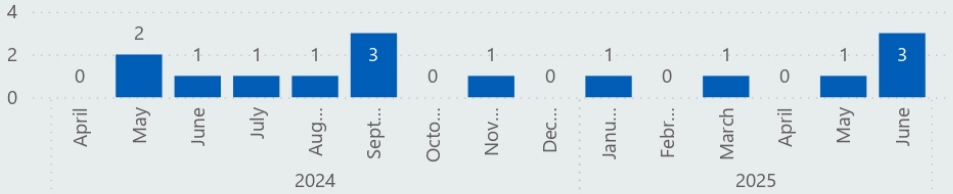
Number of incidents by PSIRP priority - Pressure Ulcers



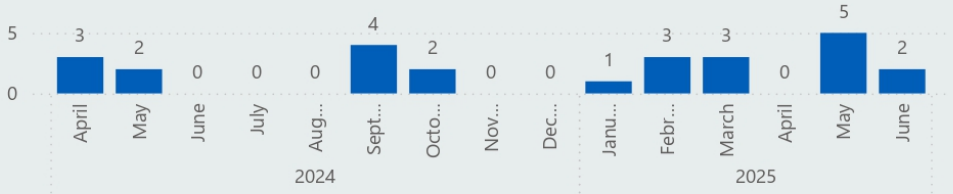
Number of incidents by PSIRP priority - Falls



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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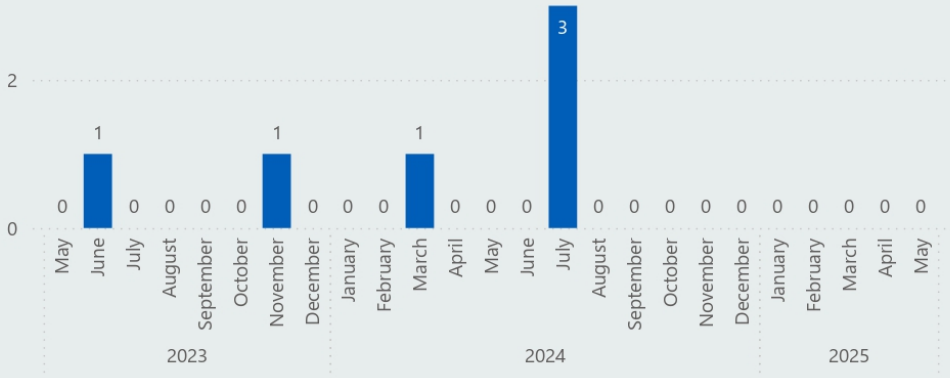
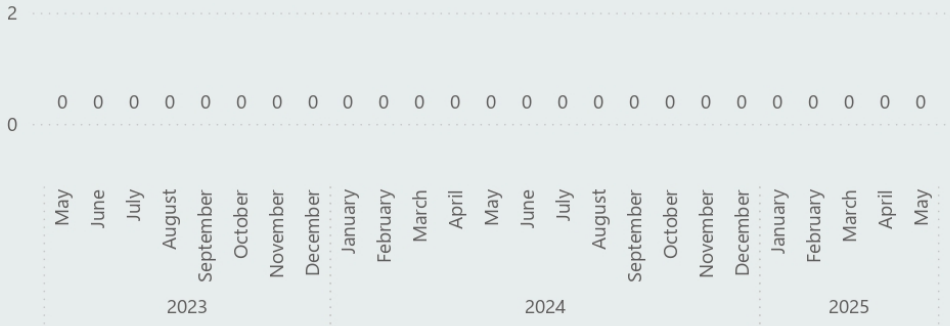
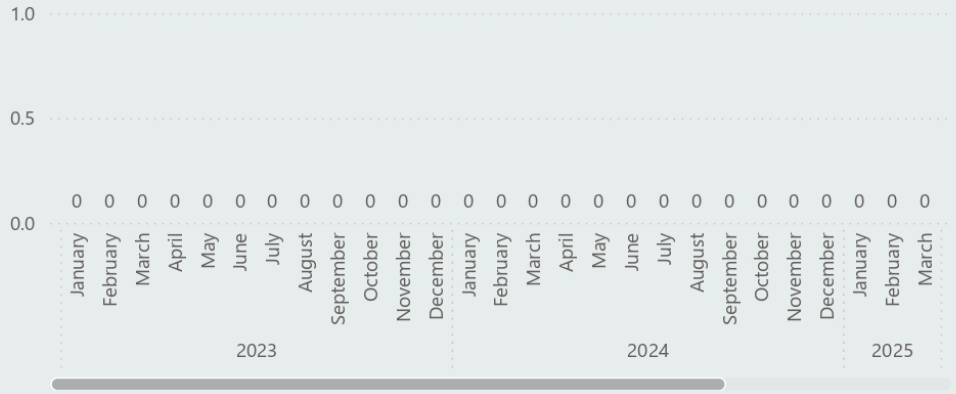
Attributed MRSA Bacteraemia - infection rate**



Clostridium Difficule - infection rate**

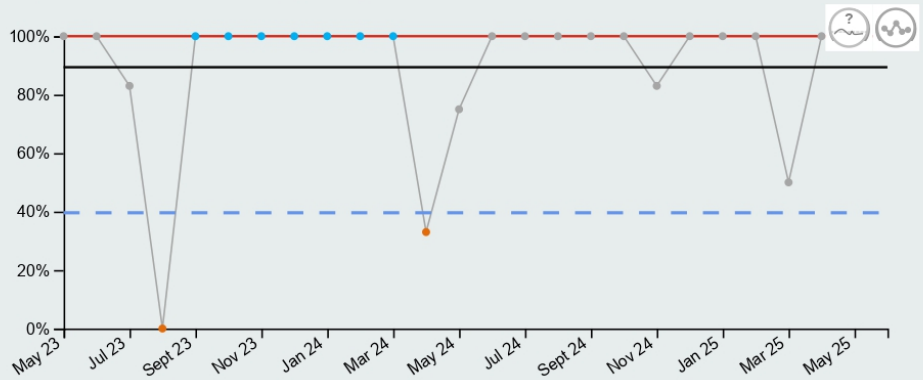


Incidents of E.Coli, bacteraemia

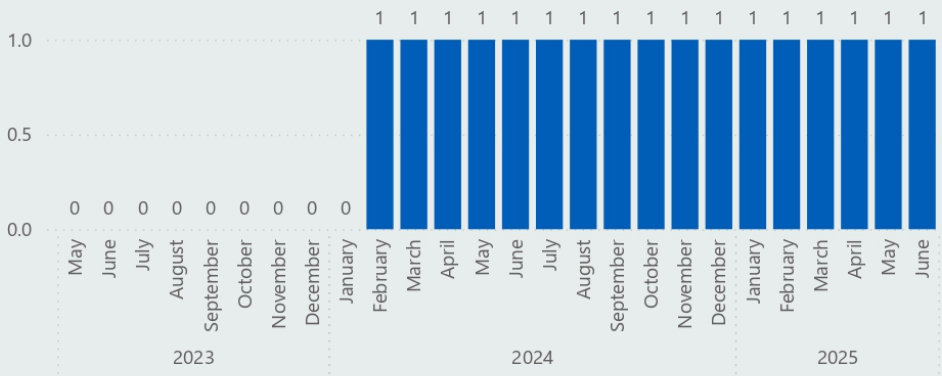


Safe - Other

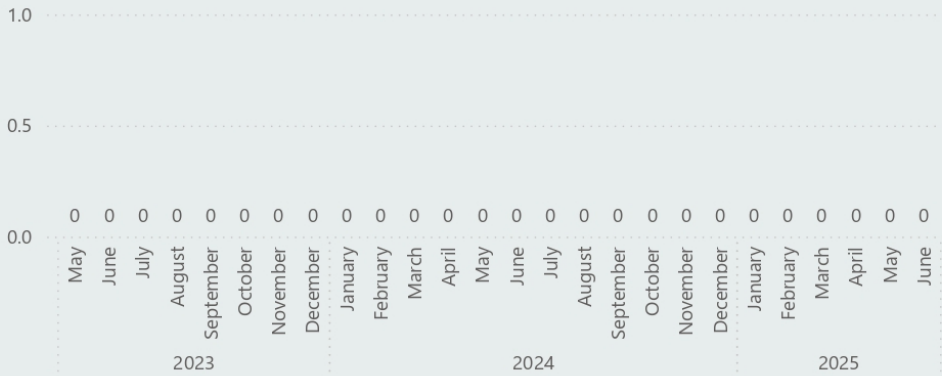
Compliance with statutory Duty of Candour



CAS Alerts Outstanding**



Never Event Incidence**



Safe - Safer Staffing

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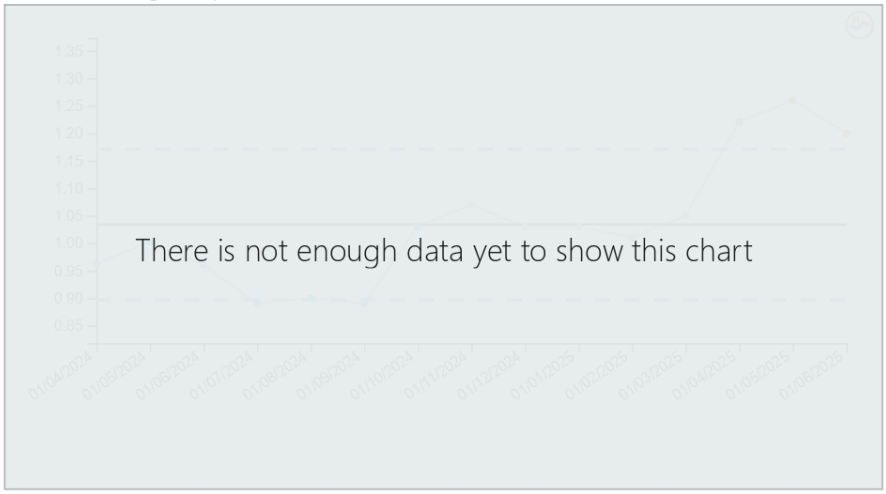
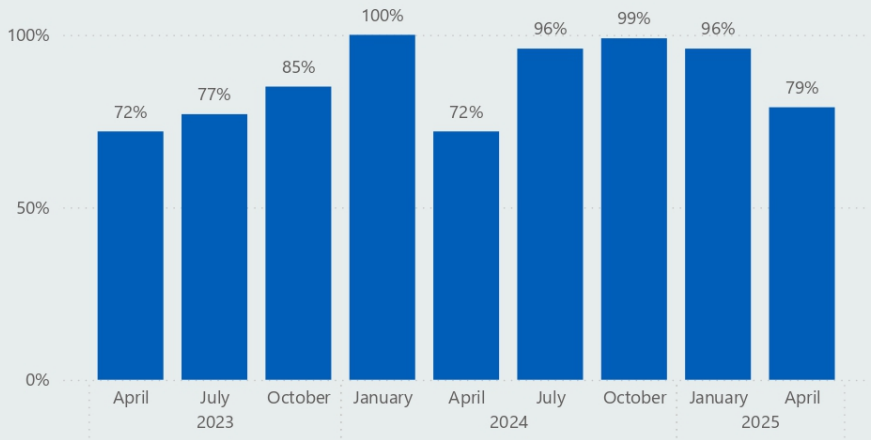
Safer Staffing – Inpatient Services



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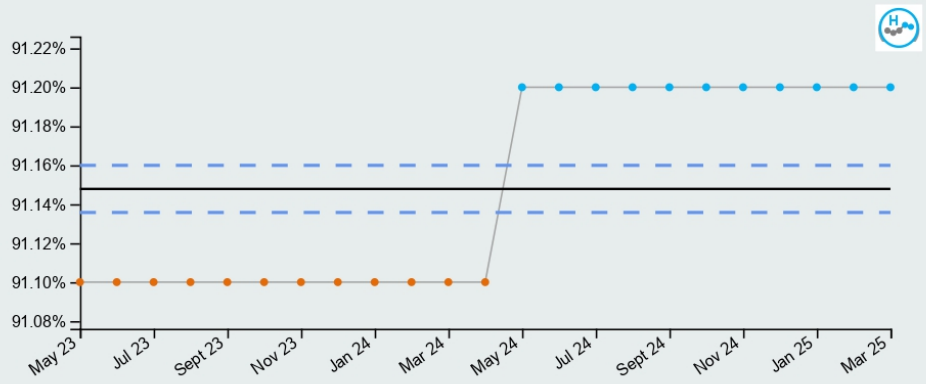
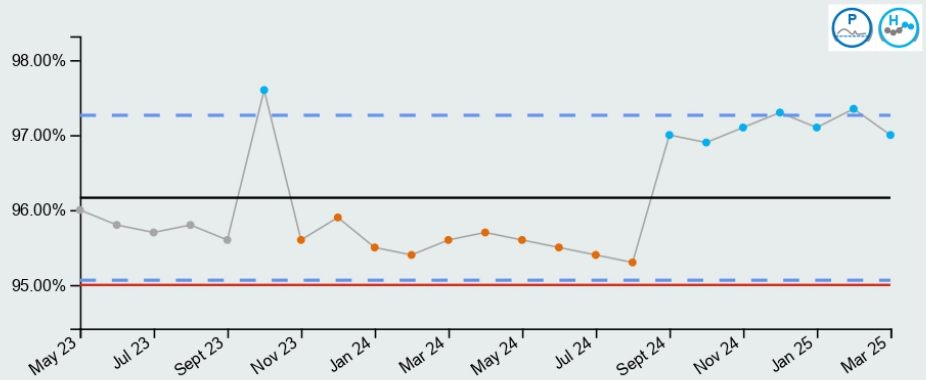
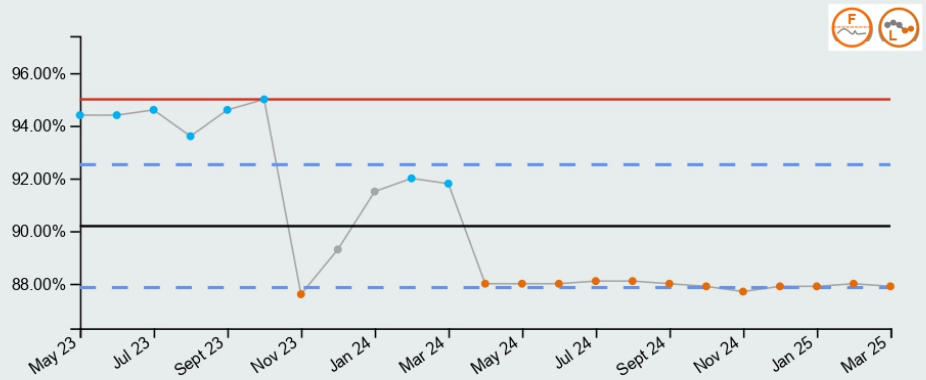
Data Quality Maturity Index (DQMI) - CSDS dataset score**



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



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



Caring Domain

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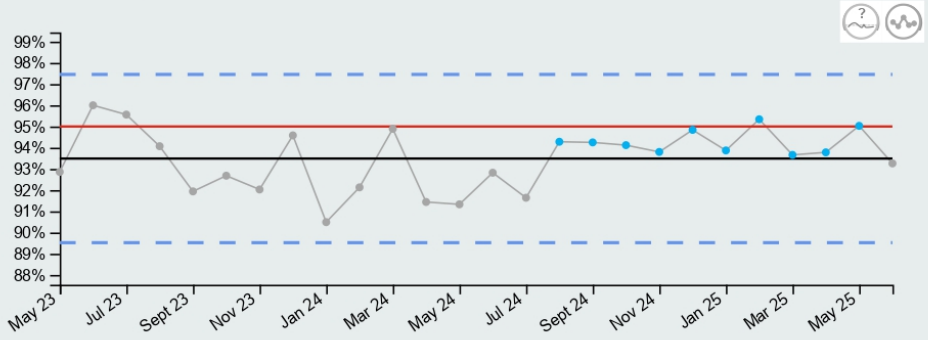
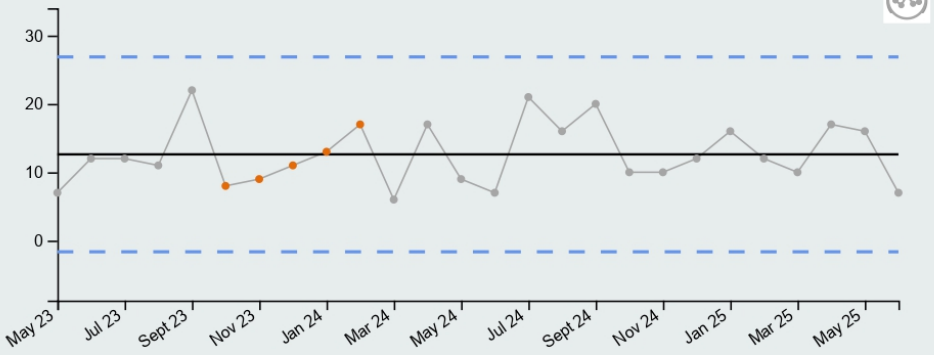
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)



Total Number of Formal Complaints Received



Mixed Sex Accommodation Breaches

No breaches Reported

Effective - Equity

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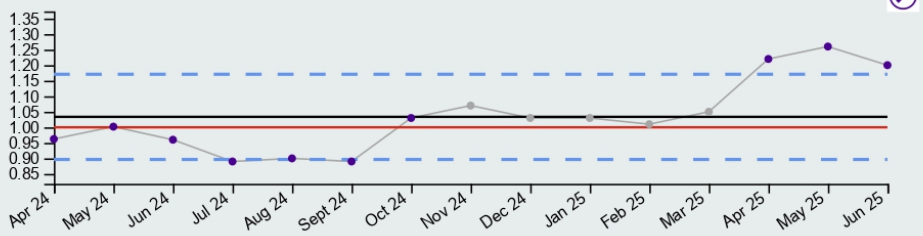
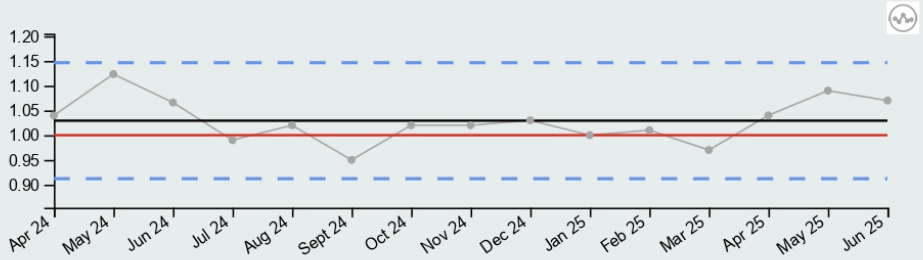
NHS Trust

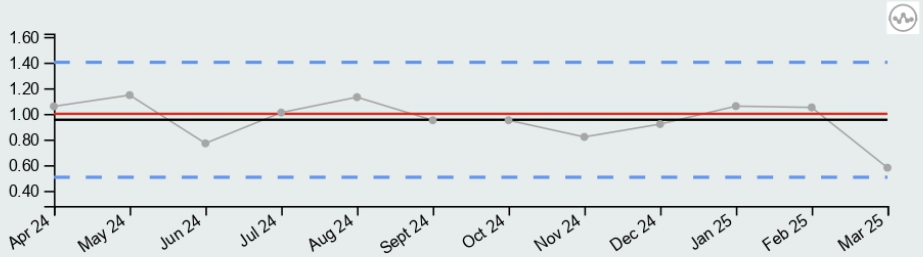
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 18 week standard



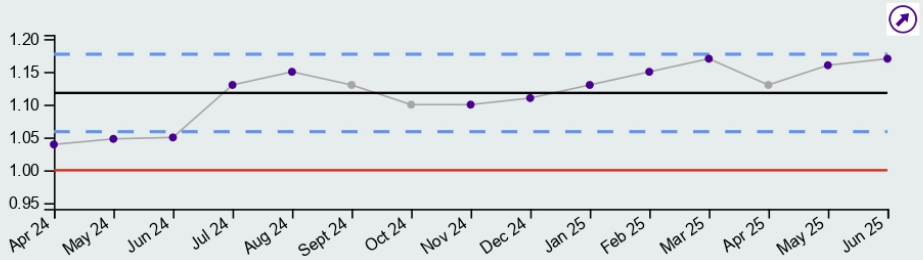
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 52 week standard



