Bundle Public Board Meeting 6 November 2025

0 Agenda
Final Agenda Public_Board_Meeting_6 November_2025

1 09:30 - Welcome, introductions and apologies:

2 Declarations of interest

3 Questions from members of the public
Minutes adoption for approval

4 Minutes of previous meeting action log and matters arising

4.a Minutes of the meeting held on: 4 September 2025
Item 4ai Draft Public Board Minutes 4 September 2025

4.b Action log
Item 4b Public Board Action log 6 November 2025

5 09:40 - Patient Lived Experience: Children's Speech and Language Therapy (Lynsey Ure)

6 10:00 - Interim Chief Executive's report: Interim Chief Executive's Report •Provider Capability Self-Assessment (Dr Sara Munro)
Item 6i Chief Executive's report - November 2025
Item 6ii Cover report LCH capability assessment Public
Item 6iii Provider-capability-self-assessment template LCH 22.10.25
Item 6iv Provider capability self assessment evidence list LCH 17.10.2025

7 10:15 - Internal Audit – Audit Yorkshire (Jonathan Hodgson)

8 10:20 - Health Equity Five Year Tactical Plan (Dr Ruth Burnett)
Item 8 Board equity update Nov 2025 v4

9 10:30 - Trust Priorities – Mid-Year Update (Andrea Osborne)
Item 9i Operational Plan Mid Year update WIGs
Item 9ii Appendix 1 Trust Priorities Mid Year Update

10 10:40 - People Headlines and Strategy Update (Laura Smith/Jenny Allen) –reviewed by the P&CC in September 2025
Item 10i TRUST BOARD People Headlines and Strategy Update Nov 2025 V1.0
Item 10ii Appendix 2 Workforce Strategy Measures Dashboard - Sept 25

11 10:50 - Quality Committee Chair's Assurance Report: 23 September 2025 (Professor Ian Lewis)
Item 11 Chairs assurance report - Quality Committee September 2025 v2 FINAL

12 10:55 - Infection Prevention and Control Annual Report 2024/25 – for Approval - reviewed by the Quality Committee 23 September 2025 (Lynsey Ure)
Item 12 IPC Annual Report 24-25 Version 4 FINAL Board

13 11:00 - Safeguarding Annual Report 2024/25 – for Approval - reviewed by the Quality Committee 23 September 2025 (Lynsey Ure)
Item 13i Safeguarding Annual Report Cover paper - October 2025

14 11:15 - Business Committee Chair's Assurance Reports: 24 September 2025 and 29 October 2025 (Lynne Mellor)
Item 14 Business Committee Chairs Assurance Report 24 September 2025 FINAL
Item 14ii Business Committee Chairs assurance report - 29 October 2025 Final

15 11:20 - Audit Committee Chair's Assurance Report: 14 October 2025 (Khalil Rehman)
Item 15 Audit Committee Chair's Assurance Report October 2025 Final_KR

16 11:25 - Charitable Funds Committee Chair's Assurance Report: 9 September 2025 (Alison Lowe)
Item 16 Charitable Funds Committee Chair Assurance Report Sep 2025

17 11:30 - Performance Report (Andrea Osborne)
Item 17i Cover paper - Performance Brief_BoardNov
Item 17ii Performance Brief_BOARD - Q1 2025-26 & Aug_Sep 2025

18 11:50 - National Operating Framework – Segmentation Update •Sickness Rate Trajectories •Waiting List Trajectories •Wider Indicators (Dr Sara Munro)
Item 18i October Access to Services LCH Waiting List Recovery Plan
Item 18ii TRUST BOARD Sickness Absence Improvement Project Update Nov 2025 V1.0

19 12:10 - People and Culture Committee Chair's Assurance Report: 23 September 2025
Item 19 PCC Chairs assurance report Sept 25 v3

20 12:15 - Annual People Inclusion Report 2024- 2025 – 2026(incorporating WRES / WDES and Pay Gap reporting) -reviewed by People and Culture Committee on 23 September 2025 (Jenny Allen/Laura Smith)
Item 20i Annual People Inclusion report 2024-25 Trust Board 6 November 2025 Final
Item 20ii APPENDICES A Trust People Inclusion Improvement plan 2025- 26
Item 20iii APPENDICES B Risks and Mitigations for ESR Data Challenge and NHSEDI Hign Impact Actions

21 12:25 - Significant Risks And Risk Assurance Report •Risk Management Policy and Procedure - For Approval (Lynsey Ure)
Item 21i Board Significant Risks report 061125
Item 21ii Risk Management Policy and Procedure v7 Nov 25 Cover
Item 21iii PL354 Risk Management Policy v7 - TB 06112025

22 12:35 - Board Assurance Framework – Quarterly Update Report (Dr Sara Munro)
Item 22i Board Assurance Framework Quarterly update Nov 25 Cover
Item 22ii BAF_2025_26_BAF_Oct_2025

23 12:45 - Board Service Visits Proposal (Dr Sara Munro)
Item 23 Board Service visits Proposal
Item 23i Learning Visit Feedback Form
Item 23ii Leadership Visit Feedback Form

24 12:50 - Review Of Emergency Powers And Urgent Decisions Procedure (Chair and CEO actions and Committee urgent actions) (Dr Sara Munro)
Item 24 Emergency powers and urgent decisions procedure Nov 2025

25 12:55 - Any Other Business. Questions On Blue Box Items And Close (Acting Trust Chair) The Board resolves to hold the remainder of the meeting in private due to the confidential or commercially sensitive nature of the business to be transacted.

26 Blue Box: Patient Safety (including patient safety incident investigations) update report – reviewed by Quality Committee September 2025
Item 26 Patient Safety Report -March 25- August 25 Report Trust Board FINAL APPROVED

27 Blue Box: Health and Safety Annual Plan – Six Monthly Update) –reviewed by Business Committee on 24 September 2025
Item 27 Health and Safety Action Plan 2025-26 for Business Committee

28 Blue Box: Mortality Quarterly Report – Reviewed by the Quality Committee 23 September 2025
Item 28 Mortality Report Q12025v2

29 Blue Box: Workplan – To Note
Item 29 Public Board workplan 2025-26 v4 30 10 2025

NHS
Leeds Community Healthcare
NHS Trust

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

Date 6 November 2025
Time 9.30am – 1.00pm
Chair Helen Thomson DL, Acting Trust Chair

AGENDA			Paper
2025-26 1	9.30	**Welcome, Introductions and Apologies** *(Acting Trust Chair)*	**N**
STANDING ITEMS			
2025-26 2	9.35	**Declarations Of Interest** *(Acting Trust 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 Trust Chair)* *For approval*	
4a		Minutes of the meetings held on: • 4 September 2025	**Y**
4b		Action Log	**Y**
STRATEGY AND PARTNERSHIPS			
2025-26 5	9.40	**Patient Lived Experience: Children's Speech and Language Therapy** *(Lynsey Ure)*	**N**
2025-26 6	10.00	**Interim Chief Executive's Report** • Provider Capability Self-Assessment *(Dr Sara Munro)*	**Y**
2025-26 7	10.15	**Internal Audit – Audit Yorkshire** *(Jonathan Hodgson)*	**N**
2025-26 8	10.20	**Health Equity Five Year Tactical Plan** *(Dr Ruth Burnett)*	**Y**
2025-26 9	10.30	**Trust Priorities – Mid-Year Update** *(Andrea Osborne)*	**Y**
2025-26 10	10.40	**People Headlines and Strategy Update** *(Laura Smith/Jenny Allen)* –reviewed by the P&CC in September 2025	**Y**
QUALITY AND SAFETY			
2025-26 11	10.50	**Quality Committee Chair's Assurance Report: 23 September** 2025 *(Professor Ian Lewis)*	**Y**
2025-26 12	10.55	**Infection Prevention and Control Annual Report 2024/25 – for Approval - reviewed by the Quality Committee 23 September 2025** *(Lynsey Ure)*	**Y**
2025-26 13	11.00	**Safeguarding Annual Report 2024/25 – for Approval - reviewed by the Quality Committee 23 September 2025** *(Lynsey Ure)*	**Y**
BREAK – 10 minutes			
FINANCE, PERFORMANCE AND SUSTAINABILITY			

2025-26 14	11.15	**Business Committee Chair's Assurance Reports:** 24 September 2025 and 29 October 2025 *(Lynne Mellor)*	**Y**
2025-26 15	11.20	**Audit Committee Chair's Assurance Report:** 14 October 2025 *(Khalil Rehman)*	**Y**
2025-26 16	11.25	**Charitable Funds Committee Chair's Assurance Report:** 9 September 2025 *(Alison Lowe)*	**Y**
2025-26 17	11.30	**Performance Report** *(Andrea Osborne)*	**Y**
2025-26 18	11.50	**National Operating Framework – Segmentation Update** • Sickness Rate Trajectories • Waiting List Trajectories • Wider Indicators *(Dr Sara Munro)*	**Y**
		WORKFORCE	
2025-26 19	12.10	**People and Culture Committee Chair's Assurance Report: 23 September 2025**	**Y**
2025-26 20	12.15	**People Inclusion Improvement Plan 2025 – 2026(incorporating WRES / WDES and Pay Gap reporting) -reviewed by People and Culture Committee on 23 September 2025** *(Jenny Allen/Laura Smith)*	**Y**
		GOVERNANCE AND WELL LED	
2025-26 21	12.25	**Significant Risks And Risk Assurance Report** • Risk Management Policy and Procedure review **- For Approval** *(Lynsey Ure)*	**Y**
2025-26 22	12.35	**Board Assurance Framework – Quarterly Update Report** *(Dr Sara Munro)*	**Y**
2025-26 23	12.45	**Board Service Visits Proposal** *(Dr Sara Munro)*	
2025-26 24	12.50	**Review Of Emergency Powers And Urgent Decisions Procedure (Chair and CEO actions and Committee urgent actions)** *(Dr Sara Munro)*	**Y**
		CLOSING BUSINESS	
2025-26 25	12.55	**Any Other Business. Questions On Blue Box Items And Close** (Acting Trust Chair) The Board resolves to hold the remainder of the meeting in private due to the confidential or commercially sensitive nature of the business to be transacted.	**N**

All items listed (Blue Box) in blue text, are to be received for information/assurance, having previously been scrutinised by committees. The Acting Chair will invite questions on any of these items under Item 25.