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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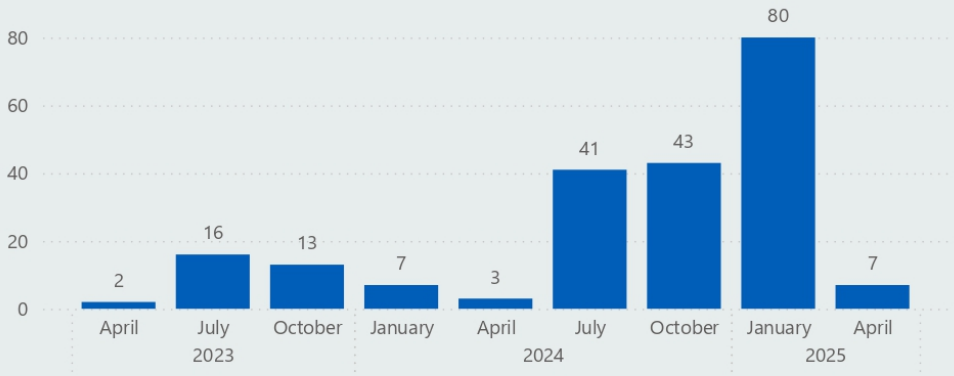
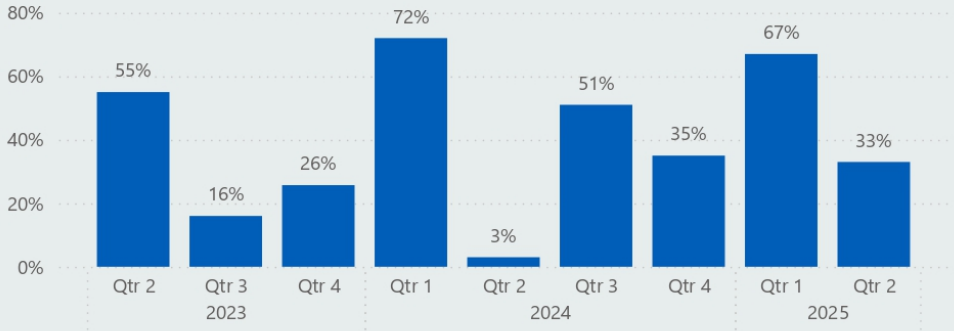
NHS Trust

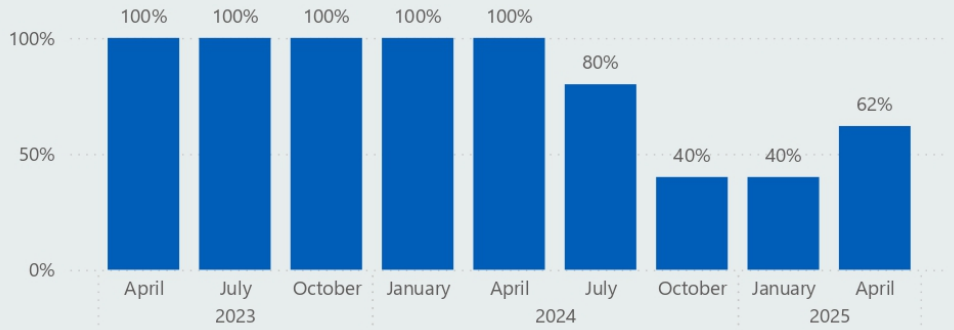
Total number of audits completed in quarter



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

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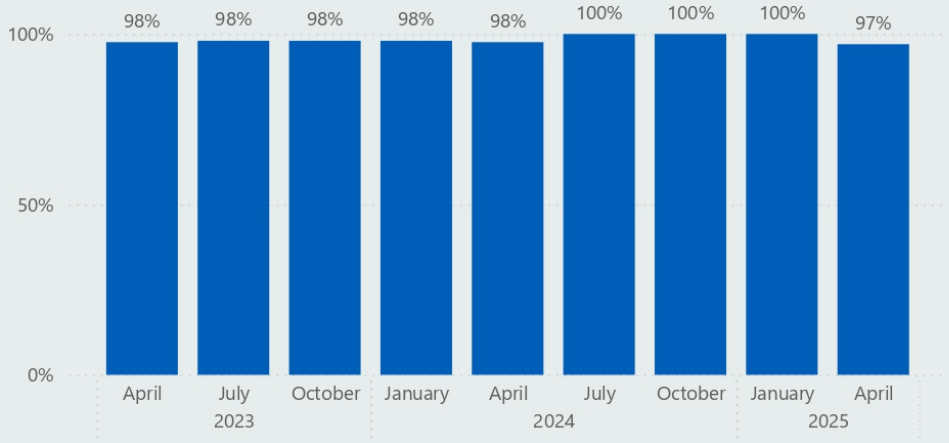
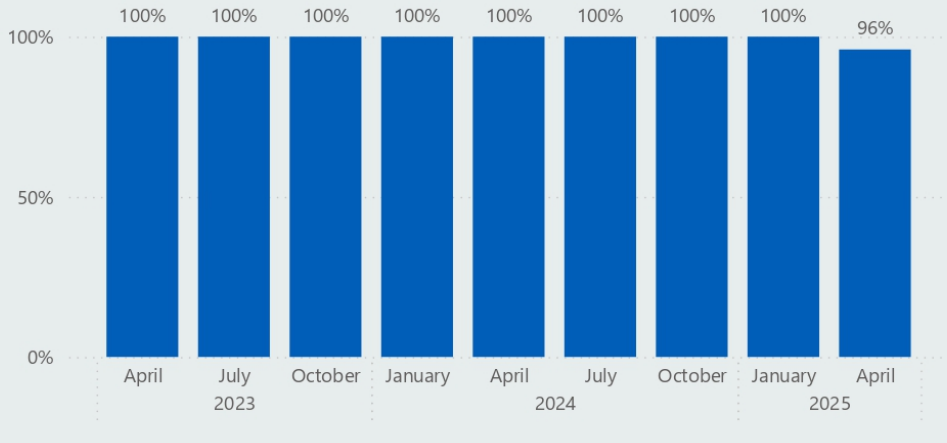
Number of NICE guidelines with full compliance versus number of guidelines published in 2019/20 applicable to LCH



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



Responsive Domain

NHS
Leeds Community Healthcare
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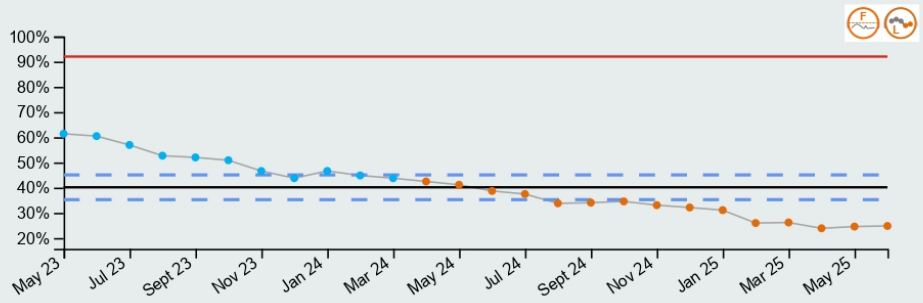
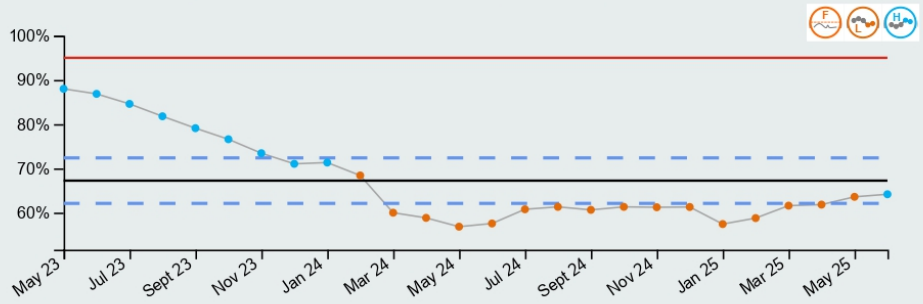
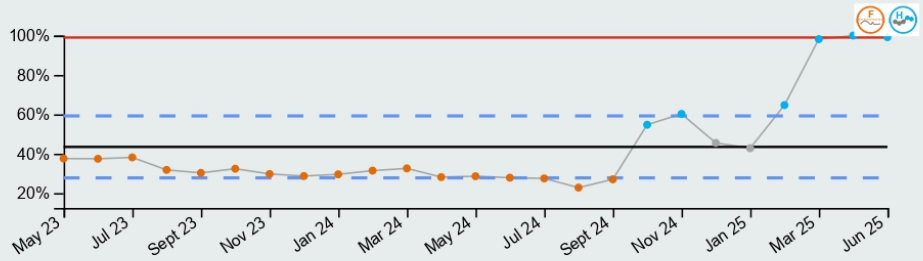
Percentage of patients currently waiting under 18 weeks (Consultant-Led)



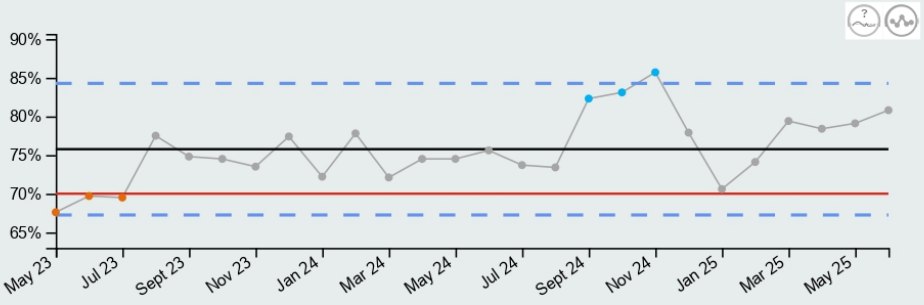
% Patients waiting under 18 weeks (non reportable)



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



Community health services two-hour urgent response standard



Responsive Domain

NHS
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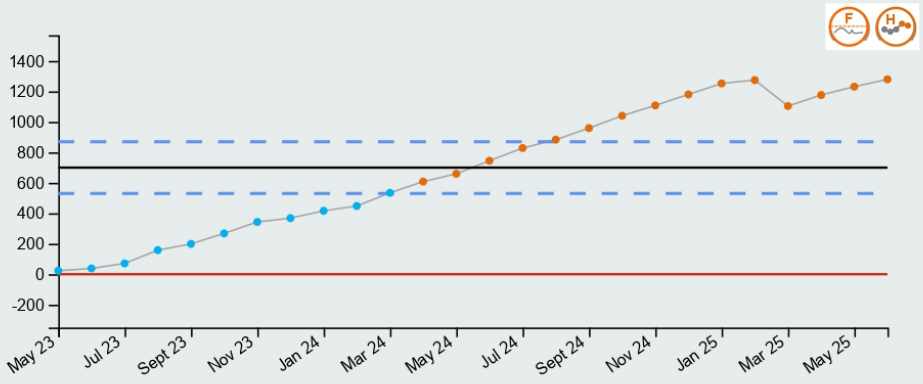
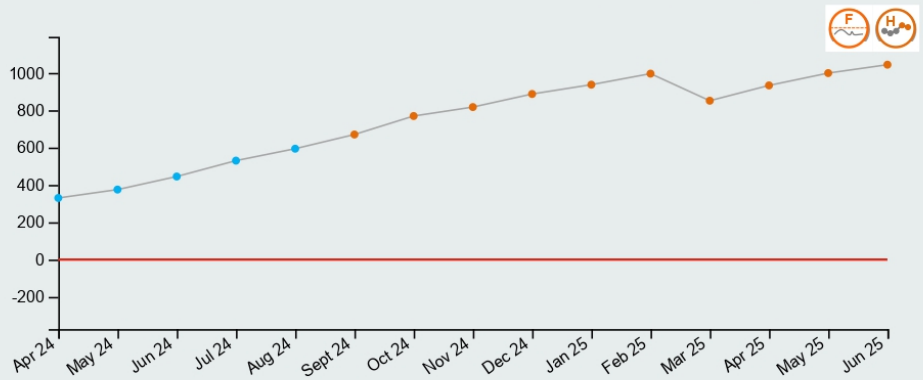
NHS Trust

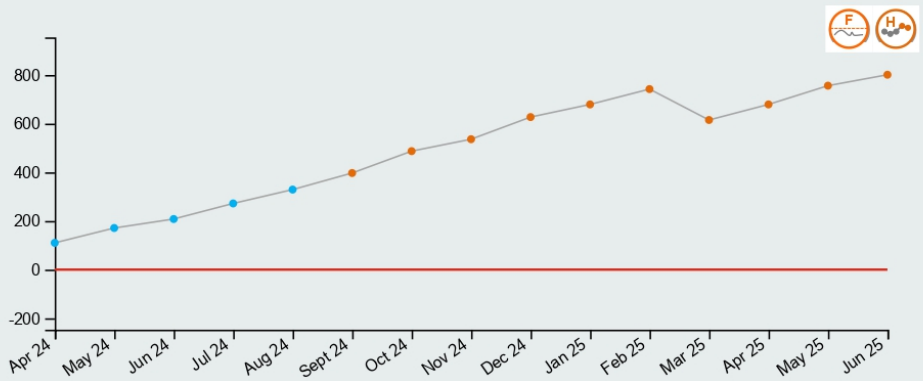
Number of patients waiting more than 52 Weeks (Consultant-Led)



Zero tolerance RTT waits over 65 weeks for incomplete pathways

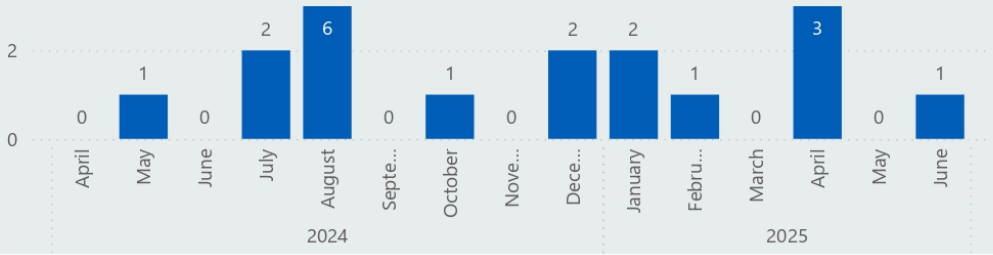


Zero tolerance RTT waits over 78 weeks for incomplete pathways

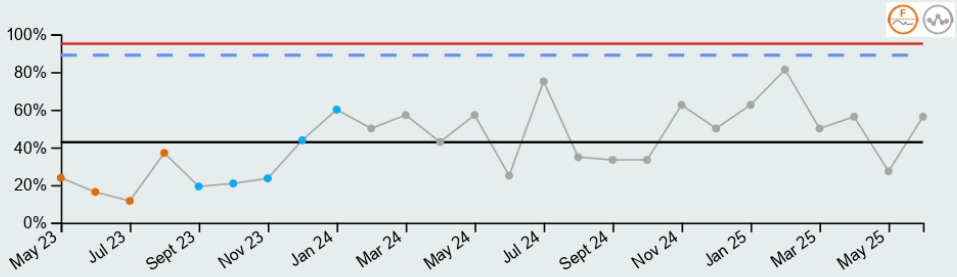


Responsive - CAMHS

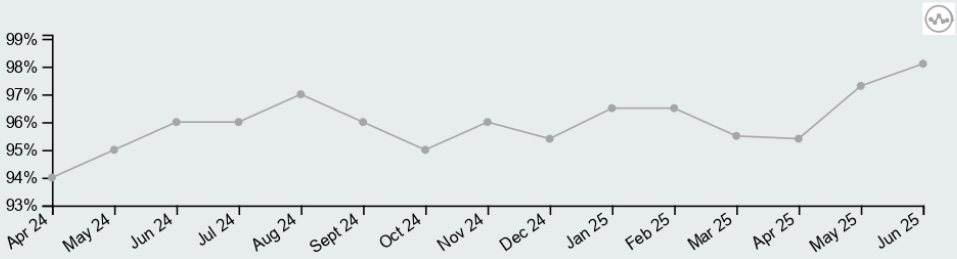
Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care



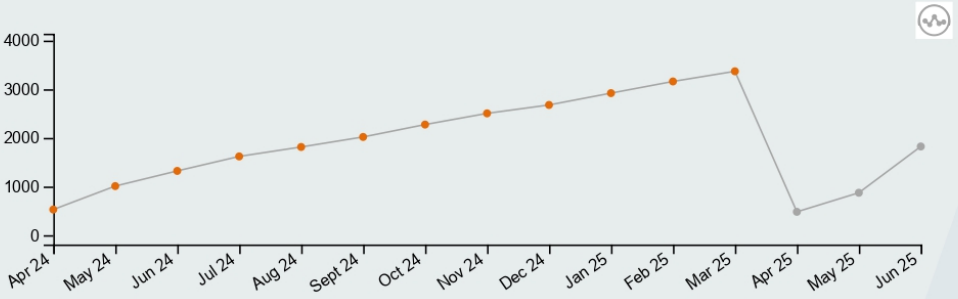
% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment



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



Number of Patients Accessing CAMHS



Responsive - LMWS

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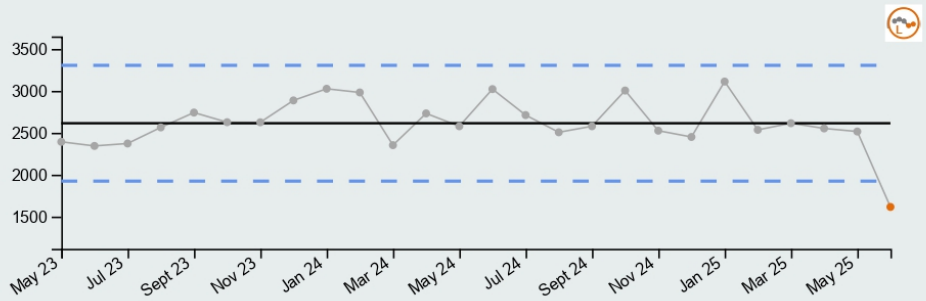
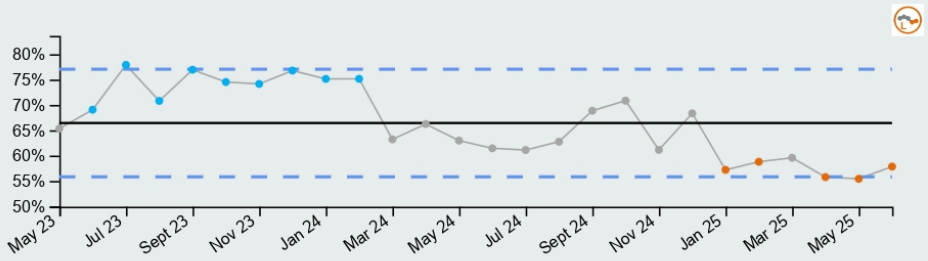
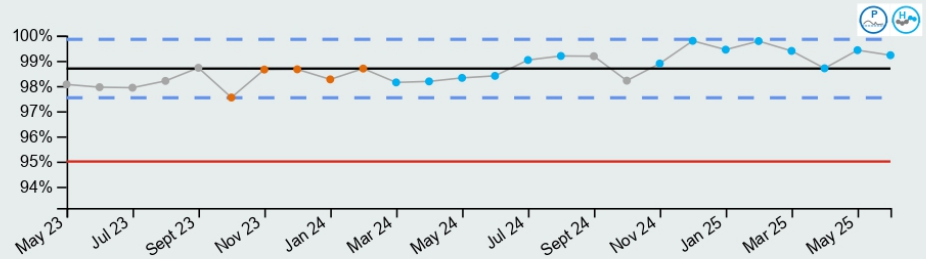
LMWS – Access Target; Local Measure (including PCMH)



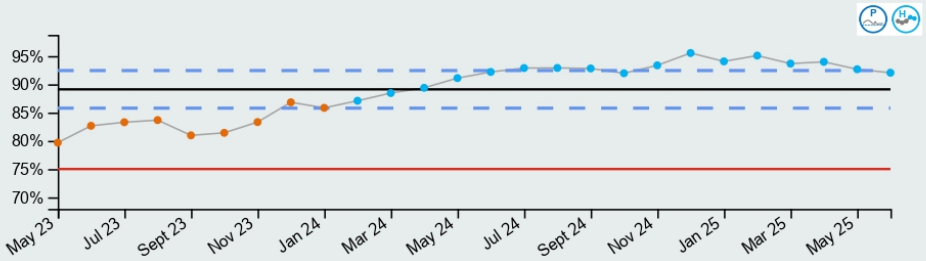
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral



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

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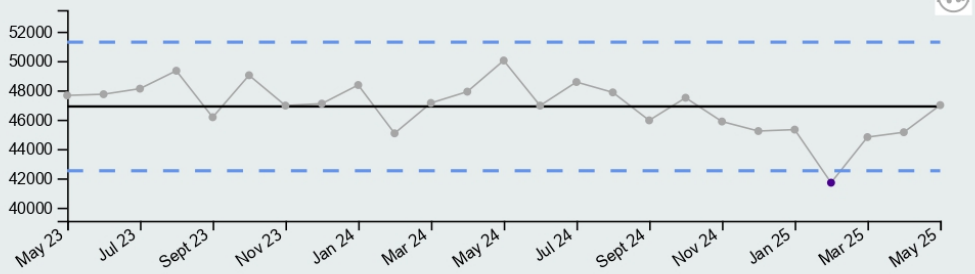
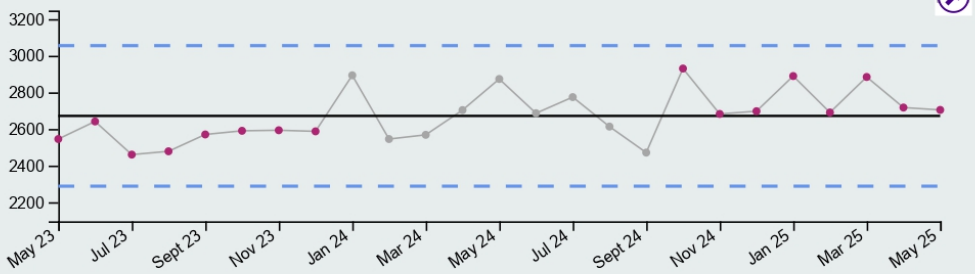
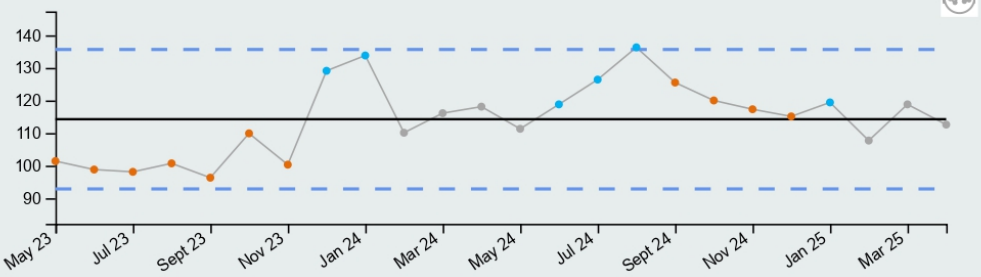
Neighbourhood Team Face to Face Contacts



Neighbourhood Team Referrals (SystmOne only)



Neighbourhood Team Productivity (Contacts per Utilised WTE)



Available virtual ward capacity per 100k head of population

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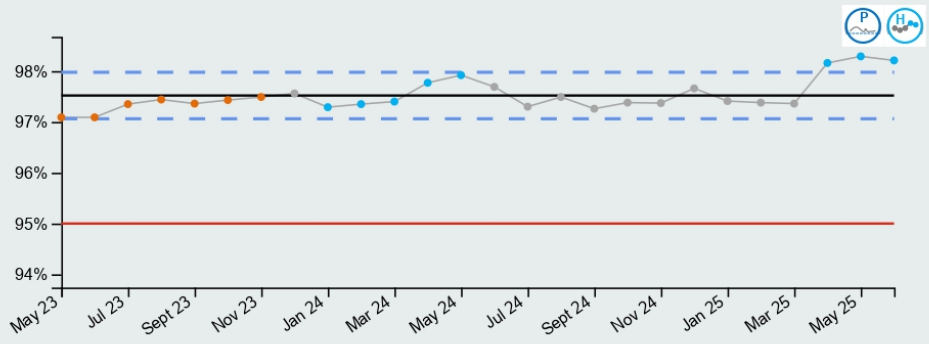
Responsive - Other

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

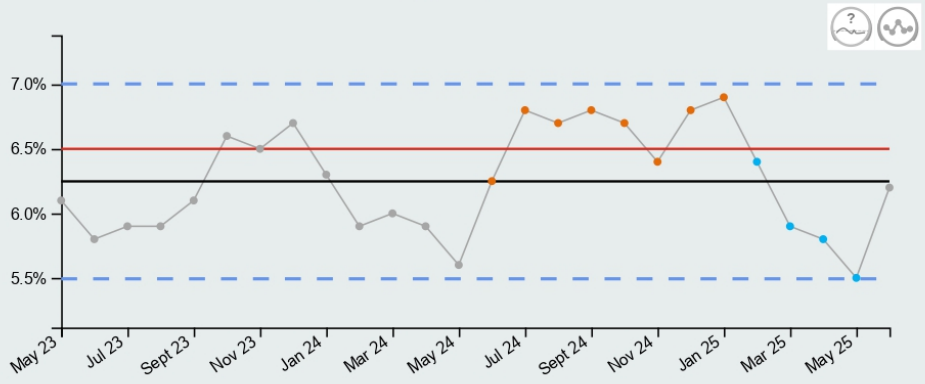
Internal Error! Please file a bug report with the following text:

This chart is under development

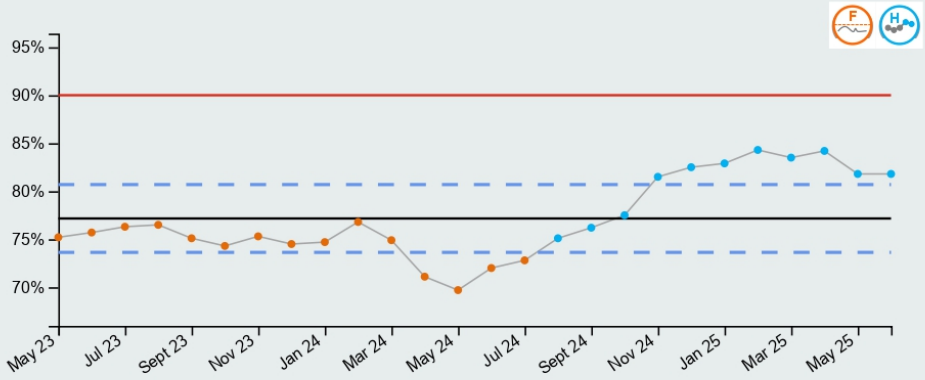
Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

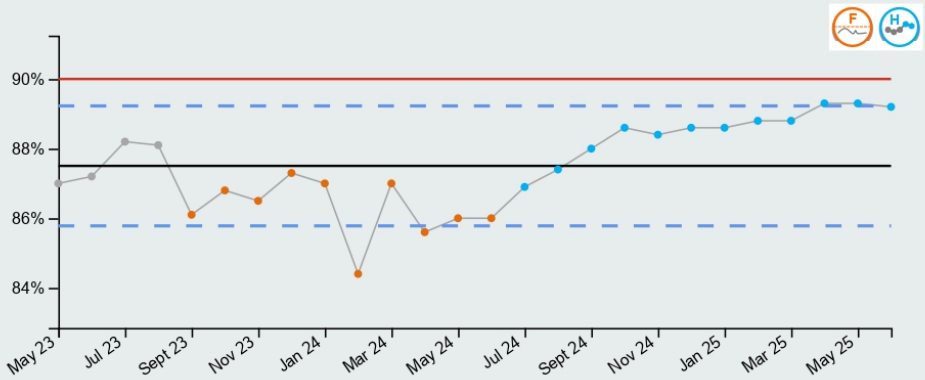
Total sickness absence rate (Monthly) (%)



AfC Staff Appraisal Rate



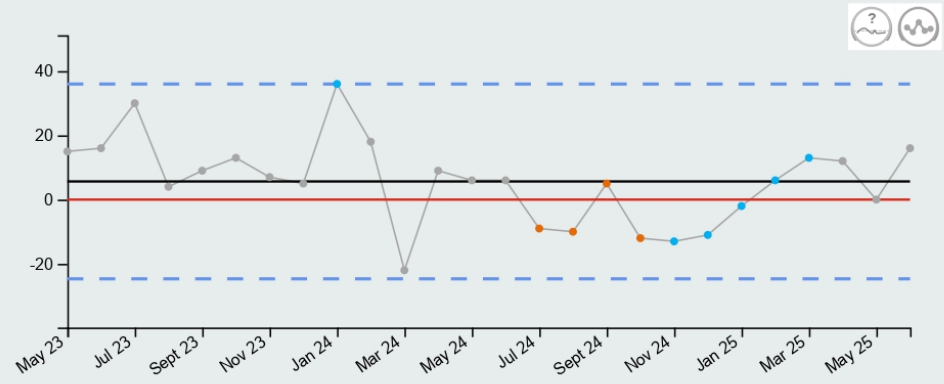
Statutory and Mandatory Training Compliance



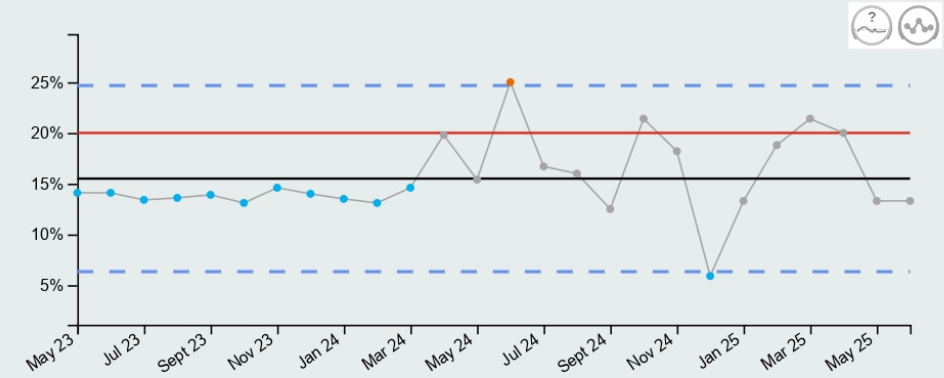
Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

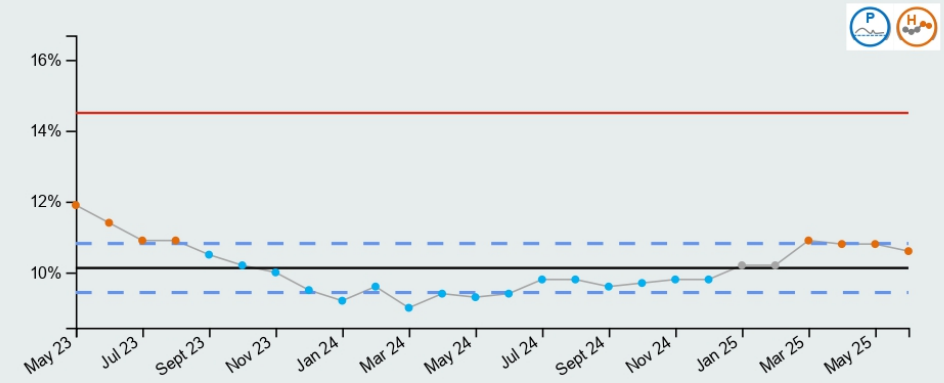
Starters / leavers net movement



Reduce the number of staff leaving the organisation within 12 months



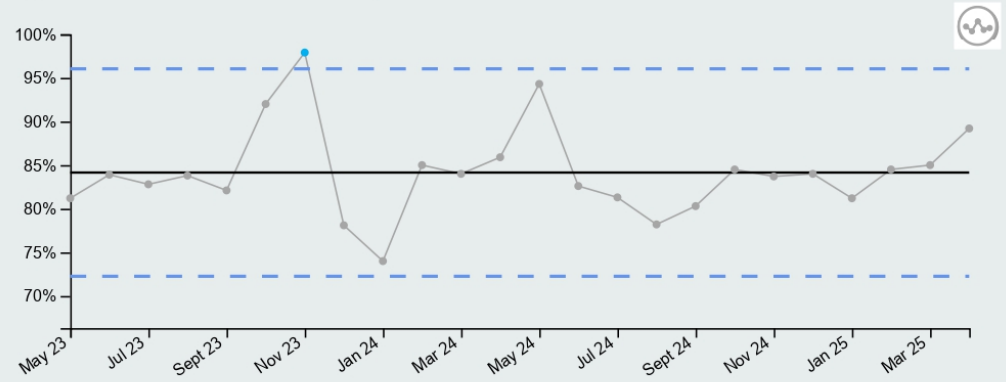
Staff Turnover



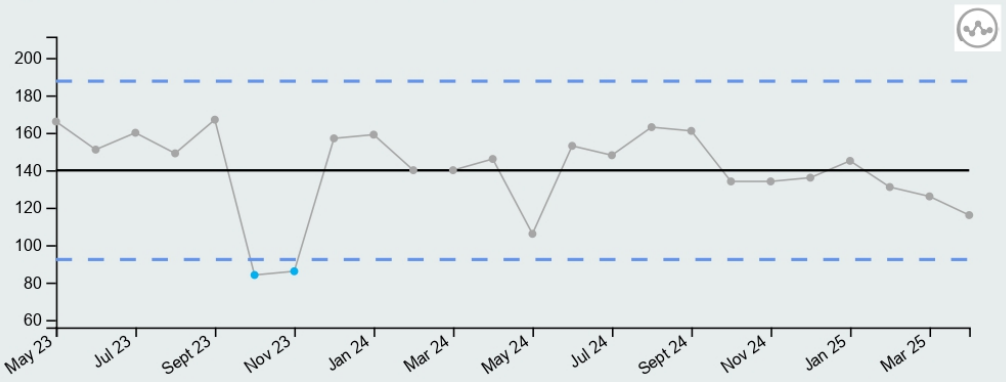
Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

Neighbourhood Team Percentage of Funded Posts Utilised



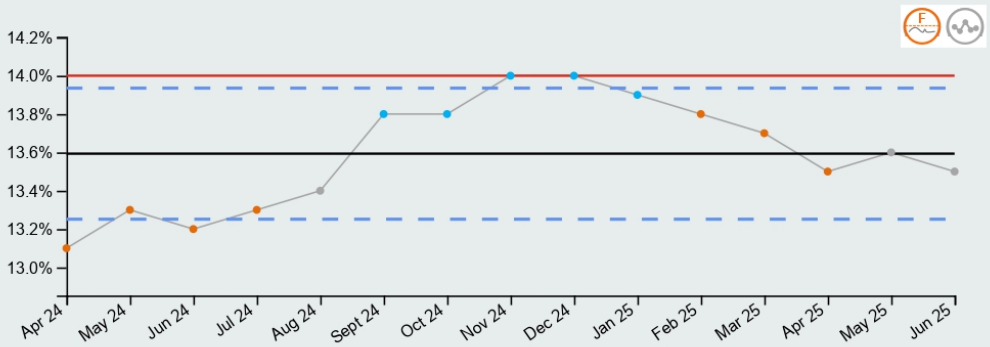
Neighbourhood Team Vacancies, Sickness & Maternity WTE



Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

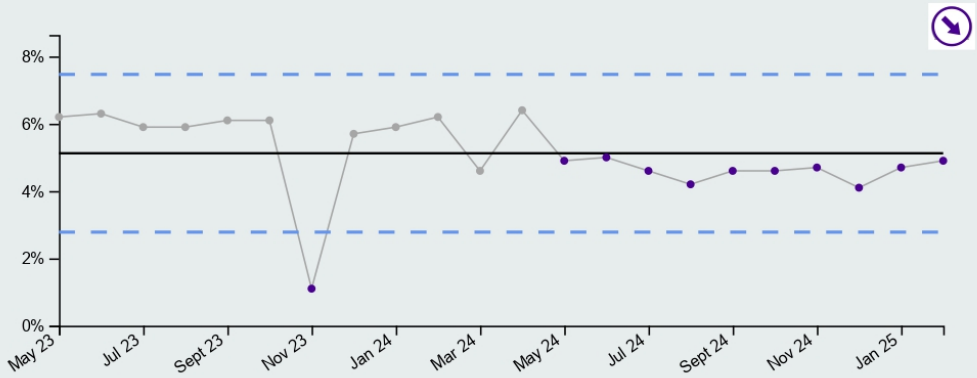
The overall percentage of staff who have identified as BME (including exec. board members)



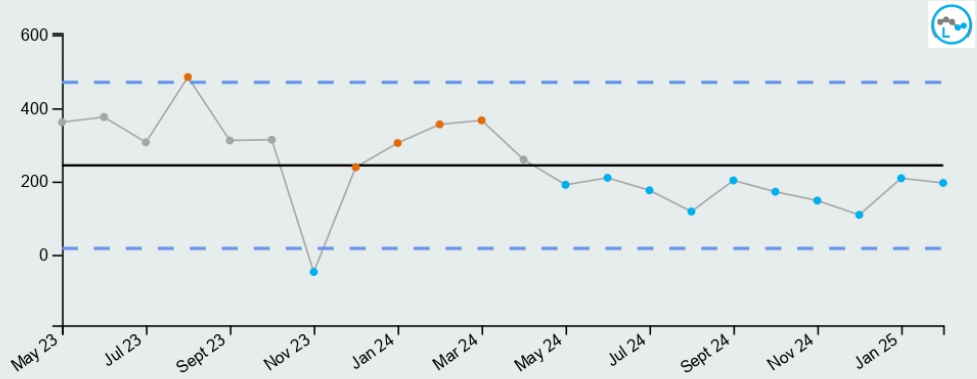
Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

Percentage Spend on Temporary Staff



Total agency cap (£k)



Well Led - Other

NHS
Leeds Community Healthcare
NHS Trust

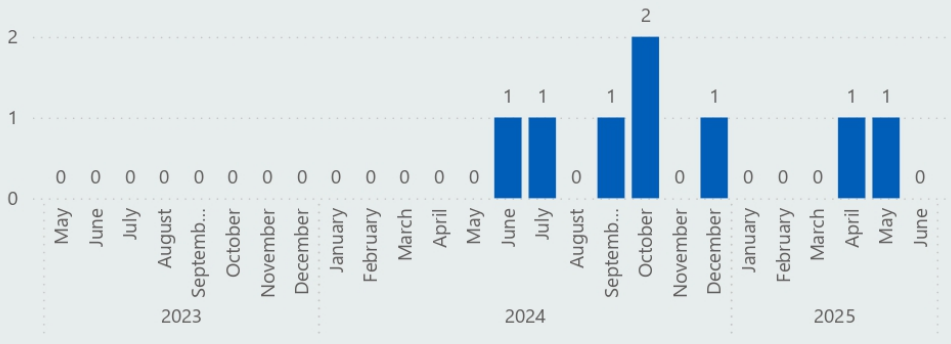
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)

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

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
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
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

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
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
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

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
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 (rolling 24 months) versus total number of expected returns	Medicines Code Assurance Checks	Complete	N/A	SPC
Safe	Safer Staffing – Inpatient Services	Safer Staffing - Inpatients	Under Development	TBC	
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

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
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	

Domain	Measure	Short Name	Development Status	Development Timeline	Visual Type
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	
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 (14i)

Title of report:	Guardian For Safe Working Hours- Quarter 1 Update

Meeting:	Trust Board Meeting Held In Public
Date:	4 September 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** • On going Grievance case in relation to CAMHS historic rota issue • Impact of Resident Doctor reforms and introduction of changes to Exception reporting system on current exception reporting pathway

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 for Safe Working Hours report

1 Introduction

The role of Guardian of Safe Working Hours (GSWH) was introduced as part of the 2016 Resident Doctor's contract. The role of the GSWH is to independently assure the confidence of Resident 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 Resident 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 16 Resident 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 Resident doctors employed directly by LCH and on honorary contracts.