***Blue Box**		
2025-26 26	**Patient Safety (including patient safety incident investigations) update report – reviewed by Quality Committee September 2025**	**Y**
2025-26 27	**Health and Safety Annual Plan – Six Monthly Update –reviewed by Business Committee on 24 September 2025**	**Y**
2025-26 28	**Mortality Quarterly Report – Reviewed by the Quality Committee 23 September 2025**	**Y**
2025-26 29	**Workplan – To Note**	**Y**

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (4ai)

Title of report:	Minutes Trust Board: Meeting Held in Public On 4 September 2025

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

Presented by:	Acting Chair					
Prepared by:	Corporate Governance Officer					
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

Minutes of TheTrust Board Meeting Held in Public On: 4 September 2025
Attendance

Present:	Helen Thomson Deputy Lieutenant (DL)	Acting 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 (From Item 66)
	Lynne Mellor (LM)	Associate Non-Executive Director
	Andrea Osborne	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Khalil Rehman (KR)	Non-Executive Director (Items 61-73)
	Laura Smith	Director of People (LS)
	Lynsey Ure	Executive Director of Nursing, Allied Health Professionals (AHPs), and Quality
Apologies:	Jenny Allen	Director of People (JA)
In attendance:	Dr. Nagashree Nallapeta	Guardian of Safe Working Hours (for Item 74)
	Christine Pearson	Service Manager, Integrated Children's Additional Needs Service (ICAN) (for Item 73)
	Helen Robinson	Company Secretary
Minutes:	Liz Thornton	Corporate Governance Officer Clinical Fellow
Observers:	Rebekah Besford	Health Visitor with the 0-19 service
	Samantha Steede	Operations Business Manager
Members of the public:	One member of the public was present	

Item 2025-26 (61)

Discussion points:

Welcome introduction, apologies, and preliminary business.

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

It was noted that a revised agenda had been tabled to accommodate the attendance of a family for the patient story item.

Apologies

Apologies for absence were received from the Director of People (JA).

Item 2025-26 (62)

Discussion points

Declarations of interest

Prior to the Trust Board meeting, the Acting 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 (63)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2025-26 (64)

Discussion points:

Minutes of the last meetings, matters arising and action log

ai) Minutes of the meeting held on 5 June 2025

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

aii) Minutes of the extraordinary meeting held on 25 June 2025

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

aiii) Minutes of the extraordinary meeting held on 10 July 2025

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

b) Action log

Five actions on the log were reviewed.

The proposals to close three actions were agreed: 2025-26 (30); 2025-26 (37) and 2025-26 (38iii).

The Board noted the updates on the two actions related to the Duty of Candour: 2025-26 (38i). 2025-26 (38ii) it was agreed that both actions would remain open to be reviewed again at the next Trust Board meeting when a further update would be provided about the assurance received by the Quality Committee on the issues raised.

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

2025-26 (65)

Discussion points:

Interim Chief Executive's report

The Interim Chief Executive presented the report and highlighted the following issues:

Veteran Aware

The Trust had received its Veteran Aware accreditation this was an important signal to the work the Trust did to value the veteran's community and a credit to all those involved in this work.

Industrial Action

Negotiations had resumed. The British Medical Association would be undertaking further ballots but no further industrial action by resident doctors was planned at this time.

Leeds Community Healthcare NHS Trust Annual General Meeting (AGM)
The AGM was scheduled for Tuesday 16 September 2025 at the Vinery Centre in Leeds. All Board members were encouraged to attend if possible.

Leeds Provider Partnership Review
A draft report was expected by mid-September. Board members would receive more detail on the outcomes when the report was available. Dr Ruth Burnett and Dan Barnett, Associate Director of Strategy, Change, and Improvement represented the Trust on the operational steering group.

Leeds Teaching Hospitals NHS Trust leadership update
The Acting Trust Chair and Interim Chief Executive had met with the new chair of Leeds Teaching Hospitals NHS Trust (LTHT) as part of his induction and had taken the opportunity to brief him on the Trust's approach to partnership working in the city and the importance of this continuing as a priority for the new leadership team at LTHT.

The Board noted that the process to appoint a successor to Professor Phil Wood – CEO at Leeds Teaching Hospitals NHS Trust had not yet begun, and the Deputy CEO and Chief Operating Officer Clare Smith had secured the CEO post at York and Scarborough Acute Trust. The Chief People Officer had also recently announced that she would be leaving LTHT.

National Oversight Framework (NOF)
The consultation had concluded, and all NHS providers would now be assessed under the new framework on a quarterly basis. The NOF set out how NHS trusts and foundation trusts would be automatically allocated to a segment based on performance from 1 (high performing) to 4 (low performing). The level a Trust was in determined the level of oversight and intervention that would be provided by NHS England (NHSE) regional teams. Board noted that LCH currently sat in segment 4.

Provider Capability Assessments
NHSE's new provider capability self-assessment framework template had been published and would be discussed at the next Trust Board development session on 11 September 2025 to agree the approach to completing the self-assessment and sign off before submission.

Integrated Care Board (ICB)
There would be no further movement on the cost reduction programme until HM Treasury provided clarity on their support for redundancy costs. NHS providers would be invited to a series of engagement events to test the changes to the new operational model.

Questions on the Interim Chief Executive's report were invited.

Non-Executive Director (RB) referred to recent social media activity, protests, and unrest across the city with the reports in the media of protests outside hotels housing asylum seekers and asked about the impact on staff wellbeing.

The Director of People (LS) acknowledged that the rise in racially motivated hate incidents was also being reflected in some local communities. Some colleagues had reported feeling unsafe when out in the community, but she had not been made aware of any specific incidents related to hate abuse and nothing had been raised at the regular check in meetings with the Chair of the Race Equality Network, however this would be a topic for discussion at the next meeting of the Trust Leaders Network.

Non-Executive Director (LM) asked about the timescale for the outcome of the National Neighbourhood Health Pilot applications.

The Executive Director of Operations said that an announcement was expected within the next two weeks. If the Leeds bid was successful, then the pilot sites would be established almost immediately.

Outcome: the Board

- Received and noted the report.

Item 2025-26 (66)

Discussion points:

Winter Planning 2025-26 – Including Board Assurance Statement

The Executive Director of Operations presented the Winter Plan which outlined how the Trust would manage seasonal pressures in 2025/26, to ensure safe and effective care delivery. It set outs service-specific risks, surge modelling, and escalation processes, alongside actions to strengthen resilience, manage sickness and absence, and maintain patient flow.

She explained that planning had been informed by learning from previous winters and engagement across all Business Units, corporate functions, and system partners. The plan provided assurance that the Trust was prepared to respond flexibly to increased demand while supporting system-wide flow.

The Board noted that the plan was still under development and would remain a live working document over winter. NHSE required that all Boards understand their organisation's Winter Plan and submit a Board Assurance Statement by 30 September 2025. The timing of this Board meeting meant that not all aspects of the Board Assurance checklist could be assured and further sign off would be required towards the end of the month.

Action: Winter Plan Board Assurance Statement was to be delegated to Acting Chair and Interim Chief Executive for sign off and reported back to the Trust Board in November 2025.

Responsible Officer: Executive Director of Operations.

The Board sought assurance that 'real time' monitoring would be in place and that there would be a robust grip and control on agency and variable pay costs. It was agreed that the Board should receive regular data monitoring updates to ensure that it was alerted at an early stage to any emerging concerns.

The Executive Director of Operations provided assurance that the expectation was that the use of agency staff would be kept to a minimum subject to ensuring patient safety and maintaining safe staffing levels. Bank capacity would be increased and could be used by managers at their discretion subject to their individual budget restrictions.

She added that the Business Intelligence Team were developing a dynamic dashboard which should be in place by winter 2025/26 and this would provide daily updates on staffing levels.

Action: Director of Operations to confirm that the dynamic winter dashboard is in place at the next board meeting.

Responsible Officer: Executive Director of Operations.

The Acting Trust Chair asked for an update on the seasonal vaccination programme for 2025/26 and the 0-19 vaccination programme outcomes.

The Executive Director of Nursing and AHPs said that the new seasonal vaccination programme campaign would be launched nationally in the next two weeks. A delivery plan for the Trust would be shared with the Trust Leadership Team (TLT) and then with the Quality Committee.