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

3 Impact

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

- **Quality**

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

- **Resources**

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

Rota Gaps (number of night shifts needing cover)		Jun 2025		Jul 2025		Aug 2025	
		CT	ST	CT	ST	CT	ST
	Gaps	n/a	11	n/a	9	n/a	11
	Internal Cover	n/a	6	n/a	8	n/a	4
	External cover	n/a	5	n/a	1	n/a	6
	Unfilled	n/a	0	n/a	0	n/a	1

- **Risk and assurance**

Feedback from Resident doctors
Resident Doctors Forum (RDF) was held on MS teams on 03/07/2025.

It was agreed to review and monitor CAMHS non-resident on call rota. Attendance was poor due to unavoidable issues for most resident doctors. In view of poor attendance and the need to review and incorporate changes as a part of the new exception reporting reforms, GSWH and people present in the meeting agreed to arrange an extraordinary RDF prior to the next meeting in Oct. This meeting is scheduled for 02/09/2025.

CAMHS Historic ST rota issue

The first grievance received by the Trust in relation to this issue has been investigated and concluded with areas for improvement noted, but no allegations upheld against the Trust.
A second grievance has also been received in relation to this matter and is currently being reviewed.

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.

Since the last Trust Board meeting, LCH people's directorate has produced a new ER forms that will be implemented from September 2025. GSWH has reviewed and requested the form to be circulated to all Resident doctors for feedback and to be discussed at the Extraordinary meeting due on 02/09/25.

➢ 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 15/08/2025

Agenda item:	2025-26 (14i)
Title of report:	Guardian Of Safe Working Hours Annual Report 2024-25

Meeting:	Trust Board Meeting Held In Public
Date:	4 September 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** **Main issues for consideration** • On going Grievance case in relation to CAMHS historic rota issue • Improved Medical staffing and HR support for Resident doctors in LCH • Impact of on-call work on community paediatric training needs • Impact of Resident Doctor reforms and introduction of changes to Exception reporting system on current exception reporting pathway

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)	• Receive this assurance regarding Resident Doctor working patterns and conditions within the Trust.

	• To note that there is a grievance case ongoing that is raised by Resident doctors affected by CAMHS historic rota issue. • Support GSWH with the work in relation to implementation of Exception reporting reforms and changes to Resident doctors contract changes. • Support GSWH with the work in relation to improving community paediatric training and educational opportunities.
List of Appendices:	Nil

ANNUAL REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

1. Executive summary

This report covers the period from May 2024 to May 2025.

Grievance case has been filed by doctors who worked as resident doctors during the period of 2018-2021 at LCH. CAMHS historic rota issue that was investigated in depth over the last few years was concluded and affected resident doctors were informed about their rights to file a grievance case if they needed to look into the issue further. The case is on going and GSWH and BMA IRO have offered LCH and affected Resident doctors the support they need.

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 is working with People's directorate team to implement the changes at the earliest.

Specialist training for Resident doctors in Community paediatric has been impacted by the number of on call shifts. This is an ongoing issue and GSWH continues to work with Paediatric college tutor to address the issue across both LCH and Leeds teaching hospital Trust where the on call work is performed.

2. Introduction

This report, as required by the Resident Doctor's contract, is intended to provide the Board with an evidenced based report on the working hours and practices of Resident Doctors within the Trust, confirming safe working practices and will illustrate areas for concern. This report is written with the information available relating to data to date in the period covered.

Purpose: to report on issues affecting trainee doctors and dentists such as working hours and the accessibility of training which forms part of the rotational training programme.

3. High level data

Number of doctors / dentists in training (total): 22

Number of doctors / dentists in training employed by LCH 10

4. Annual data summary

Trainees within the Trust
(Quarter 1- year 2024 to Quarter 4 -year 2025)

Department	Grade	Status	Quarter 1	Quarter 2	Quarter 3	Quarter 4
			2024	2024	2025	2025
Adults		LCH contract	0	0	0	0
Foundation year 1	FY1	Honorary contract	2	2	2	2
CAMHS	ST	LCH contract	6	6	3	3
	ST	Honorary contract	0	0	0	0
	CT	Honorary contract	2	2	3	3
Community Paediatrics	ST Level 1	Honorary contract	4	4	3	3
	ST Level 2 Grid trainee	LCH contract	4	4	5	5
Sexual Health	ST	LCH contract	1	1	2	2
GP	GPSTR	LCH contract	2	2	2	2
Obstetrics/ community gynae		Honorary contract	1	1	1	1
Dental Services		Honorary contract	0	0	1	1
Total			22	22	22	22

5. Exception Reporting

No exception reports have been filed over the last year Q1-Q4 24.25.

5.1 **Working Hours and work schedule review**

For CAMHS non-resident on-call , a compliant rota is in place. Work schedule has been drawn up based on the work conducted during on call and incorporating the required rest periods and breaks as per the Resident doctors contract.

GSWH has requested HRBS the need for a robust monitoring system with every cohort of resident doctors who join the trust.

5.2 **Educational Opportunities**

No exception reports submitted relating to educational opportunities.

Resident doctors in community paediatrics cover on-call work at Leeds Children's Hospital as a part of their job. Sub-speciality training (Nationally approved training post with specific requirements for specialist training) are concerned that they are not receiving the required training due to not having enough training time as recommended by the Royal college guidelines. The guidance recommends that the Resident doctor spends 70% of their time in base speciality and the rest to cover on-call work. This is currently not fully achieved in community paediatrics.

The issue is a long standing issue and progress has been made over the last year with few small changes that have positively impacted on the training time resident doctors receive.

GSWH continues to work with paediatric college tutor, GSWH from LTHT Trust and rota co-ordinators from LTHT to ensure that the training needs are optimised.

6.0 Rota Gaps

The CAMHS ST non resident on call rota consists of a 1:5 rota, and 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 Resident doctors.

6.1 CAMHS Historic ST rota issue

Disclaimer: Section 6.1 contains information that is historic and complex. It contains overview of the issue but not the nuances. GSWH will be able to guide the board with the nuances and any further updates at the meeting

Issue with compliance of CAMHS non-resident on-call rota was raised as a concern by a resident doctor in April 2021. The issue affects resident doctors on the CAMHS non-resident on-call rota employed by the Trust from the year 2016/2017 until 2021. This issue has now reached conclusion that has been put forward to affected Junior doctors.

One Junior doctor has raised a grievance case on 23/11/24 via correspondence to Director of workforce. There has not been any further update since the last Trust board meeting. The case is on-going.

7. Engagement with Resident doctors and Resident doctor forum meetings

The Virtual Resident Doctor's Forum (JDF) was held in July 2024, October 2024, January 2025 and April 2025.

Resident doctors have found the JDF platform a useful platform to voice their feedback around HR issues, training opportunities. Attendance continues to be an issue despite the virtual nature of the meeting. Ideas and suggestions have been included to improve engagement with resident doctors.

8 Fines

No fines have been levied by the GSWH over the past year.

9 Recommendations

Board is recommended to:

- Receive this assurance regarding Resident Doctor working patterns and conditions within the Trust.
- To note that there is a grievance case ongoing that is raised by Resident doctors affected by CAMHS historic rota issue.
- Support GSWH with the work in relation to implementation of Exception reporting reforms and changes to Resident doctors contract changes.
- Support GSWH with the work in relation to improving community paediatric training and educational opportunities.

Agenda item:	2025-26 (15i)

Title of report:	Annual Medical Director's report 2024-2025

Meeting:	Trust Board Meeting Held In Public
Date:	4 September 2025

Presented by:	Dr Ruth Burnett Executive Medical Director					
Prepared by:	Dr Ruth Burnett Executive Medical Director					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	To provide Board with an update and overview regarding our responsibilities as an employer of Medical and Dental staff within the Trust, including: • Appraisal and medical revalidation • Managing concerns • Pre-employment checks. It fulfils the requirements set by NHS England in relation to: • Annual Organisational Audit • Designated Body Annual Board Report • Statement of Compliance This Executive Medical Director's report covers the period 01/04/24 to 31/03/25 and includes information and activity relating to the Trust responsibilities regarding employment of medical and dental staff; based on the four key principles identified in the handbook and guidance regarding "Effective Clinical Governance to support revalidation" published by the GMC in 2024. It is accompanied by the recommended template for the Statement of Compliance for 24/25. Whilst this template formally refers to our employment of medical professionals, for the purpose of the report it also references our employment of dentists, unless specifically noted otherwise.

Previously considered by:	Quality Committee – 29 July 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?	The Trust has a highly diverse workforce.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	Board is recommended to: • Note the contents of the 2024/25 Annual Executive Medical Director's Report • Note the requirements by NHS England to include the statement of compliance from the Board. • Approve the statement of compliance and submission to NHS England

List of Appendices:	Appendix 1 – Professional Standards Framework for Quality Assurance and Improvement 2024-2025 Leeds Community Healthcare NHS Trust (Statement of Compliance)

Medical Directors Annual Report
(including NHSE Statement of Compliance 24-25)

➢ 1 Introduction

The report details key areas of progress and further identified work against each of the four key principles identified in the GMC document of 2024 as those that underpin effective clinical governance in this context. These are:

- **Principle 1: An effective environment**
  Organisations create an environment which delivers effective clinical governance for doctors.
- **Principle 2: Continuous Improvement**
  Clinical governance processes for doctors are managed and monitored with a view to continuous improvement.
- **Principle 3: Fairness**
  Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination.
- **Principle 4: Supporting Process**
  Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practice.

Leeds Community Healthcare NHS Trust is a Designated Body responsible for the appraisals of all doctors employed by the Trust. Regulations require that all Designated Bodies must nominate or appoint a Responsible Officer, who must be a licensed doctor. This post is held in LCH by the Executive Medical Director and is therefore represented on the Board.

The Responsible Officer is supported by a Deputy Medical Director (Professional Standards) and a Head of Medical Education and Revalidation. The Deputy Medical Director post has been held by an individual holding consultant status since Sept 2019. This individual has undergone NHSE approved Responsible Officer training.

This report covers the period of 01/04/24 - 31/03/25. During this period LCH had a prescribed connection with 39 doctors, and responsibilities to 8 dentists who undergo annual appraisal but whose regulatory body the General Dental Council (GDC) does not have a revalidation process.

Of the 39 doctors that were due an appraisal, 100% (39 doctors) completed their appraisal within 24/25. 8 dentists were due an annual appraisal for 24/25 of which 100% were completed. 7 doctors were due for revalidation in 24/25, 100% of which were successfully revalidated for five years.

LCH had one doctor in a remediation or MHPS process during 24/25. The Trust Board have been regularly updated in private session.

➢ 2 Current position/main body of the report

Analysis of the Medical and Dental Workforce in LCH can be seen below, this includes **39** doctors with a prescribed connection to the Trust, **8** dentists, and **22** training posts (10 LCH employed Higher Trainees and 12 Lead Employer

Agreement posts who hold Honorary Contracts with LCH - 3 GP VTS Trainees, 3 Core Psychiatry Trainees, and 6 Paediatric Higher Trainees).

Medical and Dental Workforce						
	23/24 Data			24/25 Data		
Ethnic Group	Headcount	%	FTE	Headcount	%	FTE
White	21	30.43%	13.84	**26**	**37.68**	**17.18**
Ethnic Minority	17	24.64%	12.25	**13**	**18.84**	**9.63**
Unspecified/Not Stated	31	44.93%	22.55	**30**	**43.48**	**20.78**
Grand Total	69	100.00%	48.64	**69**	**100.00**	**47.58**

Compared to the previous year there is an increase in the percentage of staff recording their ethnic group as 'White' (21 in 23/24), and a decrease in staff recording their ethnic group as 'Ethnic Minority (17 in 23/24). This is in part due to the rotations of resident doctors. Staff recording their ethic group as 'Unspecified/Not Stated' has decreased from last year (31 in 23/24), the total number of staff recorded has remained the same as the previous year.

Age profiles of Medical and Dental Workforce 23/24						
Age Band	23/24 Headcount	23/24 %	23/24 FTE	24/25 Headcount	24/25 %	24/25 FTE
26-30	8	11.59%	6.33	5	7.25%	3.90
31-35	8	11.59%	4.55	9	13.04%	6.65
36-40	12	17.39%	7.60	12	17.39%	9.06
41-45	9	13.04%	6.75	9	13.04%	5.55
46-50	16	23.19%	9.70	16	23.19%	8.64
51-55	9	13.04%	8.63	9	13.04%	8.38
56+	7	10.14%	5.09	9	13.04%	5.41
Grand Total	**69**	**100.00%**	**48.64**	**69**	**100.00%**	**47.58**

The number of staff recorded as 26-30 has reduced due to changes in resident doctors rotating in and out of the Trust. The analysis of the workforce based on ethnicity demonstrates a highly diverse workforce.

Medical Job Planning

In May this year NHSE renewed their focus on the importance of job planning for the medical workforce as a means to effectively deliver clinical services – increasing productivity and delivering efficiency gains as well as supporting staff in a fair and consistent fashion. The Trust has job plans well established in the medical workforce however we do not currently use job planning software which would enable better understanding of workforce capacity.

The 'Levels of Attainment' are benchmarks used to measure a trust's progress in adopting and using e-job planning software. They are:

- Level 0: No e-job planning
- Level 1: Basic individual e-job planning
- Level 2: Advanced individual e-job planning

- Level 3: Team e-job planning
- Level 4: Organisational e-job planning

Currently LCH is scoping the procurement of e-job planning software and will need funding and resource to be able to implement the system and deliver the benefits. Therefore, the Trust will report a level 0 level of attainment to NHS England.

Temporary Staffing

Over the last year the following services have been supported by temporary bank staff:

CLASS Data 24/25	
Service Worked for	**Total Hours worked (previous years hours)**
Community CYPMHS	**1044** (2306)
Leeds Sexual Health	**12** (830)
ICAN Service	**192** (0)
Community Gynaecology Service	**239.35** (147)
Total Hours	**1487.35 (3,283)**

The significant decrease in utilisation of temporary staff in the CYPMHS service reflects a larger number of staff on the rota due to successful National recruitment resulting in fewer gaps.

In the ICAN service following the retirement and return of a SAS doctor to LCH Bank for ad-hoc sessions, ICAN were able to increase capacity by delivering additional Initial Health Needs Assessment (iHNA) clinics and seeing expedited Paediatric Neuro Disability Clinic patients. Previously, without paediatricians on Bank, the service relied solely on locums, so this has provided a more flexible staffing solution.

The increase in Community Gynaecology was the result of work to decrease the waiting list in the service.

Leeds Sexual Health Service had previously employed a number of doctors via CLASS to support clinical activity, these doctors have subsequently been offered contracts of employment, so their hours are no longer logged through Bank.

Education

In the year 24/25 Leeds Community Healthcare was able to offer the following educational placements:

Medical Education Undergraduate and Postgraduate Placement Figures 2024-2025 (Previous Year)			
Service	**Undergraduate***	**Foundation Year**	**Postgraduate****
ICAN	380 (380)	1 (0)	10 (8)
LSH	150 (150)	0 (0)	3 (1)
Community Gynaecology	70 (50)	0 (0)	1 (1)
CYPMHS/Psychiatry	37.5 (37.5)	1 (0)	8 (11)
Elderly Medicine/Neuro Rehabilitation	192 (192)	0 (0)	0 (0)

GP VTS Trainees	0 (0)	0 (0)	3 (3)
MSK	120 (120)	0 (0)	0 (0)
Total	**949.50 (929.50)**	**2 (0)**	**25 (24)**

*Undergraduate placements are calculated based on 6 cohorts per academic year, multiplied by number of students per cohort, multiplied by days to give a representation of 'placements' provided, the same students may have been at LCH in different services during different cohorts.
**Postgraduate – The Trust has 22 formal training posts, but headcount can fluctuate due to LTFT trainees job sharing posts.

ICAN and CYPMHS/Psychiatry postgraduate figures fluctuated from previous years due to LTFT trainees job sharing posts rotating in and out of the Trust. LSH has increased by two due to two trainees returning from Maternity Leave.

LCH provides clinical placements for Postgraduate and Undergraduate Medical Education working in partnership with NHS England and the University of Leeds, to oversee clinical training for all levels of medical students and doctors in training.

The Trust has a medical education governance structure, led by the Medical Director, and supported by the Associate Director for Teaching and Student Support (ADTSS) for undergraduates and Director Medical Education (DME) for postgraduates, clinical staff, trainers and a dedicated administration team focussed on delivering and supporting high quality education and training.

LCH hosts over 400 Undergraduate Medical Students with over 900 placement opportunities, 2 Foundation Year, and 22 Postgraduate training posts across 7 different services per year. Community placements provide experience of delivering care in a wide range of settings including in people's own homes as well as in clinics, Community Centres and schools.

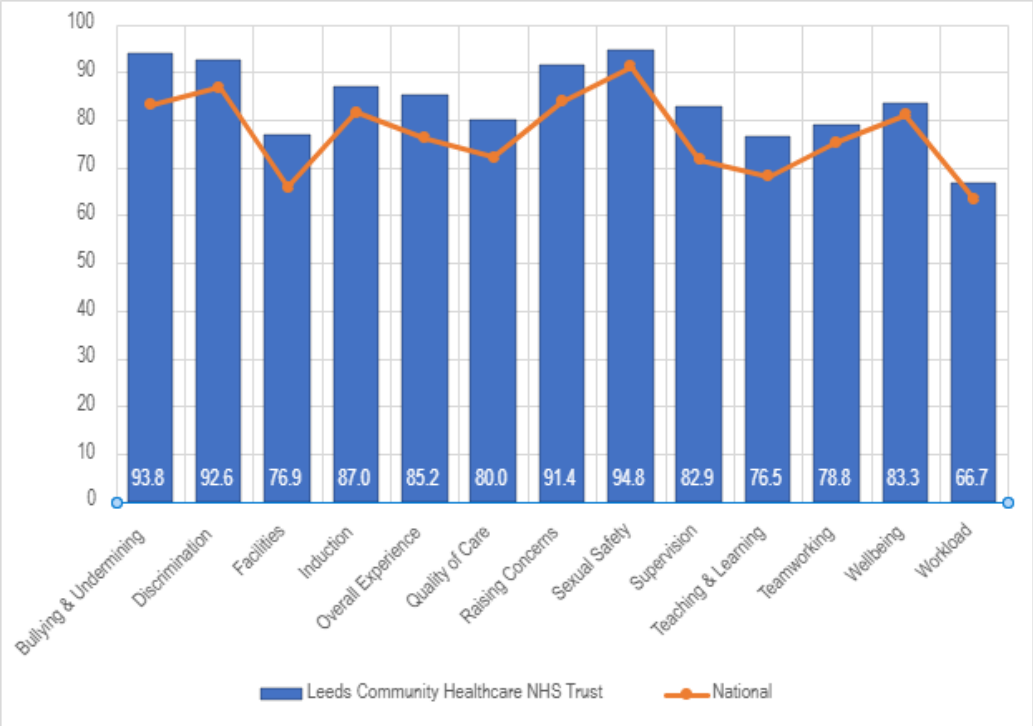
The Trust supported LTHT in creating additional Foundation Year One posts to mitigate against the oversubscription. Posts were created in the Community Paediatrics and CYPMHS shared with LTHT acute on-call rotas. This provided an opportunity to gain experience of working in community earlier on in their medical career. Feedback from Doctors in training, the services and colleagues at LTHT has been very positive and resulted in the posts being embedded for the upcoming academic year.

Teaching and training standards, and support are reviewed annually via the NHS England Self-Assessment Return (SAR), in which organisations carry out their own quality evaluation against the National Quality Framework. It is based on continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

The Quality Framework identifies the standards that organisations are expected to meet to provide high quality learning environments. The education placements offered by LCH have been reviewed by Leeds University for undergraduate placements, and in May by NHSE for postgraduate and these reviews have been very positive.

The NHS England National Education and Training Survey (NETS) is a national survey of healthcare trainees' and students' experiences of their education and training environments, gathering the views of c.40,000 respondents nationally in

2023. The Trust scored well across all domains and outperformed the National benchmarks.



The Trust ranked as 1st in the Yorkshire and Humber Region based on 'Overall Learner experience':

Trust level indicators:
Overall Experience indicator league table (YH)

1st	**Leeds Community Healthcare NHS Trust**	**85.2**
2nd	Rotherham Doncaster and South Humber NHS Foundation Trust	84.4
3rd	Yorkshire Ambulance Service NHS Trust	82.5
4th	Bradford District Care NHS Foundation Trust	81.9
5th	Leeds and York Partnership NHS Foundation Trust	80.8

In NHS England's 'Education Quality Report' they stated:

"The trust is one of the best performing organisations within the GMC NTS. In 2024 the trust ranked 21st of 230 UK acute, mental health and community trusts. The trust continues to receive positive feedback for the trust-wide teamwork indicator and in 2024 it was an above outlier. 100% of respondents agreed that the organisation "encourages a culture of teamwork between multi-discipline healthcare professionals". The indicator score has markedly improved from 2023 when it scored 72.78, placing it in the lower quartile (pink), but scored 88.18 in 2024, placing it in the interquartile range (white). 81% of respondents now rate the quality of induction as "very good" or "good"."

NHS England Education quality review – May 2025

➢ 3 Impact

Position statement for 24/25

Principle 1: An effective environment (Organisations create an environment which delivers effective clinical governance for doctors)

LCH has a combination of individual service and central mechanisms which hold information pertinent to effective clinical governance for medical and dental staff. Each service is responsible for meetings and discussions regarding these, and medical and dental staff of all employment statuses are encouraged to participate and actively contribute.

The Trust process in relation to incidents ensures that the Medical Directorate is informed when a doctor is involved in an incident, this allows appropriate support and oversight to the individual and the Business Unit involved.

The four Trust policies related specifically to the employment of medical and dental staff were approved by SMT in 2021 and are in place, the policies are currently being reviewed.

The Trust has robust processes in place to ensure appropriate checks are undertaken to confirm all doctors and dentists undertaking employed work in the Trust are appropriately qualified and fit for role.

The Revalidation Team coordinate with Workforce and QPD colleagues to share information in order to provide central assurance of any issues relating to medical and dental staff. Revalidation Panels were carried out as required during 24/25, linking with Trust systems to ensure that appropriate submission and reflection on incidents and complaints was included in the relevant appraisals.

The Trust has strong processes in place to support individuals who speak up and raise concerns; from the operational or clinical line manager of the individual, directly with an Executive Director or with the Freedom to Speak up Guardian.

Principle 2: Continuous Improvement (Clinical governance processes for doctors are managed and monitored with a view to continuous improvement)

Leeds Community Healthcare meets regularly with the GMC to discuss issues regarding incidents relating to doctors, and doctors in an MHPS process. Verbal feedback at the last meeting was complimentary of the processes in place and the open nature of the discussion, also reflective of the complexity of cases seen in this environment.

The Medical Directorate proactively sought out partnering organisations to undertake a peer review of appraisal and revalidation processes. The Trust partnered with Birmingham Community Healthcare NHS Foundation Trust and Derbyshire Community Health Services NHS Foundation Trust. The partnering organisations have built on that relationship to arrange a Mutual Quality Assurance process. The new process ensures that samples remain anonymous and are reviewed by people outside of the Trust, removing the risk of bias.

The Trust has presented information to both the University and NHSE on the quality of education provided at both an undergraduate and postgraduate level. There has been positive feedback from both meetings. Doctors are supported in their job plans to participate in education and training.

Principle 3: Fairness (Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination)

Revalidation Panels ensure that all revalidation recommendations are supported by a thorough consideration of all aspects of the five years of appraisal preceding the recommendation. The panels strengthen the Trust processes and reduces the possibility of bias or discrimination with the introduction of an independent observer from a peer Trust.

The Trust has a 'Freedom to Speak Up Guardian' (FTSUG). In 24/25 there were 5 individual concerns/conversations from doctors, doctors in training and dentists with the FTSUG, this is on a background of 188 raised across the Trust. The number of staff raising concerns from medical and dental workforce is higher than the previous year of one report in 23/24.

No concerns have been raised by any doctor in relation to decisions regarding the clinical governance of doctors; decisions relating to deferral of revalidation are usually made in conjunction with the doctors and in line with GMC guidance.

During 24/25 there has been one grievance raised by a doctor or dentist employed by LCH, this has been managed appropriately.

Principle 4: Supporting Process (Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practice)

LCH has a longstanding history of robust clinical governance processes to support medical revalidation and has continued to perform well in this regard. Revalidation submission and recommendations are in line with the National average.

Submissions summary - GDE (gmc-uk.org)

There are systems in place to respond and manage concerns related to the fitness to practice of doctors. These systems work in conjunction with the GMC and the Practitioners Performance Advice, part of NHS Resolution. This system will also address concerns related to locum doctors and doctors in training in conjunction with NHS England

4 Recommendations

The Board is recommended to:

- Note the contents of the 2024/25 Annual Executive Medical Director's Report
- Note the requirements by NHS England to include the statement of compliance from the Board.
- Approve the statement of compliance and submission to NHS England

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of Leeds Community Healthcare NHS Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	No update required
Comments:	Dr Ruth Burnett is LCHs appointed Responsible Officer, with Dr Stuart Murdoch as Deputy, both are fully trained.
Action for next year:	No update required

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	No update required
Comments:	Sufficient funds, capacity and resources are available for the RO to carry out the responsibilities for the role. The Trust utilises the SARD Medical Appraisal System.
Action for next year:	No update required

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	No action required
Comments:	The SARD system is maintained to provide an accurate up to date overview of the appraisal and revalidation position within the Trust, backed up by a limited access, password protected Excel database.
Action for next year:	No action required

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	Carry out a cross check with other Medical Workforce Policies.
Comments:	Medical and Dental Policies are in the process of being updated and will be shared with the Trust's Joint Negotiating Committee.
Action for next year:	No Action required

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	LCH will independently look to undertake a peer review exercise with a similar sized organisation.
Comments:	Peer Review completed with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust, the peer review gave opportunity to share procedures, policies and best practice, and has resulted in an ongoing peer partnership with mutual quality assurance arranged for the 24/25 appraisal cycle.
Action for next year:	Further collaborative work planned with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust for 25/26 to include ongoing Quality Assurance and membership of Revalidation Panels.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Review of long-term locums in the Trust.
Comments:	LCH now offers appraisal support for Locum and Short-Term Contract Doctors. Scope of work letter completed to support doctors' full scope of work when employed elsewhere when requested. All doctors, regardless of employment status, are involved in governance processes relating to incidents and complaints. The Trust encourages them to be actively involved in any issues raised by patients, will ensure they have access to the relevant clinical record and will provide copies of documentation relating to these incidents for the purposes of appraisal. Training and development opportunities are available and will be supported as appropriate for all doctors regardless of employment status.

	Every member of LCH staff has access to regular support from their clinical and operational line managers, including discussion regarding development needs and opportunities, clinical supervision and encouragement, and opportunities to be involved in local governance and service improvement processes. Doctors working for the Trust who have an alternative Responsible Officer connection to their locum agency or alternative employer are offered support for appraisal and revalidation in the form of a "Scope of Work" letter provided by their Medical Lead, detailing their work within the Trust.
Action for next year:	No action required

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	No action required
Comments:	All doctors are supported to have a Medical Appraisal within the SARD system, where they can store supporting information and reflect. Complaints, concerns and incidents are reviewed at Revalidation stage.
Action for next year:	No action required

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	No action required
Comments:	Any doctors who have not had an appraisal have had an understandable reason for this and submitted plans to complete this within an approved timeframe.
Action for next year:	No action required

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	No action required
Comments:	The Trust has a 'Medical and Dental Appraisals and Revalidation Policy' in place, this is regularly reviewed in line with National guidelines, and is discussed at the Trust's Local Negotiating Committee, before being ratified by Trust Board.
Action for next year:	No action required

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	No actioned required
Comments:	Due to retirement of 2 existing appraisers, the Trust is actively working to recruit new appraisers, one new appraiser will be added to the appraiser network for 25/26.
Action for next year:	Work to future proof the appraiser network, train at least one new appraiser for 25/26 appraisal cycle.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	No actioned required
Comments:	Appraisers are all supported to attend appraisal network/development attempts and are provided with both individual feedback and anonymised Trust feedback from the quality assurance process. regular 'Trust Appraiser Updates' are held to provide an opportunity for supported peer discussion and development in the context of appraisal. Appraisees have been reminded about the need to have a whole of practice appraisal, including leadership or education roles in addition to work in other settings.
Action for next year:	No actioned required

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	Complete the 24/25 Quality Assurance process with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust.
Comments:	Peer review carried out with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust. Mutual quality assurance programme developed to build a robust process free from bias.
Action for next year:	Complete the 25/26 Quality Assurance process with a reversed triangulation of the three Trusts, Leeds Community Healthcare NHS Trust, Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	Continue to engage with the GMC appropriately.
Comments:	Regular Revalidation panels are held as required. The Executive Medical Director, Deputy Medical Director, and Head of Medical Education and Revalidation meet with the GMC Employee Liaison Advisor quarterly.
Action for next year:	Continue to engage with the GMC appropriately.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	No update required
Comments:	The outcome of Revalidation Panels is communicated directly with the doctor, indicating their revised revalidation date. The Responsible Officer made 7 positive recommendations to the GMC during the period covered by the report, all in a timely manner and supported by a Revalidation Panel. This covers all doctors for who recommendations were due during this period.
Action for next year:	No update required

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	No update required.
Comments:	The SARD system records all Designated Body Doctors appraisal and revalidation data. LCH has robust pre-employment processes in place for all new medical staff joining the Trust on a permanent or temporary basis. Concerns raised in relation to doctors are reviewed as appropriate and escalated within the organisation. The Medical/Dental Lead role job description is updated and is in use.
Action for next year:	No update required.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	Continue to embed LFPSE Framework is embedded alongside PSIRF.
Comments:	LFPSE Framework is embedded alongside PSIRF. The Revalidation Team regularly liaises with the Trust's Patient Experience Team. We now get information from Datix with regards to individually named doctors. This happens infrequently.
Action for next year:	No update required.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	No action required
Comments:	The SARD Medical Appraisal system is used to ensure doctors can access their appraisal information easily. SARD acts as a repository for supporting information.
Action for next year:	No action required

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	No action required
Comments:	Concerns raised in relation to doctors are reviewed as appropriate and escalated within the organisation. The Maintaining High Professional Standards (MHPS) policy and the Remediation, Reskilling and Rehabilitation policy are both current. The RO has regular meetings with the GMC ELA and PPA advisors to discuss any potential cases of concern.
Action for next year:	No action required

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	Inclusion of neutral panel member from a Partnering Trust in Revalidation Panels.
Comments:	The trust invited staff from partnering community trusts from Peer Review to Revalidation panels to provide an unbiased viewpoint. Due to the size of the organisation concerns are infrequent, we have an independent non-exec board member who supports the process.
Action for next year:	No action required

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	No action required.
Comments:	The Trust can respond promptly to any request, this is signed off by the Responsible Officer (RO) prior to the transfer of information. LCH has robust processes for requesting appropriate information from partner organisations on transfer to the Trust of new Designated Body doctors, and for providing it when doctors transfer out. - Any concerns are raised with the RO or Deputy RO if there are concerns, externally concerns are raised with the DBs RO.
Action for next year:	No action required.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	Inclusion of neutral panel member from a Partnering Trust in Revalidation Panels.
Comments:	The Trust holds this information and is able to triangulate RO Team, HR and Workforce, panels now have a member from a peer partnering Trust to ensure the processes are fair and free from bias and discrimination
Action for next year:	Continue to invite peer partner members to panels.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	Continue to review guidelines as appropriate.
Comments:	As the Trust receives outputs from National reviews, reports and enquiries they are reviewed at appropriate committees and groups and incorporated into the organisation as necessary. Recent work has focussed on 'Letby' with a paper discussed at Quality Committee and Trust Board.
Action for next year:	Continue to review guidelines as appropriate.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Support the review of the Professional Registration Policy in time for renewal next year.
Comments:	Professional Registration Policy has been implemented.
Action for next year:	No action required.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	No action required
Comments:	The Trust has robust processes in place to ensure that appropriate checks are undertaken to confirm that all doctors and dentists undertaking employed work in the Trust are appropriately qualified and fit for role. These processes are in line with NHS mandatory pre-employment checks. The Workforce Directorate ensures that the processes undertaken with regards to bank and agency doctors and dentists is robust. These applications are reviewed by the Medical or Dental lead (or appropriate deputy) for fitness for role prior to any employment commencing and a new form has been developed that ensures additional checks are incorporated in line with best practice (e.g. Confirmation of Responsible Officer).
Action for next year:	No action required

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	No action required
Comments:	The Trust strives to ensure that all staff are engaged in providing community healthcare services to the population we serve. We support our staff to develop and present opportunities to them so that they can develop in their careers and their ability to support colleagues and trainees.
Action for next year:	No action required

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	Continue to monitor compliance with the Equality act and work with the human resources team and groups within the organisation to ensure fairness is being delivered.
Comments:	All policies within the Trust detail how adjustment should be made to ensure equality for all staff as set out in the Equality Act of 2010. The Trust pays due regard for the need to • Eliminate unlawful discrimination, harassment and victimisation • Advance equality of opportunity for all staff This includes removing or minimising disadvantages to staff and taking steps to protect people with different needs.
Action for next year:	Continue to monitor compliance with the Equality act and work with the human resources team and groups within the organisation to ensure fairness is being delivered.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	Continue to monitor concerns raised
Comments:	The Trust has in place a Speaking Up-Raising Concerns Policy which enables all staff to speak up at the earliest opportunity. It is authored by the Freedom to Speak up Guardian who addresses concerns from all staff groups. The Trust has a cultural approach called Speaking Up is a Practice Not a Position. This means that there are several speaking up channels at the trust. Staff are encouraged to use any of these channels to ensure their voice is heard. The mechanisms are: • Managers and colleagues • Easy Access to Senior Managers and Directors • Ask the CEO anonymous Q and A on the trust intranet • Trade Unions • Workforce Department (HR) • Freedom To Speak Up Guardian • Race Equality Network Speaking Up Champions

	In addition to this there are regular engagement meetings between all medical staff and the Medical Director, and the Resident doctors have regular meetings with the Guardian of Safe working hours, and the education team in which concerns can be raised.
Action for next year:	Continue to monitor concerns raised

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	Continue to monitor processes. In the last four years there have been no formal complaints and feedback is consistently good.
Comments:	The Trust policy on appraisal has an ability for doctor to raise a complaint or grievance from the appraisal process with the Responsible Officer or Deputy Medical Directors. If this process does not result in a satisfactory outcome the complaint can be raised with the Chief Exec of The Trust. The appraisal system utilised by the Trust allows feedback from appraisers to appraisees which is analysed and fed back. Any issues identified are addressed with individuals.
Action for next year:	Continue to monitor processes. In the last five years there have been no formal complaints and feedback is consistently good.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	Continue to monitor concerns and processes in relation to involvement by doctors and protected characteristics.
Comments:	The Trust is aware of differential raising of concerns, entry into MHPS processes and referral to the GMC, in relation to country of primary medical qualification and protected characteristics. The number of doctors with a connection to LCH is relatively small and the number of doctors involved in incidents is small. It would be difficult to identify any concerns about issues, but we are vigilant and continue to question our processes and decisions.
Action for next year:	Continue to monitor concerns and processes in relation to involvement by doctors and protected characteristics.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	Continue to build on relationship with other Trusts and attend appropriate meetings
Comments:	The Trust attends the regional RO and Appraisal Leads Networks, In the last year it has begun a peer review/support programme with two other similar Trust to explore processes and procedures and ensure learning is shared. The RO regularly meets with the regional GMC liaison officer.

Action for next year:	Continue to build on relationship with other Trusts and attend appropriate meetings

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	**39**

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	**39**
Total number of appraisals approved missed	**0**
Total number of unapproved missed	**0**

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	**7**
Total number of late recommendations	**0**
Total number of positive recommendations	**7**
Total number of deferrals made	**2**
Total number of non-engagement referrals	**0**
Total number of doctors who did not revalidate	**0**

2D – Governance

Total number of trained case investigators	**2**
Total number of trained case managers	**1**
Total number of new concerns registered	**0**

Total number of concerns processes completed	**1**
Longest duration of concerns process of those open on 31 March	
Median duration of concerns processes closed	
Total number of doctors excluded/suspended	**0**
Total number of doctors referred to GMC	**0**

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	**0**
Number of new employment checks completed before commencement of employment	**0**

2F Organisational culture

Total number claims made to employment tribunals by doctors	**0**
Number of these claims upheld	**0**
Total number of appeals against the designated body's professional standards processes made by doctors	**0**
Number of these appeals upheld	**0**

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

Leeds Community Healthcare NHS Trust has a robust system in place for ensuring appraisal and revalidation of doctors employed by the Trust, for the appraisal of dentists and ensuring appropriate fitness to practice and fitness for role of other medical staff who work for the Trust. 39 doctors and 8 dentists have had an annual appraisal for the year April 2024 and March 2025. 7 doctors have been successfully revalidated. The Trust has continued to provide high quality appraisal, supported and developed doctors and dentists regarding both appraisal and their general wellbeing, improved engagement with medical and dental staff and continued to further improve our systems to better support our medical and dental staff.
Actions still outstanding
Work identified in the 23/24 Medical Directors report to undertake an independent peer review of appraisal processes with Derbyshire and Birmingham Community NHS Trusts has completed the first

stage, further steps are identified for progress during 25/26 including reversing the peer review triangulation, attending revalidation panels and completing a mutual quality assurance exercise.

Current issues

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- Further collaborative work planned with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust for 25/26 to include ongoing Quality Assurance and membership of Revalidation Panels.
- Work to future proof the appraiser network, train at least one new appraiser for 25/26 appraisal cycle.
- Complete the 25/26 Quality Assurance process with a reversed triangulation of the three Trusts, Leeds Community Healthcare NHS Trust, Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust.
- Continue to engage with the GMC appropriately.
- Continue to invite peer partner members to panels.
- Continue to review guidelines as appropriate.
- Continue to monitor compliance with the Equality act and work with the human resources team and groups within the organisation to ensure fairness is being delivered.
- Continue to monitor concerns raised
- Continue to monitor processes. In the last five years there have been no formal complaints and feedback is consistently good.
- Continue to monitor concerns and processes in relation to involvement by doctors and protected characteristics.
- Continue to build on relationship with other Trusts and attend appropriate meetings

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Achievements

Leeds Community Healthcare meets regularly with the GMC to discuss issues regarding incidents relating to doctors, and doctors in an MHPS process. Verbal feedback at the last meeting was complimentary of the processes in place and the open nature of the discussion, also reflective of the complexity of cases seen in this environment.

LCH has a longstanding history of robust clinical governance processes to support medical revalidation and has continued to perform well in this regard. Revalidation submission and recommendations are in line with the National average

Challenges It has not been possible to progress the collection of meaningful data for non-procedure-based specialties and we note the national commissioning of outcomes which we hope will reflect our work. We will continue to explore useful data for meaningful benchmarking.

The small number of medical staff in the organisation mean that remaining up to date with MHPS processes can be a challenge when looking for case investigators, as well as the familiarity with colleagues.