She said that more data on the 0-19 vaccination programme outcomes would be provided following the meeting.

Action: More data on the 0-19 vaccination programme outcomes to be provided following the meeting.

Responsible Officer: Executive Director of Nursing and AHPs.

Non-Executive Director (LM) asked for an update on the work to address the gaps in mobile signal coverage on staff devices.

The Executive Director of Finance and Resources said that the West Yorkshire Procurement Collaborative was taking forward this work at a regional level.

The Board agreed that final sign off the Board Assurance Statement could be delegated to the CEO and Chair and formally reported at the next Trust Board meeting for ratification.

Outcome: the Board

- Reviewed the Trust's draft Winter Plan for 2025-2026.
- Reviewed the Board Assurance Statement required for submission to the Integrated Care Board by 30 September (Appendix 1 to the report)
- Agreed that authority for final sign could be delegated to the CEO and Chair and formally reported at the next Trust Board meeting for ratification.

Item 2025-26 (67)

Discussion points:

Health Equity Strategy Update

The Executive Medical Director presented the report. Through the approach of a SWOT analysis tool, an update was provided on the progress against the Trust's strategic goal of equity and statutory obligations and considered how they were contributing to the value as well as the quality agenda.

She highlighted the recommendations from an Internal Audit in December 2024, and the improvement actions which had been delivered since then. She added that the EQIA process had been rigorously embedded within the Quality and Value programme and EQIA training continued to be delivered across the organisation.

The Executive Director of Operations outlined how the Trust was trying to influence inequity by reviewing the DNA rates for first appointments by piloting an approach of reaching out to patients in advance of appointments to ask if they required any support to attend.

Non-Executive Director (KR) felt that the strategy required an urgent re-fresh to map out quantitive data on how the Trust was addressing inequities and to ensure that resources were targeted appropriately. He asked for an updated version to be presented to the Trust Board in November 2025.

Action: Refreshed/updated Health Equity Strategy to be presented to the Trust Board in November 2025.

Responsible Officer: Executive Medical Director.

Non-Executive Director (AL) said that she had raised significant concerns at the Quality Committee meeting in July 2025 about the application of the Trust's EQIA processes.

The Acting Chief Executive agreed to follow this up this with the Trust's Associate Director of Strategy, Change, and Improvement.

Action: Acting Chief Executive to discuss the Trust's EQIA processes with the Associate Director of Strategy, Change, and Improvement.

Responsible Officer: Acting Chief Executive.

The Acting Chief Executive acknowledged that a shift in culture was required across all the different services provided by the Trust and accepted the ambitious challenge from Board members in relation to a re-fresh of the strategy. This would include ensuring that there was appropriate capacity in the Health Equity Team to support the delivery of a refreshed strategy.

Outcome: the Board

- Agreed to the inclusion of equity measures in the Integrated Performance Report.
- Agreed that Board and Committee paper cover sheets should continue to include the equity data question.
- Agreed that a discussion should take place between the Equity Lead and Committee Chairs about how this could be most effectively utilised going forward.

Item 2025-26 (68)

Discussion points

Quality Committee Chairs Assurance Reports – 29 July 2025

The Acting Trust Chair (HT), Chair of the Committee at the time of the meeting, provided the update and highlighted some of the key issues discussed including:

- Digital Letters: the Committee received an update on the clinical review of digital letters. It was noted that no significant risks had been identified by the review and most risks identified were very low or low.
  Patient Safety Incident Response Plan (Internal Audit): the Committee expressed concern that although work had been done to develop the process, the audit outcome was limited assurance. It was agreed that a robust plan was required to respond to the recommendations. The Executive Director of Nursing and AHPs would report progress on the implementation of recommendations in the report to the Audit Committee in October 2025 with an update report made to a future meeting of the Quality Committee.
- Research: the Clinical Head of Research had presented a new Research Long Term Plan, which replaced the five-year strategy aligning it to the Trust and the wider 10-year plan. Next steps would be to build partnerships and confirm readiness. The Committee discussed the provision of financial support for the new strategy, agreeing this would need to be signed off with approval from the Executive Director of Finance and Resources when there was more clarity on what the funding requirement was.
- Safe Staffing Report: had been reviewed. The Committee noted that safe staffing had been maintained across both inpatient units for the time period. The report had been made available to Trust Board members for information.

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

Outcome: the Board

- Noted the assurance provided, the matters highlighted including the Safe Staffing Report.

Item 2025-26 (69)

Discussion points:

Business Committee Assurance Reports: 28 May 2025; 25 June 2025 and 30 July 2025

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

- Digital Letters: the Committee received an update on the issue of digital letters and discussed a need for urgent action including resolution of the technology issues.
- Green Plan: the Committee had received a refresh of the Green plan including the reinvigoration of the Sustainability Pledge campaign.
- Procurement: the Committee received an update in support of the Trust's procurement strategy, working in tandem with Leeds York Partnership Foundation Trust, and received assurance that the plan was on track including reviewing system level improvements, and the resourcing to manage the review of twelve strategic projects.
- HSJ Digital Innovation Award: the Committee received a presentation about the Leeds Sexual Health System and noted the benefit for patients and the community with an innovative digital approach and collaborative use of partners.

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

Non-Executive Director (IL) referred to the discussions on the Neighbourhood model/Community Collaborative and expressed the view that the clinical and quality impacts should be scrutinised by the Quality Committee or Trust Board going forward.

Action: Executive Director of Operations to confirm where and when this would be discussed.

Responsible Officer: Executive Director of Operations.

Outcome: the Board

- Noted the assurance provided and the matters highlighted.

Item 2025-26 (70)

Discussion points:

Audit Committee Assurance Report: 8 July 2025

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

- External Audit: the Committee received the Annual Report summarising the work of Forvis Mazars during 2024/25. The delay to issuing of the audit completion certificate was noted.
- Appraisals Internal Audit Report (low assurance): the Director of People had attended the meeting to discuss the outcome. Reassurance was 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. A further discussion would be held at People & Culture Committee in September 2025.
- PSIRF Internal Audit Report (limited assurance): weaknesses had been identified in the application of PSIRF within Datix. This would be discussed in more depth at the Quality Committee, and the Executive Director of Nursing and AHPs had been invited to October's meeting of the Audit Committee to provide an update on progress against the 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.
- Board Assurance Framework: a process report was received, with Committee agreeing it had received significant assurance around the effectiveness of the BAF process.
- Cyber security update Report: a discussion took place around a recent phishing exercise and lack of uptake on Audit Yorkshire training offered as a follow up. Further training to be offered to staff but this was not mandatory.
- Information Governance and Data Security Update: a six-monthly report was received. Concerns raised around 155 out of compliance mobile phones with outdated operating systems, leading to inability to achieve Cyber Essentials +. This had been noted as a risk on the corporate risk register.
- Data Security Protection Toolkit: an independent assessment had rated the Trust's overall risk environment for data security and information governance as high, and confidence in the DSPT self-assessment was medium. An implementation plan against the recommendations would be reported back to Committee in October 2025.

The Board noted that the risk assigned to the Committee, Strategic Risk 5: 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 (71)

Discussion points:

Charitable Funds Assurance Report: 1 July 2025

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

- 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 a second runner. A £100 contribution was required to secure the place with a minimum fundraising target of £2000.
- The Giving Voice Choir joined the Specialist Business Unit Celebration Event in June. The latest donation from members was £716.28.
- The Charitable Funds Officer presented a proposed 3-year plan for the charity.
- A Finance report covering December –June 2025 was received and accepted.
- Discussion on progression of the Charitable Funds Officer role.

Outcome: the Board

- Noted the assurance report and the matters highlighted.

Item 2025-26 (72)

This Item was taken out of Agenda order
Discussion points:
Performance Report
The Executive Director of Finance and Resources presented the report which highlighted the key areas of performance; including areas that were performing well, areas where improvement work was underway, and early warning of deteriorating performance.
Performance data was split across six Domains, and a summary of overall performance and improvement initiatives was given for each domain, followed by a focused update into specific indicators that met criteria for inclusion in the narrative section of the report.

The Board noted that the overall picture of performance in the organisation shown by the measures in the report remained broadly similar to the last report presented to the Board in June 2025.

The Executive Director of Finance and Resources provided a brief update on the financial position.
As at the end of July 2025, the Trust reported a year-to-date (YTD) surplus of £0.1m, favourable to its break-even plan. The Trust was on track to deliver its full-year break-even position. Progress on the Quality & Value Programme had secured £3.5m in recurrent savings to date. These results had been formally submitted to the West Yorkshire Integrated Care Board (WYICB) and NHSE.

By the end of July, the Trust had identified £10.1m of its £14m recurrent savings target for 2025/26. This represented an increase of £0.4million compared with the £9.7million reported in June 2025. The remaining £3.9million would be delivered through non-recurrent measures enabled by strengthened grip and control.

These non-recurrent elements were assessed as low risk, with active work underway to transition them into sustainable, recurrent savings via the Quality and Value (Q&V) Programme. The Trust continued to forecast full in-year delivery of the £14million target. Of the £10.1m recurrent plans identified, £9.8million was fully developed and in delivery, with £3.4million delivered in the year to date.

Non-Executive Director (IL) asked whether within the current financial restraints there was an opportunity for additional in-year financial investment.