Aspirations A further peer review and mutual quality assurance process is planned for 2025/26 with Birmingham and Derbyshire Community Trusts, with a view to ensuring processes are free from discrimination and bias.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Leeds Community Healthcare NHS Trust

Name:	
Role:	
Signed:	
Date:	

Agenda item:	2025-26 (16i)

Title of report:	Significant Risks and Risk Assurance Report, including the Risk Appetite Statement 2025/26

Meeting:	Trust Board Held In Public
Date:	4 September 2025

Presented by:	Lynsey Ure, 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 16 risks scoring 12 (very high). The Board reviewed the Trust's risk appetite statement at its workshop held on 10 July 2025. The updated risk appetite statement for 2025/26 is attached at Appendix 1 for approval.

Previously considered by:	Trust Leadership Team 27 August 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; • Consider whether the Board is assured that planned mitigating actions will reduce the risks; and • Approve the risk appetite statement for 2025/26

List of Appendices:	Appendix 1 Risk Appetite Statement 2025/26

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 summarises all risk movement, the risk profile, themes and risk activity since the last risk register report was received by the Board (June 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 the BAF strategic risks to advise the Board of potential weaknesses in the control of strategic risks, where further action may be warranted.

1.4 In addition to the risk register report information, the Trust's updated risk appetite statement for 2025/26 is included in this report for approval by the Trust Board, see section 6 of the report.

2. Risk register movement

2.1 The table below summarises the movement of risk since the last risk register report.

	Current	Previous (June)
Total Open Risks	91	82
Risks Scoring 15 or above	2	2
New Risks	17	10
Closed Risks	8	4
Risk Score Increasing	1	5
Risk Score Decreasing	7	5

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	Months at current score	Risk Appetite
1048: Mind Mate SPA increasing backlog of referrals (system-wide risk).	**Operational**	**15**	**19**	**Cautious (4 – 6)**
At the time of writing the report, the Mind Mate Single Point of Access (SPA) risk is being re-assessed. Due to significant progress, the risk has reduced, and it is planned to separate into two risks: Emotional wellbeing waiting list and Neurodevelopmental waiting list. The reduction will be reflected in future risk reports.				

Emotional wellbeing waiting list, it is proposed to reduce the score from 15 to 9. Commissioned Targeted Service Leader (TSL) and Northpoint (NP) work cleared original non-complex backlog of 657. Now working on 56 new referrals added to the non-complex list. Northpoint to address 207 remaining routine complex waiting list in September 2025. Letters sent to all routine waiters regarding the SPA including safety netting advice and signposting. Mind Mate website updated to this effect also.
Action – Extend contracts for both TSL and NP until December 2025 to address new referrals and NP for complex list.

Neurodevelopmental (ND) waiting list: - it is proposed to reduce this risk from 15 to 12 with a further decrease on completion of the actions below.
LCHT and ICB agreed to commission Northpoint to work on 1300 of 2675 waiting list over a 6-month period
Actions – Implement the ND backlog work. Monitor the ICB led ND pilots over the next 12-18 months and associated outcomes.
(updated 17/8/25).

Risk	Risk Type	Current Score	Months at current score	Risk Appetite
1179: Impact/Management of Neurodevelopmental Assessment Waiting List.	**Operational**	**15**	**10**	**Cautious (4 – 6)**

Preschool children on the waiting list have been outsourced using 2024/25 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 Mind Mate SPA.
(Updated 29/4/25, next update overdue since 1/7/25)

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)	Months at current score
877	Risk of reduced quality of patient care in neighbourhood teams (NT) due to an imbalance of capacity and demand	12	12	12
954	Diabetes Service waiting times	12	12	3

ID	Description	Rating (current)	Rating (previous)	Months at current score
957	Increase in demand for the adult speech and language therapy service.	12	12	4
1042	Provision of equipment from Leeds Community Equipment Services (LCES)	12	12	12
1125	National supply issues with enteral feeding supplies by Nutricia	12	12	3
1198	Impact of ADHD medication waiting list	12	12	15
1221	Likelihood of a cyber attack	12	12	7
1294	Clinical Governance Team capacity and resilience due to vacancies and absence	12	12	6
1295	Primary Care Industrial Action	12	12	6
1298	Patient missed appointments due to printing issues with new digital letters system	12		New
1303	Out of compliance mobile phones (Operating system not compliant with CE+)	12	12	4
1312	The Trust Risk and Incident reporting system (Datix) is preventing accurate reporting / assurance both internally and externally.	12		New
1313	Climate Adaptability Resilience Planning	12	12	3
1319	The number and long waits of high priority patients on the ABU Therapy waiting lists	12		New
1329	Failure to deliver financial plan	12		New
1336	The reporting of Health and Safety, Fire Safety, Security and Moving and Handling accidents and incidents	12		New

11 of the 16 risks scoring 12 have not changed since the last report (static). One of the 11 risks has been static for over 12 months. Risk 1198, Impact of ADHD Medication Waiting List, the target date to reduce this risk is 31/12/25. The update for this risk was due on 31/7/25 and is being chased to ensure the risk is up to date.

When risk scores have been static for over 12 months, the detail is flagged to TLT and the Quality and Business Committees. Static risks are also included in the scope of the Risk Management Group (RMG).

4. Risk profile – all risks

4.1 The total number of risks on the risk register is currently 91. Of these there are 26 clinical risks and 65 operational risks. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	2	1	0	0	3
4 - Major	0	7	5	0	0	12
3 - Moderate	2	13	25	11	1	52
2 - Minor	1	5	12	3	1	22
1 - Negligible	1	0	1	0	0	2
Total	4	27	44	14	2	91

5. Risks by theme and correlation with Board Assurance Framework strategic risks

5.1. For this report the high risks (scoring 8 and above) on the risk register have been themed where possible according to the nature of the hazard and the effect of the risk and then linked to the strategic risks on the Board Assurance Framework. This themed approach gives a holistic view of the risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance on the management of risk.

5.2 Themes within the current risk register are as follows:

Theme One: 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 pressures, capacity to complete clinical supervision, clinically essential training, and safe operation of medical devices. Specifically, twenty-one risks relate to patient safety[1]	The BAF strategic risks directly linked to patient safety are: BAF Risk 1 Failure to deliver quality of care and improvements BAF Risk 2 Failure to respond to increasing demand for services BAF Risk 3 Failure to comply with legislative and regulatory requirements
Theme Two: Compliance with Standards/Legislation	
The second strongest risk theme is compliance with standards/ legislation[2].	The BAF strategic risks directly linked to compliance with standards / legislation are:

[1] Risks: 877, 1109, 1125, 1139, 1168, 1169, 1187, 1196, 1231, 1278, 1284, 1285, 1295, 1298, 1301, 1307, 1308, 1309, 1319, 1324, 1341

[2] Risks: 902, 1089, 1178, 1204, 1206, 1221, 1242, 1250, 1294, 1296, 1303, 1312, 1313,

This includes health and safety, compliance with information governance and cyber security, and business continuity and emergency planning.	BAF Risk 3 Failure to comply with legislative and regulatory requirements BAF Risk 5 Failure to maintain business continuity
Theme Three: Demand for Services	
There is also a risk theme relating to demand for services exceeding capacity, due to an increase in service demand and high numbers of referrals [3]	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 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: Transformation	
Four risks relate to 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

[3] Risks: 772, 913, 954, 957, 994, 1015, 1042, 1048, 1098, 1179, 1198, 1311

[4] Risks: 1227, 1228, 1318

[5] Risks: 1217, 1327, 1328, 1329

6. Risk Appetite Statement 2025/26

The Trust's Risk Management Policy and Procedure stipulates that the risk appetite statement will be reviewed annually, and any proposed changes are to be approved by the Board. The Board reviewed the Trust's risk appetite statement at its workshop held on 10 July 2025. The updated risk appetite statement for 2025/26 is attached at Appendix 1 for approval.

7. Impact

7.1 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.

8. Next steps

Risks will continue to be managed in accordance with the risk management policy and procedure, and the Board will receive an update report at the meeting to be held on 6th November 2025.

9. Recommendations

The Board is recommended to:

- Note the changes to the significant risks since the last risk report was presented to the Board;
- Consider whether the Board is assured that planned mitigating actions will reduce the risks; and
- Approve the risk appetite statement for 2025/26

Author: Anne Ellis, Risk Manager
Date written: 19 August 2025

Leeds Community Healthcare NHS Trust

Board Risk Appetite Statement – Approved 4 September 2025

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.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
Delivering equitably high-quality services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, safe and effective services. The Trust is supportive of innovation and will accept some risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. The Trust has a **cautious** appetite to risk that could compromise the delivery of equitably high quality, safe services.					
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.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
The Trust is supportive of innovation and transformation and looks to **seek** measured risks in pursuing innovation and transformation of current working practices without compromising the quality of patient care.					

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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.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
We have a **minimal** risk appetite to risks which will impact on our ability to meet our legislative and regulatory compliance requirements. Where the laws, regulations and standards are about the delivery of safe, high-quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that have been set.					
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.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
Our appetite for financial risk is **cautious,** whilst remaining compliant with statutory requirements. We strive to deliver our services within the budgets set out in our financial plans and are open to measured risks that will support innovation and transformation to achieve long term financial sustainability, improvements to service delivery, patient safety and quality of care. We will ensure that all such financial responses deliver optimal value for money. We adopt a zero-tolerance approach to fraud.					

Risk 5 Failure to maintain business continuity: If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
The Trust has a **minimal** risk appetite to business continuity risks impacting on maintaining Category 1 (C1) rated critical service elements, information security and cyber security. In responding to such incidents, Category 2 and 3 service elements could be temporarily stood down to provide additional capacity to support critical C1 service elements.					
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.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
While we will not accept risks which may compromise the safety of our staff or that contradict our Trust values, we acknowledge that transforming services to ensure their future sustainability will require changes in staffing models and an agile, resilient workforce. We have a **cautious** appetite to risks associated with the implementation of new models of working where these enhance or improve patient safety, quality of care or service delivery. We will support our people to adapt and thrive during change.					

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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					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
The Trust is committed to promoting equity in access, experience, and outcomes. The Trust will **seek** opportunities for collaboration with people and communities to ensure their experience influences equitable approaches to innovation and transformation, such as for the Quality and Value Programme. To deliver outcomes that are inclusive of an equity focus.					
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.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
We are committed to bringing value and opportunity across current and future services through system-wide partnership and **seek** risks associated with collaborative and new ways of working. This includes seeking opportunities to work with partners to deliver the neighbourhood health model and other drivers outlined in the 10 year plan, alongside the findings of the Leeds Provider review.					

Leeds Community Healthcare NHS Trust

Risk Appetite Target Scores

The risk appetite is defined by the 'Good Governance Institute risk appetite for NHS organisations' matrix, which Leeds Community Healthcare Trust has adopted. This has been aligned to the Trust's own risk assessment matrix as shown in the table below.

Good Governance Institute matrix	Risk appetite level	Risk target score (range)
Avoid: Avoidance of risk and uncertainty is a key organisational objective	**Zero**	**Nil**
Minimal: (As little as reasonably possible) Preference for ultra-safe delivery options with low inherent risk and only for limited reward potential	**Low**	**1-3**
Cautious: Preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward.	**Moderate**	**4-6**
Open: Willing to consider all potential delivery options and choose, whilst also providing an acceptable level of reward (and VFM)	**High**	**8-12**
Seek: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	**Extreme**	**15-20**
Mature: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.	**Extreme**	**25**

Agenda item:	2025-2026 (17i)

Title of report:	Board Assurance Framework Quarterly Update

Meeting:	Trust Board Held In Public
Date:	4 September 2025

Presented by:	Dr Sara Munro, Interim Chief Executive Officer					
Prepared by:	Helen Robinson, Company Secretary					
Purpose: (Please tick ONE box only)	Assurance	✓	Discussion		Approval	

Executive Summary:	It is a requirement for all Trust Boards to ensure there is an effective process in place to identify, understand, address, and monitor risks. This includes the requirement to have a Board Assurance Framework (BAF) that sets out the risks to the strategic plan by bringing together in a single place all the relevant information on the risks to the Board being able to deliver the organisation's objectives. As previously noted, following the agreement of the Trust's strategic objectives and priorities for 2025/26, the BAF is reviewed on a quarterly basis and the outcome shared with the Board.

Previously considered by:	Trust Leadership Team 9 July 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)	The Board is asked to:

	• Receive the BAF and to be assured of the appropriateness of updates, including risk scoring and mitigating actions.

List of Appendices:	Appendix 1 – 2025_26_BAF_June_2025

Board Assurance Framework – Quarterly Update

1. Introduction

1.1 In June 2025 the Board received a report summarising the processes undertaken to review the BAF in readiness for the 2025/26 financial year. At that meeting the Board approved the eight Strategic Risks for 2025/26.

2. Quarterly Review of Strategic Risks

2.1 During June 2025, meetings were held with the Executive Directors in order to undertake the first quarterly review of the 2025/26 BAF. Each strategic risk has been reviewed in terms of the following:

- Operation of the current controls / whether any additional or gaps in controls need to be added
- Progress against the actions
- Impact of the actions on the score
- Any further actions identified to reduce the risk to target
- Whether there are any missing sources of assurance that need to be added.

The key changes for each strategic risk are outlined on page 3 of the attached BAF.

2.2 On 10 July the Board agreed it's risk appetite at a Board development session, and this information was added into the BAF document.

2.3 A full review of the BAF was then undertaken by the Trust Leadership Team in July 2025 to ensure that it is reflective of the associated high-level risks aligned to the Trust's strategic objectives.

2.4 During July 2025 the Audit, Quality and Business Committees reviewed the strategic risks for which they have oversight, considered the sources of assurance and allocated an assurance rating to each risk from the information presented to them, shared with Board via their Committee Escalation and Assurance reports. The outputs of those discussions is visible on pages 4 and 5 of the attached BAF. It should be noted that the People and Culture Committee will also be responsible for reviewing a strategic risk (SR6), but it has not met in this period so has not allocated an assurance rating for it's strategic risk as yet.

2.5 The Board is reminded that the BAF is presented here for assurance on its completeness as of August 2025.

3. Next Steps

3.1 All strategic risks will continue to be assigned to an Executive Director and to a Committee(s) for oversight. The Executive Directors will 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.

3.2 The Committees will continue to be required to report to the Trust Board following each meeting via the Committee Escalation and Assurance reports on

whether the risks to the success of its strategic objectives are being managed effectively.

3.3 The BAF will subsequently be reviewed on a quarterly basis and the outcome shared with the Board.

4 Recommendations

The Board is recommended to:

- Receive the BAF and to be assured of the appropriateness of updates, including risk scoring and mitigating actions.

Helen Robinson
Company Secretary

11 August 2025

Board Assurance Framework (BAF) 2025/2026

Introduction

The Board Assurance Framework (BAF) provides the Board with a register of strategic risks that have the potential to impact on the achievement of the Trust's strategic objectives and gives assurances that the risks are being managed effectively. The Framework aligns strategic risks with the strategic objectives and highlights key controls and assurances.

Where gaps are identified, or key controls and assurances are insufficient to manage the risk to acceptable levels (within the Trust risk appetite), action needs to be taken. Planned actions will enable the Board to monitor progress in addressing gaps or weaknesses and to ensure that resources are allocated appropriately.

The risk appetite relates to the Trust's willingness to take risks / opportunities to achieve the strategic goals, the risk tolerance score indicates the maximum acceptable risk. Risk appetite and risk tolerance are used to support decision making at a strategic level.

Assurance

The Board receives the BAF quarterly. The risks aligned to the Board Committees are also reported to the relevant Committee bi-monthly, where the relevant Committee agrees a level of assurance for each risk.

The BAF provides the basis for the preparation of a fair and representative Annual Governance Statement. It is the subject of annual review by both Internal and External Audit.

Trust Objectives (Strategic Goals) with the underpinning 2025/26 Trust Priorities

Strategic Goal - Work with communities to deliver personalised care

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

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

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

Strategic Goal – Collaborating with partners to enable people to live better lives

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

Strategic Goal - To embed equity in all that we do

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

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

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

Risk Scoring

Each strategic risk is assessed (measured) in terms of consequence (how bad could it be) and likelihood (how likely is it to happen). The risk score is calculated by multiplying the consequence by the likelihood.

To maintain an objective and consistent approach across the organisation, the Trust's risk assessment matrix is used to 'score' each risk, see below:

LIKELIHOOD / CONSEQUENCE	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Catastrophic (5)	5	10	15	20	25
Major (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Minor (2)	2	4	6	8	10
Negligible (1)	1	2	3	4	5

Strategic Goals	1. Work with communities to deliver personalised care	2. Use our resources wisely and efficiently both in the short and longer term	3. Enable our workforce to thrive and deliver the best possible care	4. Collaborating with partners to enable people to live better lives
	5. To embed equity in all that we do			
Strategic Risks	**Risk 1 Failure to deliver 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, in the short (less than one week) or longer term (above 1 week), 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)			

Summary of Strategic Risks as of 23 June 2025

Ref	Strategic Risk	Lead Director	Current Score (Jun 2025)	Target Score (2025/26)	Key changes since last review
1	**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.	Exec Director of Nursing and AHPs	16	12	The risk description was reviewed by the Trust Board in May 2025 and approved by the Trust Board on 5/6/25. Following approval of the risk description, the risk has been reviewed and updated for 2025/26 by the Lead Director. The target risk score has been amended to ensure that it is realistic for the 12 months to the end of 2025/26. Taking into consideration the risk appetite and any constraints to reducing the risk.
2	**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.	Exec Director of Operations	16	12	The risk description was reviewed by the Trust Board in May 2025 and approved by the Trust Board on 5/6/25. Following approval of the risk description, the risk has been reviewed and updated for 2025/26 by the Lead Director. The target risk score has been amended to ensure that it is realistic for the 12 months to the end of 2025/26. Taking into consideration the risk appetite and any constraints to reducing the risk.
3	**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.	Chief Executive	15	6	The risk description was reviewed by the Trust Board in May 2025 and approved by the Trust Board on 5/6/25. Following approval of the risk description, the risk has been reviewed and updated for 2025/26 by the Lead Director. The target risk score has been amended to ensure that it is realistic for the 12 months to the end of 2025/26. Taking into consideration the risk appetite and any constraints to reducing the risk.
4	**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.	Executive Director of Finance and Resources	16	12	The risk description was reviewed by the Trust Board in May 2025 and approved by the Trust Board on 5/6/25. Following approval of the risk description, the risk has been reviewed and updated for 2025/26 by the Lead Director. The target risk score has been amended to ensure that it is realistic for the 12 months to the end of 2025/26. Taking into consideration the risk appetite and any constraints to reducing the risk.
5	**Risk 5 Failure to maintain business continuity:** If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.	Exec Director of Operations	12	8	The risk description was reviewed by the Trust Board in May 2025 and approved by the Trust Board on 5/6/25. Since the risk was approve by the Board the following wording to the risk description has been added for clarity: 'in the short (less than one week) or longer term (above 1 week),' Following approval of the risk description, the risk has been reviewed and updated for 2025/26 by the Lead Director. The target risk score has been amended to ensure that it is realistic for the 12 months to the end of 2025/26. Taking into consideration the risk appetite and any constraints to reducing the risk.
6	**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.	Director(s) of Workforce	12	9	The risk description was reviewed by the Trust Board in May 2025 and approved by the Trust Board on 5/6/25. Following approval of the risk description, the risk has been reviewed and updated for 2025/26 by the Lead Director. The target risk score has been amended to ensure that it is realistic for the 12 months to the end of 2025/26. Taking into consideration the risk appetite and any constraints to reducing the risk.
7	**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	Medical Director	12	9	The risk description was reviewed by the Trust Board in May 2025 and approved by the Trust Board on 5/6/25. Following approval of the risk description, the risk has been reviewed and updated for 2025/26 by the Lead Director. The target risk score has been amended to ensure that it is realistic for the 12 months to the end of 2025/26. Taking into consideration the risk appetite and any constraints to reducing the risk.
8	**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.	Chief Executive	8	3	The risk description was reviewed by the Trust Board in May 2025 and approved by the Trust Board on 5/6/25. Following approval of the risk description, the risk has been reviewed and updated for 2025/26 by the Lead Director. The target risk score has been amended to ensure that it is realistic for the 12 months to the end of 2025/26. Taking into consideration the risk appetite and any constraints to reducing the risk.

Board Assurance Framework Levels of Assurance

Details of strategic risks (description, ownership, scores)								Level of Assurance				
Risk		Risk ownership		Current risk score				Committee agreed level of assurance				
Strategic Goal(s)	Risk	Responsible Director(s)	Responsible Committee(s)	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	Additional Information
Work with communities to deliver personalised care	Risk 1 Failure to deliver 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.	DoN	QC	4	4	16				✓		July Quality Committee - Reasonable assurance overall but limited in terms of the digital letters issues update
Work with communities to deliver personalised care	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.	DoO	QC/BC	4	4	16				✓		July Business Committee: Waiting Lists were discussed in conjunction with the NOF. Safe Staffing report provided reasonable assurance
Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To	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.	CEO	C/BC/P&(	3	3	9				✓		July Business Committee: NOF and Digital letters discussed.
Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do	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.	DoF	BC	4	4	16				✓		July Business Committee: Reasonable assurance but emerging risk on cash related to interest receivable noted.
Use our resources wisely and efficiently both in the short and longer term / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do	Risk 5 Failure to maintain business continuity:If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.	DoO	BC/AC	3	4	12				✓		July Business Committee: Digital Letters was discussed in detail including mitigation of risks to patient safety and business continuity.

Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do	**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.	DoP	P&CC	4	3	**12**						Not assessed as P&CC not met during this period.
Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do	**Risk 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.	MD	QC/TB	4	3	**12**			✓			July Quality Committee - Limited in terms of EQIA process around impact on staffing being taken into account, and Internal Audit report on PSIRF
Collaborating with partners to enable people to live better lives / To embed equity in all that we do	**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	CEO	BC	2	4	**8**				✓		July Business Committee: Neighbourhood Health Model, Provider Partnership review, and Third Sector Strategy update were covered in detail with LCH collaboration. Reasonable assurance overall.

Strategic 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.

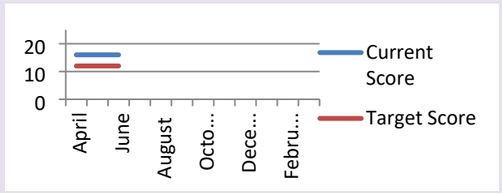
Strategic Objective: Work with communities to deliver personalised care / To embed equity in all that we do

Risk Appetite	Cautious (4-6)	**Status: In or out of Appetite**	Out	**Lead Director/risk owner:** Executive Director of Nursing and Allied Health Professionals

Committee with oversight: Quality Committee

Date last reviewed: 4/6/25

Risk Rating
(likelihood x consequence)
Current score:
4 x 4 = 16
Target score (end of 2025/26):
3 x 4 =12



Rationale for Current Risk Score:
The current risk score of **16** reflects the significant challenge of delivering quality care and achieving improvements in an equitable way amidst the ongoing Quality and Value (Q&V) programme. The programme is required to deliver substantial financial savings while also managing existing capacity and demand pressures. These combined pressures may result in a decline in the quality of care and a potential increase in patient harm. While Q&V work is underway to mitigate these risks, the complexity and scale of the programme mean the risk remains high at this stage. However, it is anticipated that the score will reduce to **12 by March 2026**, as improvements are realised and embedded.

Rationale for Target Score (including any constraints to reaching risk appetite within the next 12 months):
The elevated risk score reflects the early stage of the Q&V programme, where the full scope and impact of changes to patient pathways are not yet fully understood. Until greater clarity is achieved, uncertainty remains regarding the potential effects on care quality. As the programme progresses and mitigation strategies take effect, the risk is expected to decrease. However, due to the programme's three-year timescale, it is unlikely that the risk will fall within the organisation's risk appetite in the next 6 months. A reduction in score is projected by **March 2026**, after which further progress is expected toward reaching the target and aligning with risk appetite.

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

- Learning and Development Strategy
- Annual Clinical Audit Programme
- Performance Monitoring
- Health Equity Strategy
- Clinical Risk Management
- Infection Prevention and Control (IPC) Strategy
- Clinical Supervision
- Quality Challenge & Process
- Quality Strategy
- Engagement Principles
- EQIA process
- Safeguarding Strategy
- Children's strategy
- Patient Safety Incident Response Framework (PSIRF) and Plan (PSIRP)
- Research and Development Strategy
- CQC preparedness and single assessment framework processes
- Patient Safety Partners playing active part in Trust safety
- Service re-design steering group
- Additional short-term resource to develop and embed EQIA processes
- Trust movement to Statistical Process Controls (SPC) reporting including safety domains

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

Action	**Owner**	**Due by**
The Well-Led review identified gaps in control relating to quality performance review. To address this the development and continued embedding of Statistical Process Control (SPC), which is linked to QAIG and Quality Performance (QP) review following Well-Led Recommendations.	Medical Director	Sept 25
Implementation of the new CQC Single Assessment Framework, aligned with the Quality Challenge+ programme will continue, to comply with best practice and CQC requirements.	Executive Director of Nursing and AHP's.	March 2026
The Well-Led review identified gaps in control relating to quality governance. To address this the implementation of Well-Led review recommendations relating to QAIG and quality performance governance, to reshape current quality governance structures in LCH.	Executive Director of Nursing and AHP's.	Sept 25

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

1. Service Level Assurance	**2. Specialist Support / Oversight Assurance**	**3. Independent Assurance**
• IPC Board Assurance Framework • Clinical Governance report • Health Equity report • (Patient) Engagement report • Service spotlights at Committee • Business cases for new service or service transformation (quality scrutiny) • Patient safety (including patient safety incident investigations) update report • Safeguarding annual report • Learning and development report • IPC Annual report • Quality Account • Patient Group Directions • PSIRP (Y2 org plan) • Organisation Strategy Update	• Performance Brief (safe, caring effective) • Mortality report • QAIG assurance report, flash report and minutes • Risk report • Safeguarding Committee minutes	• Internal audit report • PLACE inspection report • Patient experience report: complaints, concerns, and feedback

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

Action	**Owner**	**Due by**
There is a gap in assurance from the EQIA process. To address this clear oversight by clinical Directors will be implemented with appropriate escalation through the corporate governance processes to provide assurance to QAIG and Quality Committee. Routine assurance reporting on EQIA oversight and escalation will be established and embedded.	Executive Director of Nursing and AHP's	October 25

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

1179: Impact/Management of Neurodevelopmental Assessment Waiting List (15)
1048: Mind Mate SPA increasing backlog of referrals (system wide risk) (15)
1125: National Supply Issues with Enteral Feeding Supplies by Nutricia (12)
1042: Provision of Equipment from Leeds Community Equipment Service (LCES) (12)
1298: Patients not receiving clinical information due to printing issues with the new digital letters system (12)
1285: Clinically Essential Training (9)
1139: General risk of non-concordance with the overarching organisational process for medical devices (9)
1311: Inclusion Nursing Service Capacity (9)
1308: Documentation of the Self Harm SOP being adhered to (WYOI) (9)
1324: Safeguarding Core Staffing (9)
1278: Pudsey Neighbourhood Team (9)
1228: Quality and Value – negative impact on the patient (9)
874: Sickness Levels – Neighbourhood Teams (9)
1307: Triage Hub Clinical Decision Making – Capacity and Demand (9)
1109: Clinical Incident Management in Neighbourhoods (9)
1220: Digital Exclusion of the Population we serve (9)
1217: Digital and BI teams have insufficient capacity (9)
772: Waiting times in ICAN PND services are above acceptable levels (9)

Strategic 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.

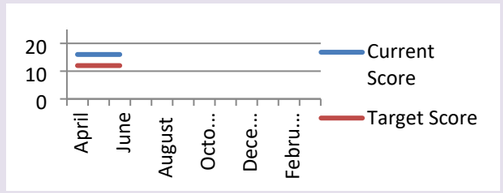
Strategic Objective: Work with communities to deliver personalised care / To embed equity in all that we do

Risk Appetite	Seek (15-20)	**Status: In or out of Appetite**	In	**Lead Director/risk owner:** Executive Director of Operations

Committee with oversight: Quality and Business Committees

Date last reviewed: 13/6/25

Risk Rating
(likelihood x consequence)
Current score:
4 x 4 = 16
Target score (end of 2025/26):
3 x 4 = 12



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

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Ultimately the risk appetite is 3 – the identified mitigations will begin to reduce the waiting lists over three years however tactical actions to improve financial position may have consequence on waiting lists. The risk will not be reduced to appetite by the end of March 2026, an interim target score of 12 is set for 2025/26.

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

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

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

Action	Owner	Due by
There is a gap in control relating to the management of waiting lists. The Quality and Value programme is a three-year programme that includes the following to improve the waiting list position: • Transformation programme to improve prioritisation and flow, • Service review, review of access criteria and ways of providing services. • A continue pipeline of business cases will be maintained to address specific services as funding allows. Completed year 1, different services have been included for year 2.	Executive Director of Operations	Year 2 Mar 2026
There is a gap in control relating to the ability to optimise staffing to align workforce with patient demand. To address this the Trust is implementing e-allocate. This has been delayed awaiting SystmOne changes.	Executive Director of Operations	Sept 2025
There is a specific gap in control in relation to the capacity to meet the demand for the MindMate Single Point of Access – to address this the Trust is undertaking joint work with third sector re alternative single point of access. The Business Committee agreed the way ahead on 26/2/25. This is due by the end of October 2025.	Executive Director of Operations	31 Oct 25

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

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

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

Action	Owner	Due by
There is a gap in assurance in relation to awareness of the business of the Scrutiny Board. To address this, the approved Scrutiny Board minutes will be included in the Board papers from September onwards.	Executive Director of Operations	Sept 2025

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

1179: Impact/Management of Neurodevelopmental Assessment Waiting List (15)
1048: Mind Mate SPA increasing backlog of referrals (system wide risk) (15)
954: Diabetes Service waiting times (12)
1198: Impact of ADHD medication waiting list (12)
957: Increase in demand in the adult speech and language therapy service. (12)
1298: Patients not receiving clinical information due to printing issues with the new digital letters system (12)
877: Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand (12)
1098: Wait Times for patients referred into the Continence, Urology and Colorectal Service (CUCS) (10)
1217: Digital and BI teams have insufficient capacity (9)
913: Increasing numbers of referrals for complex communication assessments in ICAN service breaching waiting time target (9)
1284: Staff capacity in children's speech and language therapy school age learning and dysphagia (SALD) service. (9)
994: Waiting times for Community Dental Services (9)
772: Waiting times in ICAN PND services are above acceptable levels (9)
1220: Digital Exclusion of the Population we serve (9)

Strategic 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.

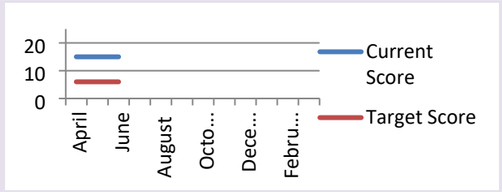
Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity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

Risk Appetite	Minimal (1-3)	**Status: In or out of Appetite**	Out	**Lead Director/risk owner:** Chief Executive Officer

Committee with oversight: Quality, Business and People and Culture Committees

Date last reviewed: 6/6/25

Risk Rating
(likelihood x consequence)
Current score:
5 x 3 = 15
Target score (end of 2025/26):
2 x 3 = 6



Rationale for current risk score:
The likelihood is assessed as almost certain (5) due to the Trust being placed in segment 4 of the NHSE Oversight Framework the consequence of this is moderate (3). The Trust faces challenging recommendations which can be addressed with the appropriate action plans. In addition, the Well-Led review made challenging recommendations with an action plan in relation to the governance arrangements. Additionally, the Trust has reported an IG issue to the ICO relating to the digital letters launch.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Quality Committee regular assurance that demonstrates compliance with CQC standards is required to reduce the risk to unlikely (2) by the end of 25/26.

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

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

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

Action	**Owner**	**Due by**
As part of our commitment to continuous quality improvement and in alignment with the Quality Challenge+ programme, we will begin implementing the new CQC Single Assessment Framework into internal governance and quality processes throughout the 2025/26 financial year. The official go-live date is planned for 31st March 2026. Board Development Session: A dedicated session will be held to brief and engage Board members on the new CQC framework and its implications. Senior Leadership Team (SLT) Session: Focused session to prepare leadership for the integration of the framework into operational practice. Integration with NHSE Oversight Framework: The implementation will align with the NHS England Segment 2 Oversight Framework, ensuring consistency with regulatory expectations. CQC QA Process and RM Governance Embedding: Quality Assurance processes and Risk Management governance structures will be reviewed and adapted to ensure full alignment with the new CQC requirements. CQC Relationship Management: Regular strategic relationship management meetings with the CQC will be established or continued to ensure open communication and early resolution of emerging issues.	Executive Director of Nursing and Allied Health Professionals	31 March 2026
Gaps in control were identified though the Well-led review and action plan (3-year action plan). Actions relating to compliance and governance have been prioritised for implementation in the 1st year.	TLT	End of 2025/26
There is a gap in control relating to ensuring completeness of the regulatory and legislator requirements to inform this strategic risk. To address this a comprehensive list of legislative and regulatory requirements will be pulled together. A paper was taken to TLT on 11 June.	TLT	End of Q1 2025/26

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

1. Service Level Assurance	**2. Specialist Support / Oversight Assurance**	**3. Independent Assurance**
• Clinical Governance report (QC) • Patient safety and serious incident report (QC)	• Emergency Planning quarterly updates and annual report (BC)	• CQC system assessment reports • Internal audit

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

Action	**Owner**	**Due by**
There is a gap in assurance in relation to implementation of the Well Led review recommendations. To address this, 6 monthly updates on Well-Led will be presented to the Board.	Head of Strategy, Change and Development	End Q1 2025/26

• Safeguarding report/minutes (QC) • Quality Strategy report (QC) • IPC BAF Report (QC) • Premises Assurance Model update (BC) • Health and Safety compliance report (BC) • Sustainability report (BC) • Workforce report (BC) • Information Governance Reporting (BC) • CEO report to Board (Board) • Employee relations report (Board) • Code of Governance compliance report (Board)	• Performance brief (statutory compliance) (QC and BC) • NICE guidance compliance (QC) • Mortality report (QC) • Medical Director's Report (appraisals info) (QC and Board) • Annual report to Board (Board) • MHLDA Committees in Common minutes and report (Board)		The first update will be taken to the July Board workshop – subsequently has been scheduled on Board workplan (April and Oct).		

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

1329: Failure to Deliver the Financial Plan (12) 1312: The Trust Risk and Incident reporting system is preventing accurate reporting / assurance both internally and externally. (12) 1294: CGT capacity and resilience due to vacancies and absence (12) 1250: Staff shortage Domestic Services (cleaners) (12) 1178: Uncoordinated fire evacuation arrangements (10)	902: Incompatibility of shelving system, manoeuvring space, stored items and available lifting equipment at Assisted Living Leeds. (9) 1304: Management and recording of risks that have reached the target score (9) 1296: Non-Compliance with Data Security Protection Toolkit (DSPT) (9) 1305: Resilience of Risk Management Function (9) 1089: Children Looked After, Initial Health Needs Assessment (9)

Strategic 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.

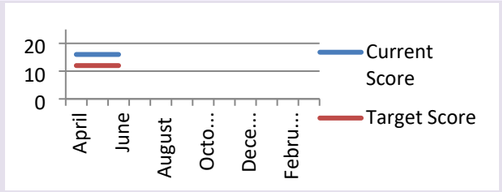
Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do

Risk Appetite	Cautious (4-6)	**Status: In or out of Appetite**	Out	**Lead Director/risk owner:** Executive Director of Finance and Resources

Committee with oversight: Business Committee

Date last reviewed: 6/6/25

Risk Rating
(likelihood x consequence)
Current score:
4 x 4 = 16
Target score (end of 2025/26):
3 x 4 = 12



Rationale for current risk score:
The scale of financial challenge across the NHS is significant, rising demand for services and inflationary cost pressures are increasing the levels of efficiency and productivity required of all organisations. The Trust has established a Quality and Value programme that has supported successful delivery of the financial plan in 25/26 however there remains an over reliance on non-recurrent savings.
The risk is scored against recurrent delivery of savings to achieve financial sustainability. The risk remains 16 due to not having the conditions to enter the new year with robust plans to deliver financial balance. Plans need to be identified before the start of the financial year. Benchmarking data flags LCH as an outlier in certain areas of spending, providing opportunity to make savings. Require assurance that Q&V delivers recurrent efficiency savings. In addition, the Trust does not yet have an organisational strategy that is underpinned by long term financial plan, inclusive of a multi-year Q&V plan.

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

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

- Board Approved Annual Plan, revenue, and capital
- Financial controls including budgetary controls are in place with routine performance monitoring and assessment of financial risk/mitigations to inform achievement of the financial plan
- Staff Cost Controls including ECF Process, agency, and temporary staffing controls in place
- Financial Policies (incl. but not limited to SFIs/ Scheme of Delegation / Investment Policy)
- Training programme for Non-Finance Managers commissioned and being rolled out
- Quality & Value Programme - Established & Embedded
- Budget Setting Process & Procedures clearly defined.
- Internal Audit assessment of Q&V programme structure (Part 1 and 2)
- Established process for Place /System Oversight supporting "difficult decisions"

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

Action	**Owner**	**Due by**
There is a gap in control around medium-term financial planning and identification of recurrent savings. To address this the following actions have been identified:		
1. Establish a rolling Medium-Term Financial Plan and underpinning Q&V Programme rolling 3-year savings plan	EDFR	Q3 25/26
2. Use of benchmarking data to inform the Q&V programme	EDFR	Q4 25/26
3. Consolidated workplan drawn from best practice "checklists" ensure no gaps in key controls that are required to underpin Financial Sustainability	EDFR	Q2 2025
4. Refresh of Performance & Accountability Framework - aligned to outputs from Well Led review	EDFR/COO	Q3 25/26

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

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

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

Action	**Owner**	**Due by**
There is a gap in assurance that the Q&V programme delivers recurrent efficiency savings. To address this the following actions have been identified:		
1. Enhanced financial performance reporting including progress against the Q&V programme, risk-based forecasting and underlying financial position to support oversight assurance. NHSE guidance to be aligned to the Q&V programme re financial risk and programme risk. Financial reporting will continue to be reviewed and developed during 25/26	EDFR	Q3 25/26
2. Improve service level assurance based on the refresh of the Performance and Accountability Framework. Due date aligned with the action to refresh the framework and outputs from the Well Led review	EDFR/COO	Q3 25/26

Link to Risk Register (material risks scoring 9 or above):
1329: Failure to Deliver the Financial Plan (12)
1298: Patients not receiving clinical information due to printing issues with the new digital letters system (12)
1217: Digital and BI teams have insufficient capacity (9)

Strategic Risk 5:

Failure to maintain business continuity: If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.

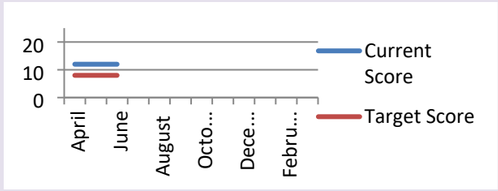
Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

Risk Appetite	Minimal (1-3)	**Status: In or out of Appetite**	Out	**Lead Director/risk owner:** Executive Director of Operations

Committee with oversight: Business and Audit Committees

Date last reviewed: 13/6/25

Risk Rating
(likelihood x consequence)
Current score:
3 x 4 = 12
Target score (end of 2025/26):
2 x 4 = 8



Rationale for current risk score:
The risk in relation to EPRR has reduced to 9, however the risk relating to cyber continues to be 12 due to the high threat level. – working towards compliance with the NHSE EPRR annual assurance process and implementation of the actions arising from the IT resilience review.
Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Ability to test Business Continuity plans with clinical services to test for prolonged service loss.
Deployment of the revised Cyber Incident Response Plan.