The Executive Director of Finance and Resources said that there was a plan to identify areas for potential additional investment, for example waiting lists.

Outcome: the Board

- Received and noted the performance report.

Item 2025-26 (73)

Discussion points:
Patient Story: Hannah House
The Acting Trust Chair welcomed Ruby a child who received respite care from Hannah House, her mum Danielle, and members of staff from the Trust who provided support to the family.

Danielle shared an infographic which set out more detail about Ruby's complex health issues and needs. Danielle talked about the challenges she faced to ensure that Ruby received appropriate care at home, accessed the 24 nights per year respite care provided at Hannah House and the difficulties she was currently facing as Ruby transitioned from child to adult care.

Danielle emphasised the importance of parents receiving support and being able to connect with other parents and carers with similar experiences.

The Board was disappointed to hear about the lack of support Danielle felt she was receiving through the transition process from child to adult care.

The Executive Director of Operations said that she would attempt to liaise with colleagues in the city and ensure that feedback on the family's experience and the challenges were captured and feedback given to the appropriate services.

The Acting Trust Chair thanked Ruby and Danielle for attending the meeting and sharing their story.

Item 2025-26 (74)

Discussion points:
Guardian for Safe Working Hours (GSWH)

74(i) Quarter 1 Report

The GSWH presented the report for Quarter 1 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:

- An ongoing grievance case in relation to CAMHS historic rota issue.
- The impact of Resident Doctor reforms and introduction of changes to exception reporting system on current exception reporting pathway.

Outcome: The Board:

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

74 (ii) Annual Report 2024/25

The GSWH presented the Annual Report for 2024/25 which reported on issues affecting trainee doctors and dentists such as working hours and the accessibility of training which formed part of the rotational training programme.

Outcome: The Board

- Received assurance regarding Resident Doctor working patterns and conditions within the Trust.
- Noted the ongoing grievance case ongoing raised by resident doctors affected by CAMHS historic rota issue.
- Supported the GSWH with the work in relation to implementation of exception reporting reforms and changes to resident doctor's contract changes.
- Supported the GSWH with the work in relation to improving community paediatric training and educational opportunities.

The Executive Medical Director pointed out that due to the timing of the presentation of the Annual Report to the Board, the grievance referred to in the report had now been concluded with no findings against the Trust but with some lessons learnt to note.

It was noted that another grievance had been filed and was under investigation.

Item 2025-26 (75)

Discussion points:
Annual Medical Director's Report 2024/25

The Executive Medical Director presented the report for 2024/25 which provided an update and overview regarding the Trust's responsibilities as an employer of Medical and Dental staff including:

- Appraisal and medical revalidation.
- Managing concerns.
- Pre-employment checks.

The report fulfilled the requirements set by NHS England in relation to:

- Annual Organisational Audit.
- Designated Body Annual Board Report.
- A Statement of Compliance – for 2024/25 for approval by the Board.

Outcome: the Board

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

Item 2025-26 (76)

Discussion points:

Significant Risks Risk Assurance Report and Risk Appetite Statement

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. Presented alongside the report was an updated risk appetite statement for 2025/26 for final approval.

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 16 risks scoring 12 (very high).

The Trust's Risk Management Policy and Procedure stipulated that the risk appetite statement would be reviewed annually, and any proposed changes approved by the Board. The Board reviewed the risk appetite statement at its workshop on 10 July 2025. The updated risk appetite statement for 2025/26 was presented for approval.

The risk register report was presented, showing movement in clinical and operational risks scoring 8 and above. The Board noted that the Trust's newly formed Risk Management Group should improve future reporting.

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.
- Approved the risk appetite statement for 2025/26.

Item 2025-26 (77)

Discussion points:

Board Assurance Framework (BAF) – Quarterly Update

The Interim Chief Executive presented the report. Following the agreement of the Trust's strategic objectives and priorities for 2025/26, the BAF was reviewed on a quarterly basis and the outcome shared with the Board.

It was agreed that strategic risk 3 would require an update in the next quarterly review to reflect the discussions around the National Oversight Framework at the Board Development Workshop meeting on 11 September 2025.

Non-Executive Director (LM) agreed to discuss the gaps in controls and mitigating actions in place for strategic risk 5 with the Executive Director of Finance and Resources outside this meeting.

Outcome: the Board

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

Item 2025-26 (78)

Discussion points:

Changes To Non-Executive Director Roles And Responsibilities

The Acting Trust Chair presented the report which informed 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. She explained that it took into consideration the UK Corporate Governance Code where appropriate and the existing Board approved terms of reference for each Committee.

One amendment to committee membership was noted:

- Sam Prince had replaced Lynsey Ure as one of the two Executive members of the Charitable Funds Committee

Outcome: the Board

- Noted the interim arrangements for the Chair, Deputy Chair and Senior Independent Director roles
- Noted the Committee membership update.

Item 2025-26(79)

Discussion points:

Any other business Blue Box Items and Close.

The Workplan was noted.

No matters were raised.

The Acting Trust Chair closed the meeting at 11.15am

Date and time of next meeting.
Thursday 6 November 2025 9.30am-12.30pm

2025-26 80	Workplan – to note

AGENDA ITEM 2025-26 (4b)

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

Key		Key colour code
Total actions on action log	8	
Actions on log **completed** since last Board meeting on 4 September 2025 with a **proposal to close**	1	
Actions due for completion by 6 November 2025 – for update at the meeting	7	
Actions not due for completion before 6 November 2025	0	
Actions outstanding at 6 November 2025**: not having met agreed timescales and/or requirements**	0	

Agenda Item Number	Action Agreed	Lead	Timescale/Deadline	Status
4 September 2025				
2025-26 (66)	**Winter Planning 2025-26:** Winter Plan Board Assurance Statement to be delegated to Acting Chair and Interim Chief Executive for sign off and reported back to the Trust Board in November 2025.	Executive Director of Operations	Post meeting	• The CEO and Chairs Action form, and • The Board Assurance Statement Signed off 30 September 2025 and the plan and the board assurance statement submitted to NHSE **Propose Closure**
2025-26 (66)	**Winter Planning 2025-26:** development of a dynamic dashboard which should be in place by winter 2025/26 to provide daily updates on staffing levels.	Executive Director of Operations	Confirmation that the dynamic winter dashboard is in place to be made to the Trust Board on 6 November 2025	**Update on 6 November 2025**
2025-26 (66)	**Winter Planning 2025-26:** more data on the 0-19 vaccination programme outcomes to be	Executive Director of Nursing and	Data to be shared with Board members post meeting	**Update on 6 November 2025**

	provided following the meeting.	AHPs		
2025-26 (67)	**Health Equity Strategy:** refreshed/updated Health Equity Strategy to be presented to the Trust Board in November 2025**.**	Executive Medical Director	Updated strategy to be presented to the Trust Board on 6 November 2025	**Update on 6 November 2025**
2025-26 (67)	**Health Equity Strategy:** Acting Chief Executive to discuss the Trust's EQIA processes with the Associate Director of Strategy, Change, and Improvement.	Acting Chief Executive	Post meeting	**Update on 6 November 2025**
2025-26 (69)	**Business Committee Assurance Report:** Clinical and quality aspects of the Neighbourhood Model/Community Collaborative Pilots to be scrutinised by the Quality Committee or Trust Board.	Executive Director of Operations	Confirmation of where and when this would be discussed at the meeting on 6 November 2025	**Update on 6 November 2025**
5 June 2025				
2025-26 (38i)	**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	Update on the assurance received by the Quality Committee to be provided to the Trust board on 6 November 2025	**Ongoing update on 6 November 2025:** 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 (38ii)	**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	Update on the assurance received by the Quality Committee to be provided to the Trust board on 6 November 2025	**Ongoing update on 6 November 2025:** 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 November 2025.

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (6i)

Title of report:	Interim Chief Executive's Report

Meeting:	Trust Board Meeting Held In Public
Date:	6 November 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.

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	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.

2 Our Services and Our People

Impact of wider societal issues

Since the last board meeting we have continued to give greater focus on supporting our staff in the context of wider societal issues, racism and discrimination. Sadly, there have been further significant events such as the terror attack against the Jewish community and attacks on mosques. We know from speaking with our staff this has an impact directly and indirectly on them, and on the people we serve across Leeds, many of whom are vulnerable.

Our Directors of People have been working with colleagues from our staff networks, freedom to speak up guardian and leaders across the trust to create safe space sessions to listen and to learn. We continue to encourage all colleagues to discuss the concerns and experiences they have at team level and to support our managers to take what steps they can to keep our staff safe in our local communities, and ensure we are supporting our patients. Every incident is one too many and work is ongoing through the operational managers forum to develop clear guidance for managers and staff to try and prevent incidents occurring in the first place, and to ensure we have clear and consistent action following. We do not tolerate discrimination of any form, and it is only through working together that we can tackle it where it occurs.

NHS England (NHSE) have recently written to all organisations setting out their commitment to antiracism and antisemitism, with an ask of organisations to take clear action, and have indicated there will be further guidance, training and policy changes to follow that leads to stronger action to prevent and respond to racism and discrimination.

Service Visits

Over the past few weeks, I have been welcomed to a range of services across the trust including Police Custody at Elland Road, core CAMHS team, 0-19 service, MindMate SPA and Crisis services. Without exception all staff I have met have welcomed the visit and the opportunity to share what the services are proud of, and what the challenges are we need to know about and factor in our future thinking.

Police custody services are coming through a very difficult staffing period over the summer and the strength of collaborative working between the leadership team and the West Yorkshire Police service was very visible. Not only are they working together to make improvements in the safety and sustainability of the service, but they are also planning for what the future service model should look like when it is due for re tendering.

Core CAMHS have recently come together to deliver a more integrated service, having previously operated as separate pathways covering the city that were struggling in terms of capacity and resilience. Whilst demand remains high, the new

model appears to be bringing benefits for the team in how they work together and can better utilise their resources. We talked in detail about key areas for improvement such as transition, changing clinical need and the impact of the rise in young people with neurodiversity. They shared case examples of working together across the pathway to support young people with very complex needs. There is a programme of work commencing across West Yorkshire to bring all the Children and Young People mental health services together to review and begin to think about future clinical need, and areas for improvement in care and treatment to improve clinical effectiveness and outcomes.

Key messages to share from the time spent with the 0-19 service is they are actively working to improve performance on vaccination uptake and school readiness outcomes with support from OHID. Timescales have been agreed, and it was great to hear the approach the leadership team are taking by engaging and empowering the workforce to come up with solutions and then implement them. They are also anticipating the launch of the tender for the new contract for the service which is expected before the end of the calendar year. The leadership team are working closely with key partners in areas such as the Marmot city work and wider prevention and public health agenda in the city. We also need to be mindful that the team does have a high burden on reporting in meeting the requirements of the commissioner-set KPIs and our trust internal reporting arrangements. I met with a range of clinical staff, and they were all genuinely positive about the work they do, the team around them, the support they have and the impact they are making.

MindMate SPA let me follow the pathway from first contact, through triage and in some cases onward care being provided by the crisis service, core CAMHS etc. There was great cross working between the different teams, including the helpline and neurodiversity team which the SPA team find invaluable. We discussed the importance of maintaining these links when the service transfers to North Point in the New Year.

Staff Survey

The 2025/26 staff survey is now live and plenty of reminders are being circulated to encourage a high response rate. This is being monitored on a weekly basis and executive directors are taking a proactive approach in their own areas to support completion.

Operational and Medium-Term Planning

NHS Trusts are required to develop medium-term plans before the end of this year. We are actively involved in preparation work with the Integrated Care Board (ICB) to determine financial and operational requirements in the short term. There are not likely to be any changes in the funding and payment mechanisms in the next 12 months, and we are expecting more detailed guidance, which sets out key priority areas for service delivery linked to manifesto commitments, the spending review and continuation of existing priorities. Below is an outline of what is required of providers and the ICB.

Planning principles for providers

- **Outcome focused: Linked to the 10 Year Health Plan.** Deliver tangible and measurable improvements for our service users, public and improved value for taxpayers.

- **Accountable and transparent: Accountability is within individual organisations.** Organisations to have a governance structure to support transparent decision-making, provide regular oversight, constructive challenge and alignment with organisational strategic priorities.
- **Evidence-based: Demonstrate robust triangulation between finance, quality, activity and workforce.** Plans must be underpinned by robust analytical foundations, population health, demand and capacity, workforce analytics and financial forecasts.
- **Multi-disciplinary: Co-ordinated and coherent across organisations.** Engage with teams from across functional areas.
- **Credible and deliverable: Development of five-year plans 2026/27 to 2030/31.** Set ambitious yet achievable goals. Articulate the resources required and reflect the workforce and financial constraints together with mitigation strategies.

Core Planning Outputs

Five-year integrated delivery plans (providers):

Improve quality, productivity, operational and financial performance

Meet health needs of the population

Describe actions that will deliver the Trust's priorities (aligned with the 10YHP)

Summarise underpinning capabilities to deliver the plan

Operational plan returns (providers):

Financial, workforce, activity and performance templates

Five-year strategic commissioning plans (ICBs):

Set out population health and commissioning strategy

Include local Neighbourhood Health Plan (developed by LCC) into population health improvement plan

New care models and investment to maximise best value

Demonstrate alignment of funding and resources to meet population need

Core capabilities in the ICB blueprint developed

- **3 Leeds System Update**

Leeds City Council Update

Cllr Fiona Venner the current elected member for Equality, Health and Wellbeing, and chair of the Leeds Health and Wellbeing Board (HWBB) has announced she is stepping down to take on a new role as Director of Services at Together Women, a VCSE organisation. The cabinet portfolio will be taken up by Cllr Emma Flint who has recently been very closely involved in the Fairer Leeds Marmot city programme and will be a welcome addition to the HWBB.

Leeds City Ambitions

Following extensive engagement across the city the Leeds City Ambitions have now been launched. The ambitions have been developed reflecting on the challenges we

face across the city and learning from what has worked so far both locally and nationally. Our Ambitions:

HEALTHY: Health and Wellbeing

Leeds will be a healthy and caring city for everyone: where together we create the conditions for healthier lives so people who are the poorest improve their health the fastest, and everyone is supported to thrive from early years to later life.

GROWING: Inclusive Growth

Leeds will be a place where we reduce poverty and inequality by creating growth in our economy that works for everyone, where everyone gets a great education, businesses can find the talent they need to start, innovate and grow and innovate, investment is increasing and together we are delivering an inclusive, healthier and more sustainable future.

THRIVING: Strong Communities

Leeds will be a welcoming, safe and clean city where people have the power to make the changes that are important to them, with cohesive and united neighbourhoods where people are living healthier lives and enjoying the city's vibrant social, cultural and sporting offer.

RESILIENT: Sustainable City

Leeds will be the UK's first net zero and nature positive city in the UK, rapidly reducing carbon emissions and restoring nature, a place that supports people and businesses to make increasingly sustainable choices that improve their standard of living while creating a regenerative thriving city.

The Leeds Ambitions provide a strategic framework/roadmap to guide our city's future and achieve our core mission of tackling poverty and inequality. Each ambition has a 'convenor' who will help develop a high-level plan of action in the first instance building on work that is already underway in the city. I have agreed to be the convenor for the health ambition. Fellow convenors are:

- Peter Slee – Vice-Chancellor, Leeds Beckett University and chair of the Leeds Anchor Network is the convenor for inclusive growth.
- Anna Martin - CEO of Voluntary Action Leeds is the convenor for strong communities.
- Rosa Foster - Director Leeds Climate Commission is the convenor for sustainable city.

Leeds Place Provider Review

Dr Wood was Senior Responsible Officer (SRO) for the programme so following his retirement from Leeds Teaching Hospitals NHS Trust I have agreed with the support of partners to take on the SRO role to see through the conclusion on the review.

The review process has now concluded, and the final draft report is being shared with the key stakeholders for consideration and agreement on next steps. Recommendations focus on how we can strengthen the provider partnership in Leeds to deliver better outcomes for citizens at a neighbourhood level and ensure we have resilient and sustainable models of care for the future - which include greater integration with primary and social care. It will also help us to establish the right

governance to enable delegation of functions from the ICB as they work towards implementing the new blueprint for ICB's.

As the timing does vary for when boards will meet, the detailed report will be discussed in our private board session this month. We are planning for wider communication the week commencing the 10 November 2025 so it can be shared through all organisations at the same time.

Leeds Teaching Hospitals NHS Trust (LTHT)

Since the last board meeting there have been further changes in the leadership arrangements at LTHT. Brendan Brown has now commenced as interim CEO of the Trust for the next 12 months. Brendan was CEO at Calderdale and Huddersfield NHS Trust and CEO lead for WYATT so has very well-established relationships within the city and the ICB and remains very committed to partnership working in the city. He has already put in place interim arrangements for his executive team and begun a new programme of internal and external communication, engagement and improvement. The recent CQC inspection has been published with the Trust now rated as requires improvement. The secretary of state has also announced he is commissioning an independent inquiry into the maternity and neonatal services.

National Neighbourhood Health Pilots

The Leeds application to be part of the first wave of the National Neighbourhood Health Implementation Programme (NNHIP) has been successful, along with West Yorkshire neighbours Wakefield and Bradford District and Craven. The programme is a large-scale test, learn and grow change programme. Department of Health and Social Care (DHSC) and NHSE partners will work with 43 local areas across the country to accelerate learning and implementation of neighbourhood health. It will initially focus on targeting adults with or at risk of multiple long-term conditions, working to ensure that people experience improved health and wellbeing through the support provided at a neighbourhood level.

Through the NNHIP, Leeds will be working over the coming months to develop the programme further. Building on work already started in the city, in line with the Leeds ambitions and the Leeds Health and Wellbeing plan, the programme is testing:

- Neighbourhood Health Hubs – what processes, culture, assets, and team relationships are needed to operate in an integrated way in existing co-located buildings or virtual hubs.
- Integrated working – understanding what core components are needed to further develop multi-disciplinary teams and co-ordinate care to targeted populations.
- Single and multi-neighbourhood providers - help develop our understanding of how to organise integrated care under future new contractual and financial incentive arrangements, working closely with colleagues in General Practice.