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

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

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

Action	Owner	Due by
There is a gap in control in relation to compliance with the NHSE EPRR annual assurance process. To address this gap a workplan is in place to achieve compliance in 2025/26. Internal Audit has provided significant assurance that the Trust is on track against the action plans. The Trust seeks to obtain assurance on BCPs (end Q2 25/26)	Executive Director of Operations	End Q2 2025/26
Gaps in control were identified through the IT resilience review an action plan is in place to address including establish and implement target operating model for IT function, responding to findings from IT resilience review (risk 1187)	EDFR	Q2 2025/26
Improvements in controls relating to cyber resilience have been identified and are being enhanced through: • Maintenance of Cyber Essentials Plus Certification • Implementation of actions from the audit of the Cyber Incident Response Plan • Cyber Security Board training session	Executive Director of Finance and Resources	Sept 2025

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

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

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

Action	Owner	Due by

Link to Risk Register (material operational risks scoring 9 or above):
1221: Likelihood of a Cyber Attack (12)
1313: Climate Adaptability Resilience Planning (12)

Strategic 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.

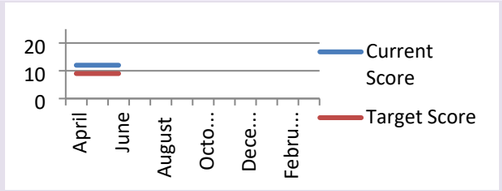
Strategic Objective: Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

Risk Appetite	Cautious (4-6)	**Status: In or out of Appetite**	Out	**Lead Director/risk owner:** Director(s) of Workforce (DoW)

Committee with oversight: People and Culture Committee

Date last reviewed: 12/6/25

Risk Rating
(likelihood x consequence)
Current score:
4 x 3 = 12
Target score (end of 2025/26):
3 x 3 = 9



Rationale for current risk score:
The risk relates to the impact of staff wellbeing and engagement on delivery of care and the objectives of the Trust. Due to both the external climate across the NHS, and the internal Trust environment in terms of financial constraints and our Quality and Value change programme, it is thought that continued high staff engagement is a real risk and more of a risk than staff health and well-being currently although the two are integrally linked. The risk is scored as likely (4) to have a moderate impact (3). It is anticipated that Staff Survey results could reduce given the context of this year.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
By the end of 2025/26 we will have more certainty of the progress of the Quality and Value programme (end of yr2), and controls will have had the opportunity to take effect. The likelihood should reduce with improved engagement and more clarity on the external context (Leeds review) and internal changes (3x3).

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

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

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

Action	**Owner**	**Due by**
As a result of current NHS climate both internal and external to the Trust there is a need for a renewed focus on engaging staff across LCH. This will be addressed through: • Refresh / realignment of the programme of communication and engagement. • Re-establishment of Leader's network and ongoing engagement across the organisation.	CEO / DoW	Dec 2025
As a result of the current NHS climate both internal and external to the Trust there is a need to monitor the impact on staff sickness and health and wellbeing. This will be undertaken through: • Routine identification of hot spots • Deep dives to identify interventions to address	DoW	End 2025/26

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

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

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

Action	**Owner**	**Due by**
There is a gap in assurance in relation to implementation of the Well Led review recommendations. To address this, 6 monthly updates on Well-Led will be presented to the Board. The first update will be taken to the July Board workshop – subsequently has been scheduled on Board workplan (April and Oct).	Head of Strategy, Change and Development	End Q1 2025/26
A People and Culture Committee has been established, the assurance reports to the committee have not yet been fully determined. This will be refined and reflected in the committee workplan.	DoW	Sept 2025
There is a gap in control relating to measurement of the People Directorate key performance indicators (KPIs) To address this KPIs are in development and enhancement and will be reported to the People and Culture Committee.	DoW	Dec 2025

Link to Risk Register (material risks scoring 9 or above):
1227: Quality and Value – negative impact on staff (9)
1327: Finance Team Capacity and Capabilities (9)
1318: Corporate Funding Reduction (9)

Strategic 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.

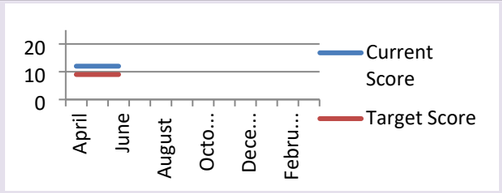
Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity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

Risk Appetite	Seek (15-20)	**Status: In or out of Appetite**	In	**Lead Director/risk owner:** Medical Director

Committee with oversight: Quality Committee / Trust Board

Date last reviewed: 4/6/25

Risk Rating
(likelihood x consequence)
Current score:
4 x 3 = 12
Target score (end of 2025/26):
3 x 3 = 9



Rationale for current risk score:

- Likely (4) as inequity is (inadvertently) embedded within existing systems and processes and therefore continuation of business as usual is likely to create inequity.
- We have identified some areas where inequality exists in our current services and processes and as our breakdown of data analysis increases awareness of inequity, we can drive action to reduce inequalities.
- Consequence is both outcomes for population at risk of inequity and consequence for the Trust (e.g. for failure to comply with statutory duties relating to equity)
- Work has begun to embed action to address inequity, but change is slow for such a pervasive issue

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

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

- Elevation of the equity agenda to a Trust strategic objective
- We have a strategy and action plan and links with Quality and Value programme
- Programmes of work delivering on statutory duties
- Development of measurement framework for equity
- Member of Tackling Health Inequalities Oversight Group
- Process and governance for Equity and Quality Impact Assessment (EQIA) within the Quality and Value Programme
- Equality Delivery System (EDS) requirements met
- Armed Forces Covenant requirements met
- Veteran Aware accreditation
- Quarterly Racial Equity in Care Group meetings oversee Patient and Carer Race Equality Framework (PCREF). Reporting to Health Equity Leadership Group
- Health Equity Leadership Group (reporting into QAIG)

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

Action	Owner	Due by
There is a gap around our ability to consistently meet / fully understand our current position relating to reasonable adjustments and accessible information. To address this gap a person-centred care template, working title 'About Me' is being developed as part of the EPR optimisation programme. Funding has been agreed for project management of this but is not yet in place.	Medical Director	31 Mar 2026
There is a gap in availability, analysis and use of data to undertake equity analysis and take mitigating action. To address this gap a revised equity data dashboard to meet the requirements of the NHSE statement on inequalities will be developed. Progress against this action: To strengthen the monitoring of the current strategy a measurement framework has been developed and, with support from the BI team, prioritised measures will be reported on to measure progress. Examples of good practice for metrics are well noted and will be used to develop quantifiable metrics within a future health equity strategy (standalone or equity elements integrated into the broader trust strategy).	Chairs of relevant Committees Head of Business Intelligence and Performance	1 Jan 2026
There is a gap in control relating to resourcing of the health equity function. Co-ordination of the programme and associated activity to address inequity and deliver statutory duties needs to be sufficiently resourced. To address this a business case for Health Equity has been approved, recruitment not yet commenced.	TLT	3 Sept 2025

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

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

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

Action	Owner	Due by
There is a gap in assurance from the EQIA process. To address this clear oversight by clinical Directors will be implemented with appropriate escalation through the corporate governance processes to provide assurance to QAIG and Quality Committee.	Executive Director of Nursing and AHP's	October 2025
There is a gap in assurance from the Tackling Health Inequalities Oversight Group. To address this, it will be determined where outputs from the group will feed into the governance process to provide assurance on the operation of the group.	Medical Director	End Q2 2025/26

Link to Risk Register (material risks scoring 9 or above):
1220: Digital Exclusion of the Population we serve (9)
1309: Safeguarding Responsibilities for Leeds Children in Harrogate Schools (9)

Strategic 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.

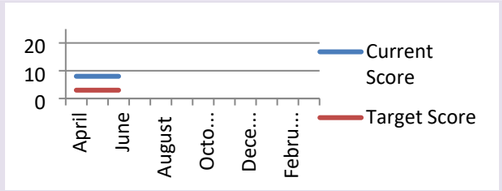
Strategic Objective: Collaborating with partners to enable people to live better lives / To embed equity in all that we do

Risk Appetite	Seek (15-20)	**Status: In or out of Appetite**	In	**Lead Director/risk owner:** Chief Executive

Committee with oversight: Business Committee

Date last reviewed: 6/6/25

Risk Rating
(likelihood x consequence)
Current score:
2 x 4 = 8
Target score (end of 2025/26):
1 x 3 = 3



Rationale for current risk score:
Positive feedback was received from partners in the Well Led review; however current financial planning suggests a possible impact on the Trust's ability to collaborate with others. Prioritisation will take place to make best use of capacity to effectively collaborate with partnerships in a coordinated way.
The Leeds System review will shape the direction re partnerships

The risk score remains at 8 as actions are in progress.

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

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

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

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

Action	**Owner**	**Due by**
There is a gap in control relating to the Trust's role and capacity to effectively collaborate with others. To address this the Trust's will produce a map of partnerships to prioritise involvement in partnerships.	Chief Executive Officer	End Q2 2025/26
There is a gap in control in relation to the changing NHS both locally and nationally, to address this the Trust will: • Establish LCH role in the Neighbourhood model • Fully engage in the Leeds provider partnership review • Seek to understand implications and respond to changes in ICB functions	Chief Executive Officer	End Q2

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

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

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

Action	**Owner**	**Due by**

Link to Risk Register (material risks scoring 9 or above):
No risks currently recorded on the risk register

Agenda item:	2025-26 (18)

Title of report:	Changes to Non-Executive Director roles and responsibilities

Meeting:	Trust Board Meeting Held In Public
Date:	4 September 2025

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

Executive Summary:	Inform the Board of changes to roles, responsibilities and Committee membership for the Trust's Non-Executive Directors following the departure of the Trust Chair in August 2025. It takes into consideration the UK Corporate Governance Code where appropriate and the existing Board approved terms of reference for each Committee.

Previously considered by:	N/A

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

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

Recommendation(s)	The Board is asked to • Note the interim arrangements for the Chair, Deputy Chair and Senior Independent Director roles • Note the Committee membership update.

List of Appendices:	N/A

Changes to Non-Executive Director roles and responsibilities

1 Introduction

Following the end of tenure of Brodie Clark CBE as Trust Chair in August 2025, a review of Non-Executive Director roles and responsibilities has taken place. The following paper outlines the interim arrangements while the Leeds Provider Review work is ongoing.

2 Interim Trust Chair and Deputy Chair

It has been agreed with NHS England that Helen Thomson, Deputy Lieutenant, will be undertaking the role of Interim Trust Chair from 11 August 2025. An expressions of interest process resulted in Ian Lewis becoming the Trust's Interim Deputy Chair from the same date.

3 Other roles

- It has been agreed that Rachel Booth will undertake the role of Senior Independent Director during this interim period, supporting the Chair, providing an independent perspective on governance issues; and carrying out the Chair's annual appraisal.
- Helen Thomson will retain the additional role of Freedom to Speak up champion.

4 Committee Membership Proposal

The Trust is considered not to have a Non-executive Director vacancy at the current time due to Helen Thomson acting into the Interim Chair role, and so the Committee membership has been reviewed based on the current allocation of Non-Executive and Associate Non-Executive Directors, in line with their skills and experience.

The arrangements includes cross-membership of Business Committee and People and Culture Committee to ensure good communication. Further to this, the agendas for each Committee also include an opportunity for escalation of items to other Committees.

Audit Committee

Non-Executives (3): Khalil Rehman (Chair), Ian Lewis, Lynne Mellor (Associate NED).

Executives: No members (Andrea Osborne attends)

Notes: Complies with UK Code of Governance and local Terms of Reference.

Business Committee

Non-Executives (3): Lynne Mellor – Associate NED (Chair), Khalil Rehman, Rachel Booth.

Executives (3): Andrea Osborne, Sara Munro, Sam Prince (Laura Smith / Jenny Allen attend)

Notes: Complies with local Terms of Reference

Charitable Funds Committee

Non-Executives (2): Alison Lowe (Chair), Helen Thomson.

Executives (2): Lynsey Ure, Andrea Osborne

Notes: Complies with local Terms of Reference.

Nom/Rem Committee

Non-Executives (3): Helen Thomson (Chair), Rachel Booth, Alison Lowe.

Executives: No members (Laura Smith / Jenny Allen attend)

People & Culture Committee

Non-Executives (3): Rachel Booth (Chair), Lynne Mellor (Associate NED), Ian Lewis.

Executives: (2) Laura Smith / Jenny Allen, Lynsey Ure (other members of the Executive team have a standing invite to attend particularly when items within their portfolio are included on the agenda).

Quality Committee

Non-Executives (3): Ian Lewis (Chair), Alison Lowe, Helen Thomson (ad hoc attendance).

Executives (3): Lynsey Ure, Ruth Burnett, Sam Prince

Notes: Complies with local Terms of Reference.

5 Risk and assurance

If the Board's Committees do not have a combination of appropriate skills, experience and knowledge, there may be an insufficient level of scrutiny and challenge. This could impact on the achievement of the Trust's strategic objectives.

6 Next steps

No changes are required to Committee terms of references at present.

7 Recommendations

The Board is recommended to:

- Note the interim arrangements for the Chair, Deputy Chair and Senior Independent Director roles
- Note the Committee membership update.

Helen Robinson
Company Secretary
7 Aug 2025

Leeds Community Healthcare NHS Trust

Agenda item 2025-26 (20)

Public Board workplan 2024-26
Version 3: 28 08 2025

TOPIC	Frequency	Lead officer	BAF Strategic Risk	1 April 2025	5 June 2025	25 June 2025- Annual Report and Accounts only	10 July 2025 Extraordinary meeting	4 September 2025	4 November 2025	5 February 2026	26 March 2026
STANDING ITEMS											
Declaration of interests	every meeting (from April 2024)	CS	N/A	X	X	X		X	X	X	X
Minutes of previous meeting	every meeting	CS	N/A	X	X			X	X	X	X
Action log	every meeting	CS	N/A	X	X			X	X	X	X
Board workplan	every meeting	CS	N/A	X	X	X		X	X	X	X
Patient story	every meeting	EDN&AHPS	N/A	X	X			X	X	X	X
STRATEGY AND PARTNERSHIPS											
Chief Executive's report	every meeting	CE	All	X	X			X	X	X	X
System flow (part of CE report from Sept 2024)	every meeting	EDO	SR 8								
Organisational Strategy Development	Annual (October)	EDO							X		
Operational Plan (Trust) priorities (for the coming year) for approval	Annual April	EDFR	SR 4,6	X							X
Operational Plan (Trust priorities) update	3x year (Feb, June and Oct)	EDFR/EDN&AHPS	SR 4,6		X -end of year update				X	X	
Estate Strategy	2xyear (April and Oct)	EDFR			X -Blue box					X -Blue box	
Business Development Strategy (Private Item from April 2025)	2xyear (April and Oct)	EDO									
Business Intelligence Strategy -part of Digital Strategy September 2024	2x year (Feb and Sept)	EDFR									
Learning and Developement Strategy	annual	EDN&AHPS	SR 1	Deferred X -Blue box							X
Patient Safety Strategy Implementation Update	Final report to Board Dec 24	EDN&AHPS	SR 1,2,3								
Health Equity Strategy	Annual (Sept)	EMD	SR1,7					X			
Quality Strategy	2xyear(June and December)	EDN&AHPS	SR 1,3		X - Blue box item					X - Blue box item	
People Headlines and Strategy update	3x year (Feb, June and Oct)	DW	SR 3,6		X				X	X	
QUALITY AND SAFETY											
Quality Committee Chair's Assurance Report	every meeting	CS	SR 1,2,3	X	X	X		X	X	X	X
Quality account	annual	EDN&AHPS	SR 1		Taken in Private Session X	X Final sign off					
Mortality reports	4x year (June plus annual report, September, December and February)	EMD	SR 1,3		X +Q4 and Annual Report			Deferred to October 2025	X	X	
Patient safety (including patient safety incident investigations) update report	2 x year (April and October)	EDN&AHPS	SR 2,3	X -Blue box					X -Blue box		X -Blue box
Infection prevention control assurance framework	2x year(April and October)	EDN&AHPS	SR 1,3	X -Blue box					X -Blue box		X -Blue box
Infection prevention control annual report	annual (Sept)	EDN&AHPS	SR 1					Deferred to October 2025	X		
Care Quality Commission inspection reports	as required	EMD	All								
Safeguarding -annual report	annual (Sept)	EDN&AHPS	SR 1,3					Deferred to October 2025	x		
FINANCE PERFORMANCE AND SUSTAINABILITY											
Business Committee Chair's Assurance Report	every meeting	CS	SR 2,3,4,5,6	X	X			X	X	X	X
Audit Committee Chair's Assurance Report	as required	CS	SR5	X	X			X		X	X
Chartitable Funds Annual Report and Accounts	Annual (December)	EDFR	N/A							X	
Charitable Funds Committee Chair's Assurance Report	4 x year (April, Sept, Oct and Feb)	EDN&AHPS	N/A					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	
Emergency Preparedness, Resilience & Response Policies	annual	EDO	SR2,5							X	
Performance Brief	every meeting	EDFR	SR 1,2,3,5,6,8	X	X			X	X	X	X
Performance brief: High Level Performance Indicators for inclusion in the performance brief	annual	EDFR	SR 1,2,3,5,6,8	Taken as part of Board Workshop March 2025							X
Financial Plan	annual			X							X
Annual report	annual	EDFR	All			X					
Annual accounts	annual	EDFR	SR 4,6			X					
Letter of representation (ISA 260)	annual	EDFR	N/A			X					
Audit opinion (Internal)	annual	EDFR	N/A			X					
Green Plan	2x year (June and Dec)	EDO	SR 3		Deferred -July 2025 (Extraordinary meeting)		X			X	
WORFORCE											
Staff survey	annual	DW	SR 6	X							X
Safe staffing report - covered in Quality Committee Chair's Assurance Report from September 2025	2 x year (Feb and Sept)	EDN&AHPS	SR 2,6								
Freedom to speak up report	2 x year (April and November)	FTSUG	SR 6	X						X	X
Guardian for safe working hours report	4 x year (April, June, Sept, Dec)	GoSWH	SR 6	X	X			X plus 2024-25 Annual Report		X	X
Medical Director's annual report	annual	EMD	SR 3					X			
WDES and WRES -annual report and action plan	annual	DW	SR 6,7						X		
GOVERNANCE AND WELL LED											
Code of Governance Compliance	annual	CEO	N/A		X						
Audit Committee annual report inlcluding Committee terms of reference review	annual	CS	N/A		X						
Standing orders/standing financial instruction	annual	CS	N/A								
Going concern statement	annual	EDFR	N/A	X							X
Declarations of interest/fit and proper persons test	annual	CS	N/A	X							X
Register of sealings	As required (from February 2025)	CS	SR 4		X				X		
Significant risks and risk assurance report	every meeting	CS	All		X			X	X	X	
Board Assurance Framework -quarterly update report	Apr, June,Sept and Dec	CS	All	X	X			X		X	X
Risk appetite statement	annual	CS	All	Deferred to June 2025	Deferred Board Workshop July 2025			X			X
Management of Risk Policy & Procedure (3 yearly)	(Next due for review in Oct 2025)	CS	All								
Declaration of interests - information from declare	Annual (September) - from 2025	CS	N/A						X		
Board Members Service Visits Report	3xyear (June, October,February) from June 2024	CE	N/A		Deferred				X	X	
Business Continuity Management Policy	as required	EDO	SR 2,5								
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 3						X - Blue box item		
Health & Safety Policy (3 yearly)	(Next due for review Feb 2026)	EDFR	SR 3								
Senior Information Risk Officer - Annual Report	annual	EDFR	SR 3,5	X						X	X
FOR INFORMATION											

Key

CE	Chief Executive
EDFR	Executive Director of Finance and Resources
EDN	Executive Director of Nursing
EDO	Executive Director of Operations
EMD	Executive Medical Director
DW	Director of Workforce
CELs	Committees' Executive Leads
CS	Company Secretary

= received
= deferred to another meeting
= not required