Sam Prince, Chief Operating Officer, is our Executive Director involved in the programme and will ensure we are fully involved in the pilots and well placed to spread the learning as they progress

➢ 4 Regional and National Updates

The Model Region Blueprint for NHS regional teams has now been published. It sets out a high-level mandate for the seven regions and articulates their purpose, core functions and activities. It is anticipated that there will be a Chair and CEO role in

each region, but that they will not be independent organisations. They will be part of DHSC in the future.

We know that some functions are still being considered, especially workforce, education and training. The Model Region Blueprint also informs the detailed design work that is taking place as part of the DHSC/NHSE transformation programme over the coming weeks and months.

Regions will essentially have three key objectives:

1. The first of those objectives is to provide **strategic leadership of regional health systems.** This means that regions will lead local reform, oversee investment and the reconfiguration of local services; support innovation; and ensure an effective leadership strategy and talent pipeline to get the best from our people. Regions will do this by developing and overseeing implementation of the regional medium-term strategic plan and leading regional implementation of the NHS planning framework. They will support innovation and system development and lead local digital transformation to ensure effective data and analytics capability. Regions will also oversee strategic plans for service and organisational change, set leadership strategy and develop the workforce through training and education.
2. The second objective will be to **performance manage and oversee local commissioners and providers**. This means regions will have holistic oversight of performance in line with national frameworks, ensure Board and leadership capability, as well as identify 'early warnings' and manage risk. To achieve this, regions will have oversight of provider and commissioner performance.
3. The final objective will be to have a **regional approach to improvement, support and intervention.** This means regions will support systems and trusts to deliver high quality and sustainable care, develop capability, and address underperformance. This will be achieved by regions providing improvement support, intervening to address challenged performance or providers, and developing commissioning capability and professional leadership.

Update on ICB changes

The board is aware of previous national announcements that require ICBs to develop a new structure and operating model that delivers a 50% reduction in headcount and aligns ICBs to a new role of strategic commissioner. A draft structure and model were developed earlier in the year but required national sign off and support to implement. As this has still not been agreed the West Yorkshire ICB has now informed all staff that there will not be consultation on any changes before the end of this financial year. Work continues between ICB, places and providers to shape future ways of working and potential impact of the changes when they are implemented.

5 Recommendations

The Board 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
October 2025

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (6ii)

Title of report:	Provider Capability Self-Assessment

Meeting:	Trust Board Meeting Held In Public
Date:	6 November 2025

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

Executive Summary:	This paper summarises the process followed by the Trust regarding the provider capability self-assessment, and shares the agreed compliance ratings post submission to NHS England on 22 October 2025.

Previously considered by:	Trust Leadership Team 8 October 2025 Extraordinary Private Board 15 October 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)	The Board is asked to: • Note the process undertaken for completion of the provider capability self-assessment; and • Note the final approved compliance ratings for each domain and summary narrative post-submission.

List of Appendices:	6iii Appendix 1 Provider Capability Self-Assessment submission 6iv Appendix 2 Provider Capability Self Assessment evidence

1 Introduction

As part of the NHS Oversight Framework (NOF), NHS England plans to assess NHS Trusts' capability using a self-assessment process alongside providers' NOF segments, in order to judge what actions or support are appropriate at each Trust. Therefore, all NHS boards were asked to self-assess against a set of criteria across 6 domains derived from The Insightful Provider Board (2024):

1. Strategy, leadership, and planning
2. Quality of care
3. People and culture
4. Access and delivery of services
5. Productivity and value for money
6. Financial performance and oversight

Trusts were required to confirm whether they met the standard, partially confirm they met the standard, or advise they did not meet the standard, for each domain. The guidance indicated that it was weighted toward positive statements/self assessment with Trusts providing rationale/mitigations accordingly.

2 Self-Assessment Process

On 15 October 2025 the Trust Board met in private to review the 16 self assessment criteria and related KLOEs, which had been pre-populated by the Trust Leadership Team.

The Board discussed the supporting information and sources of evidence, and based on this agreed compliance ratings for each domain. Further discussion took place regarding the supporting statements that would be submitted with the ratings, in order to demonstrate self-awareness and transparency regarding the Trust's capabilities, strengths, weaknesses and challenges.

The final submission was agreed via email following the private Board discussion and submission to the NHSE regional team was completed on 22 October 2025.

3 Next Steps

During November and December regional teams will review submissions, triangulate with other intelligence including the historical track record of the Trust, its recent regulatory history and any relevant third-party information,, and assign a capability rating which will be shared with the Trust.

As the year progresses, oversight teams will monitor the Trust's track record against these self-assessments, taking account of any relevant information as it emerges in order to maintain a real-time view of provider capability to inform the relationship with the organisation.

Provider Capability Ratings:

Rating	Indicative criteria
Green	*High confidence in management* • No evident concerns arising from the self-cert or subsequent performance. • No concerns arising from third parties. • High confidence in the trust's ability to deliver on its priorities based on track record over past 12-24 months.
Amber-green	*Some concerns or areas needing addressing* • After following up with the trust, some concerns emerging across more than one domain but not yet a significant issue affecting quality of care, delivery of core services, finance or the wider reputation of the NHS. • Trust has prepared plan(s) to address any problems and timing to address • Historic issues/track record
Amber-red	*Material issue needs addressing, or failure to address issues over time* • Issues with self-assessment or subsequent issues across multiple domains • Failure to deliver on agreed plans to address a material issue • Potentially in breach of licence.
Red	*Significant concerns arising from poor delivery and other issues* • Material and or long-running concerns at the organisation that management have been unable to get a grip over. • Provider likely to be, or actually, in breach of licence

Providers rated 'Red' and in NOF 4 will be considered for NHSE's Performance Improvement Program (PIP).

Recommendations

The Board is recommended to:

- Note the process undertaken for completion of the provider capability self-assessment; and
- Note the final approved compliance ratings for each domain and summary narrative post-submission.

Helen Robinson
Company Secretary
22 October 2025

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	• The Trust has an operational plan and agreed objectives for 2025/26 including robust revenue and capital plans. • The Trust has annual strategic objectives and wildly important goals which includes some shared transformation goals across the Leeds system and WY community collaborative. Following a well led review, the Trust has plans to develop an organisational strategy to provide a clearer future steer but this is not yet in place, although significant internal and external engagement is already taking place. • The Trust is complying with all conditions of its licence and is not subject to any regulatory action. • The Trust commissioned an independent well led review in 2025 which identified some areas for improvement which the board are overseeing and will be reviewed by internal audit in quarter 4. • Both the CEO and Chair are interim arrangements, which has been agreed with NHS England and is subject to the Leeds Provider Partnership Review • The Trust board has the necessary skills, competencies and experience to lead the organisation. • The Trust is an active participant and benefitting from work with system partners such as the Community Dental collaborative in WY, and Home First in Leeds. • The interim CEO is SRO for the Leeds place provider review and sits on the board of the WY ICB. The executive team are actively involved and lead system wide programmes of work. • The Trust has been placed into NOF segment 4 and improvement plans are already underway to reduce waits to access services and reduce staff sickness which is being monitored by the board. • Decisions will be made by the Board in the coming months that will impact on the future direction and form of the organisation. This will support succession planning for the Board. NHSE regional team are aware of these plans.
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Partially confirmed**	The Trust has effective arrangements to monitor, assure, and continually improve the quality, safety, and effectiveness of care. • Quality reporting cycles are established and being strengthened through Quality Assurance & Improvement Group to enhance oversight and shared learning. • Quality walks are well embedded, with Board service visits under review to maximise impact and visibility of care quality. • Staff training in quality and patient safety is well embedded, supporting a culture of continuous improvement. • Internal audits (e.g., PSIRF, Mortality) have identified areas for development, with action plans in place to strengthen assurance and learning. • The Trust needs to embed further its lessons learned framework to ensure learning from incidents and reviews leads to measurable improvements in quality, effectiveness, and patient safety. Systems are in place to monitor and act on patient experience, with clear escalation routes for safety and quality concerns to the Board. • Complaints processes are well established and used to inform improvement and organisational learning. • Work is underway to strengthen experience data within the equity domain to better understand variation and address inequalities in care. • While there is evidence of good practice in service user involvement, the Trust recognises—following the external Well-Led Review—the need to further strengthen and systematise patient engagement across all services. • Plans are in place to enhance how patient and service user feedback informs governance, decision-making, and continuous improvement in quality and safety • Patient experience data are routinely reported to the Board to support assurance and drive improvement. • Development work is underway to strengthen experience data within the equity domain to understand variation and address inequalities better. • Good practice in service user involvement is evident and is being further embedded across the organisation to enhance shared learning, patient voice, and the quality of care.
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	The Trust Board has the necessary skills, competencies and experience to lead the organisation including in relation to the people and culture agenda. Many of the needed people interventions, reporting and metrics are in place, however, we recognise we would always want to improve and we have well developed plans in place for doing so in terms of particularly our sickness absence rates and linked to our NOF segmentation. Our staff engagement scores compare well at place and across the wider West Yorkshire ICB footprint, we have low turnover and a stable employee relations climate. We have been recognised for our impactful people practices through various awards and commendations and we collaborate across the Leeds place to continuously improve our culture and the experience of our people. Staff feedback is routinely discussed and considered by the Trust Board in the form of Staff Survey and pulse results, themes emerging from our Staff Networks and Trade Union colleagues, staff stories and the way in which we regularly engage with staff throughout any organisational change processes including our Quality and Value programme. This feedback is used to shape and alter how we work with the ultimate aim of improving our experience for staff as well as in terms of the services we provide to our patients and communities. Staff survey results are good although there is always more we can do and so we utilise a 'you said, we did' approach and work hard both at an organisational and local level to listen and respond to staff feedback. Our National Training and Education (NETs) results this year were also positive and welcome. Staff have the relevant skills and competencies to carry out their roles – this is assessed at selection stage upon commencement with LCH and reviewed regularly through our staff appraisal processes as well as processes such as service retenders and changes enacted as part of our Quality and Value programme. We have a comprehensive leadership and management development offer as well as clinical skills programme, and statutory and mandatory training is regularly undertaken, refreshed and monitoring received and considered by the Trust Board on a routine basis. The Trust Board and the wider leadership team work hard at ensuring that the climate and culture within LCH is an open one and that staff are able to freely express concerns in a supportive environment. We work well with Trade Unions colleagues and have well established, trusted but open and constructive relationships. Our FTSUG is a very visible individual across the organisation and our freedom to speak up practices are very well embedded with a network on FTSU champions within LCH. Staff Survey results indicate impressive and favourably benchmarked impacts in terms of staff ability to speak out and crucially feel heard. Our Board is regularly sighted on FTSU activity at every Private Board meeting or indeed by exception outside Board meetings as needed, we have a NED sponsor for this work, and at least annually this work is reviewed in detail at Board with a focus on learning as well as ongoing strategy for this work. Further evidence in this respect includes a significant assurance FTSUG internal audit and that our FTSUG acts as a national adviser on certain aspects of this work and a peer adviser in other organisations at place.
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Partially confirmed**	The Trust has made good progress against a range of targets but is challenged in meeting the RTT standard in Community Paediatrics, specifically neuro-developmental assessment waits for children over 5. There is a costed plan in place to reduce 52-week waits by March 2026 but this relies heavily on the availability of Locum Doctors. Concerns remain with non-reportable waits but there is confidence that the costed plans in place for CUCs, Adult SLT, Podiatry and MSK will eradicate over 52 weeks in these areas by March 2026. There has been a longstanding challenge in addressing ND assessment waits for children of all ages but innovative work with third sector (Northpoint) to digitalise referral processes and change the focus from diagnosis to early help is slowing the number of children being added to the list. The Quality and Value Programme has a clear focus on productivity and our approach to a Fair Day's Work is targeting central booking and job planning to increase capacity across the Trust. Data quality work is ongoing in relation to the number of children accessing NHS funded mental health services as different counting conventions have been used by different organisations.
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Partially confirmed**	The External Audit opinion for 24/25 identified no significant weaknesses in our arrangements for securing value for money. Internal productivity data has been used to support our Quality & Value Programme and has been instrumental is supporting services in identifying and implementing opportunities for transformation and generating significant financial savings We report annual benchmarked performance through our Board sub-committees for areas such as Corporate Services, ERIC returns and the National Cost Collection. We have engaged with and commissioned independent reviews of our services, examples include a commissioned review of our CPYMHS service, with Niche and a wider community collaborative benchmarking review commissioned by the ICS. We are fully aware that service provision and pathways are varied and the lack of a common currency for community services can impact on confidence, more recently we supported an NHSE site visit and are fully engaged in the work to better understand barriers to assessing productivity We recognise that there is scope for improvements, and we have plans in place to strengthen our performance and accountability framework which includes a systematic approach to embedding benchmarking as well as measuring and delivering productivity targets. We continue to work through our corporate cost reduction programmes but to note we are finding the 50% reduction challenging. Whilst we will continue to transform our corporate functions, we recognise that that the opportunity for significant savings lie in economies of scale and will only be achieved through closer collaboration across the Leeds and WY footprint, we also note that transitional investment to streamline systems and processes is a critical enabler to this. In addition, whilst our digital maturity is improving our baseline is low and demand for investment in this area, to support productivity and efficiency, is high.
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	The Trust has a robust financial governance framework in place. We have consistently delivered our financial plan and contribute positively, where possible, to delivery of wider system performance against both revenue and capital plans. We take an active role in ensuring optimum resource allocation within the Leeds place through programmes such as Home First, Active Recovery and Enhance, recognising how we deploy our resources can generate added value for system partners and the overall benefits of the population. Our Q&V programme is now in its 2nd year of operation, through the programme we have achieved significant recurrent and non -recurrent savings supporting delivery of our financial plans as well as enabling an internal re-allocation of resources to improve access and waiting times. We continue to forecast a recurrent underlying break-even position as we enter the medium-term planning process. The programme has undergone 2 internal audits, and both have received significant assurance. Our EQIA process is well embedded within change projects and we have plans to further strengthen reporting into Board sub-committees We triangulate human factors and quality data for all of our Q&V programmes. We have a strong relationship with all of our commissioners and there have been no contract disputes in the last 12 months. Our systems are aligned, and we report finance and workforce data regularly into Business Committee, including temporary staffing against which we benchmark well but again we recognise this can be a key enabler for business continuity and transformation and therefore balanced decision making is necessary. We recognise there is always scope for improvement and are currently completing the Well Led Finance Self-Assessment Toolkit for 25/26 and await the outcome of an internal audit into our arrangements for securing financial sustainability both of which will shape our future priorities.
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	Not applicable

Signed on behalf of the board of directors

Name: Dr Sara Munro - Interim Chief Executive; Helen Thomson - Acting Chair

Date: 22 October 2025

Provider Capability - Self-Assessment evidence signpost template

		Provide links to evidence and any supplementary information to support self assessment
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	Published on LCH website: Trust Board papers: https://leedscommunityhealthcare.nhs.uk/about-us/board-of-directors/board-papers-and-meetings/ Annual Report and Accounts: https://leedscommunityhealthcare.nhs.uk/about-us/access-to-information/corporate-reports/ Standing Orders and Standing Financial Instructions: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fleedscommunityhealthcare.nhs.uk%2Fwp-content%2Fuploads%2F2025%2F01%2Fdownload-4747.docx&wdOrigin=BROWSELINK Third Sector Strategy: https://leedscommunityhealthcare.nhs.uk/about-us/access-to-information/third-sector-strategy/ Published on Leeds Health & Care Partnership website: - Transformation priorities for LHCP: https://www.healthandcareleeds.org/transformation-priorities-for-lhcp/ - WY Community Collaborative: ToR/minutes https://www.wypartnership.co.uk/our-priorities/primary-and-community-care-services/community-healthcare-collaborative - Leeds HomeFirst Annual Report: https://www.healthandcareleeds.org/about/homefirst/ Published on Leeds Older People's Forum: - Cost benefit analysis evauation of Enhance Year 3: https://www.opforum.org.uk/resources/cost-benefit-analysis-evaluation-of-enhance-year-3/ Non-Published evidence: - Operational plan 25/26 and one page summary with WIGs - West Yorkshire Finance Forum monthly papers - Digital Strategy - Trust Provider Licence and compliance statement - Well led review and action plan - Board skills matrix - Board and Committee matrix - Leeds GP Confederation constitution - Alliance Board Terms of Reference and purpose statement - Board to Board minutes (with LYPFT and LTHT) - Leeds Health & Care Partnership Leadership Team meeting notes
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	Published on LCH website: Trust Board papers (Annual MD report/Performance Brief/FTSU reports/Safe Staffing report/Mortality reports): https://leedscommunityhealthcare.nhs.uk/about-us/board-of-directors/board-papers-and-meetings/ Published on Leeds Older People's Forum: - Cost benefit analysis evauation of Enhance Year 3: https://www.opforum.org.uk/resources/cost-benefit-analysis-evaluation-of-enhance-year-3/ Non-Published evidence: - Well led review and action plan - Board skills matrix - Board and Committee matrix - Clinical Governance reports to Quality Committee - PSIRP - Board Assurance Framework - Quality Assurance and Improvement Group workplan - LCH Governance map - Internal Audit Programme 2025/26 - Quality Strategy 2024-27 - Quality walk reporting templates and process - Prevention diagnostic report - Response to Letby case Quality Committee report - Business Unit reports to Performance Panel - Healthwatch engagement report - Health Equity Strategy - Patient Experience reports to QAIG
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	Published on LCH website: Trust Board papers (FTSU reports/Staff survey report/Performance brief): https://leedscommunityhealthcare.nhs.uk/about-us/board-of-directors/board-papers-and-meetings/ Non-Published evidence: - Well led review and action plan - Engagement improvement plans - EDI Forum notes - Private Board employee relations reports - FTSU/Raising concerns and Appraisals internal audit reports - Staff survey peer benchmarking - Performance Panel minutes - Staff Survey data (team level)
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	Published on LCH website: Trust Board papers (Performance brief): https://leedscommunityhealthcare.nhs.uk/about-us/board-of-directors/board-papers-and-meetings/ Non-Published evidence: - Waiting list recovery plan - Sickness recovery plan - Children and Young People's access recovery plan - Leeds Mental Wellbeing Service performance report - Leeds Sexual Health Service performance report - Health Equity Strategy - Quality walk reports - Access LCH steering group minutes
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	Published on LCH website: Trust Board papers (MD annual report on agency use per service/LCH Risk appetite): https://leedscommunityhealthcare.nhs.uk/about-us/board-of-directors/board-papers-and-meetings/ Non-Published evidence: - Business Committee reports - Niche review for CAMHS - Attain review - WY Corporate benchmarking review - Draft KPI library - Internal Audit Annual Report - Head of Internal Audit Opinion 2024-25 - Internal Audit Programme 25/26 - Quality & Value Framework Internal Audit reports - Budgetary control and Key financial systems Internal Audit reports - PLICs framework initiated workstreams as reported through NOF papers - EQIA reporting - HomeFirst Annual report - Enhance evaluation
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	Published on LCH website: Trust Board papers: https://leedscommunityhealthcare.nhs.uk/about-us/board-of-directors/board-papers-and-meetings/ Non-Published evidence: - Business Committee reports - Internal Audit Annual Report - Head of Internal Audit Opinion 2024-25 - Internal Audit Programme 25/26 - Quality & Value Framework Internal Audit reports - Budgetary control and Key financial systems Internal Audit reports - PLICs framework initiated workstreams as reported through NOF papers - EQIA reporting - HomeFirst Annual report - Enhance evaluation

Leeds Community Healthcare NHS Trust

Agenda item:	2024-25 (8)

Title of report:	Health Equity Five-Year Tactical Plan

Meeting:	Trust Board Meeting Held In Public
Date:	6 November 2025

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

Executive Summary:	Our Health Equity strategy and plans are LCH's response to how we address unfair and avoidable differences in the health of different groups and communities, by working with communities and partners to create equitable care and pathways. This paper proposes a new draft five-year tactical plan for health equity, to sit under the developing trustwide five-year plan. This plan seeks to continue our focus of moving from intent to action, by strengthening accountability and action for addressing inequity across the trust.

Previously considered by:	None

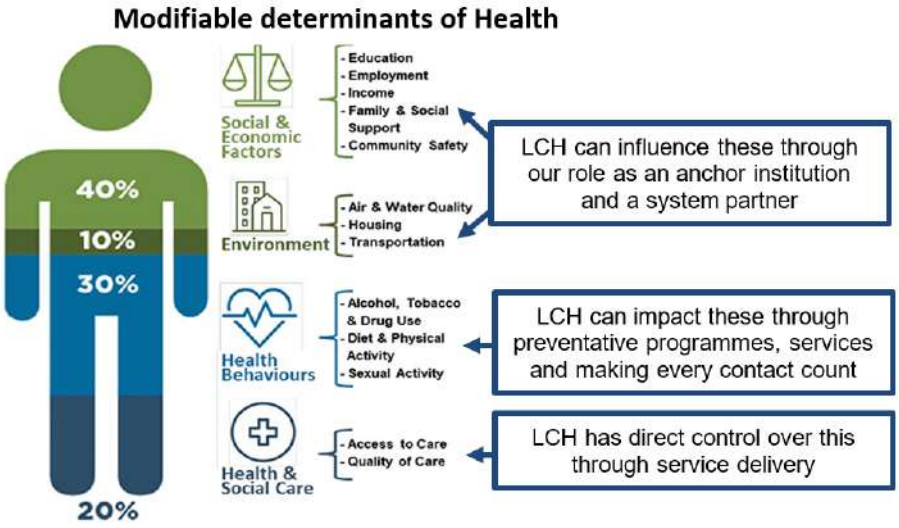
Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	✓
	Use our resources wisely and efficiently	✓
	Enable our workforce to thrive and deliver the best possible care	✓
	Collaborating with partners to enable people to live better lives	✓
	Embed equity 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, missed appointments and in the pace of improvements for people in IMD1.
	No			

Recommendation(s)	• Approve the five-year plan and note the risks to the scale and pace of delivery • Note the areas of the plan associated with each Committee's role and governance route

List of Appendices:	Appendix 1: Current position and ambitions Appendix 2: Health Equity 5-year tactical plan Appendix 3: Health Equity Index

1 Introduction



Our Health Equity strategy and plans are LCH's response to how we address unfair and avoidable differences in the health of different groups and communities, by working with communities and partners to create equitable care and pathways. While we recognise the range of modifiable determinants of health and contribute where we are able, we have prioritised identifying and addressing inequity in care and pathways as the areas over which we have direct control.

Equitable approaches in care are dependent on culturally diverse and competent workforce, policies and processes. As inclusion objectives are already in place in the workforce strategy, this work is therefore not duplicated within our Health Equity strategy and plans.

Our first Health Equity strategy ran from 2021-4 and, to align with the development of an organisational strategy, we extended the first strategy with two additional annual plans. This paper proposes a new draft five-year tactical plan for health equity, to sit under the developing trustwide five-year plan.

2 A tactical plan that takes us from our current position to achieving our five-year ambitions

2.1 Current position

Fundamental to our equity work, is the principle of moving 'from intent to action'. In 2024, at the end of LCH's first Health Equity strategy, we reviewed our building blocks for equity in our care and pathways and agreed that these all remained important to achieving our ambition.

We overlaid these building blocks with core priorities. Appendix 1 describes where we were in relation to these when we started, where we are now, and proposes our ambitions

for the next five years. The driver diagram below shares some examples of change ideas, and their delivery status, that contribute to our equity aims and objectives.

Overall aim	Primary drivers	Secondary drivers	Examples of change ideas and delivery			
			Complete	On track / ongoing	Minor risk to delivery / timescale	Major risk to overall delivery	Action not started
Identify and address inequity in LCH care and pathways	To improve **access** for people at risk of worse health outcomes	Equitable referrals	Referral data reporting by deprivation and ethnicity	Long-Covid review of referral routes and criteria	Fellowship: access to cardiac rehab	Development of trustwide opt-in and opt-out principles
		Equitable waiting	Access LCH campaign and analysis	Citywide and LCH waiting list workshops	Waiting safely project	Fellowship: recording of housing status
		Equitable missed appointments	Missed appointment data by deprivation, ethnicity and interpreter requirement	Health literacy awareness campaigns	Phone calls to people in IMD1 who have missed appointments	Information hub page on support to attend appointments
			Review of Access policy and missed appointments process	About Me: comms needs & reasonable adjustments template, comms and training	Citywide and LCH missed appointments workshops	
	To improve **experience** for people at risk of worse health outcomes	Understand differences in experience	Healthwatch engagement: future of community services	Engagement as part of EQIAs	Recording demographic data in patient experience	
		Targeted improvements to experience of key groups	Racial equity workshop: culturally competent conversations about mental health	Oliver McGowan training for LD	Cultural conversations programme	Armed Forces Covenant accreditation
			Equity Impact Assessments in clinical policies	Fellowship: trauma-sensitive care	Fellowship: cardiovascular disease in socially deprived ethnic minorities	Synergi anti-racist communication principles
			Reasonable adjustments in Dental, Diabetes & Immunisation teams	CUCS project supporting survivors of sexual abuse		
	To improve **outcomes** in LCH for people at risk of worse health outcomes	Equitable safety	Falls, medication and pressure ulcers incident data by deprivation, ethnicity and interpreter requirements	PSIRP: engagement with people experiencing multiple adverse care events	Easy read falls prevention materials	Equity analysis in deteriorating patient
		Equitable mortality	Fellowship: Preferred Place of Death in Black communities	Learning from LeDeR	Equity analysis in mortality report	Easy Read palliative care materials
		Equitable outcomes	Fellowship: diabetes in homeless populations	Fellowship: reducing self-discharges from hospital for homeless population	EQIA process reviewed. Citywide work to understand cumulative impact.	Recording Armed Forces status on SystmOne

2.2 Health equity ambitions

In five years, we want equity to be embedded in LCH. We will see the difference in:

- Governance and accountability
- Equity within LCH strategies and plans
- Capacity and capability to take action on equity
- Equity data
- Voice and influence
- Equity in decision-making
- Inequity in access
- Tackling know inequities faced by specific populations
- Prevention as a route to tackling inequity

We continue to take an intersectional approach to equity improvements, but with an initial focus on improvements to access, experience and outcomes for:

	Supporting us to deliver
People living in deprivation, incorporating inclusion health groups	Leeds ambition to improve the health of the poorest the fastest Core20PLUS5
Racialised communities	PCREF NHSE interpreting and translation improvement framework
People with disabilities and people with Learning Disabilities	Accessible Information Standards Reasonable Adjustments Learning Disability Standards
Armed Forces community	Armed Forces Covenant

2.3 Health Equity Tactical Plan

Our new five-year Health Equity tactical plan (Appendix 2) brings together four drivers of action to address inequity:

- ✓ our **trust commitment to embed equity in everything we do**

- ✓ **statutory and contractual requirements** to address inequity:
  - Equality Act and Public Sector Equality Duty
  - Statement on Information on Health Inequalities
  - Accessible Information Standards
  - Reasonable Adjustments
  - Armed Forces Covenant
  - Patient and Carer Race Equality Framework (PCREF)
  - Patient Safety Incident Response Framework (PSIRF)
  - Learning Disability Improvement Standards

- ✓ **national guidance** that advances health equity, including but not only:
  - NHS England » National Healthcare Inequalities Improvement Programme
  - NHS England » Patient safety healthcare inequalities reduction framework
  - NHS England » Improvement framework: community language translation and interpreting services
  - NHS England » National elective access policy
  - NHS England » Good communication with patients waiting for care
  - Overview | Shared decision making | Guidance | NICE

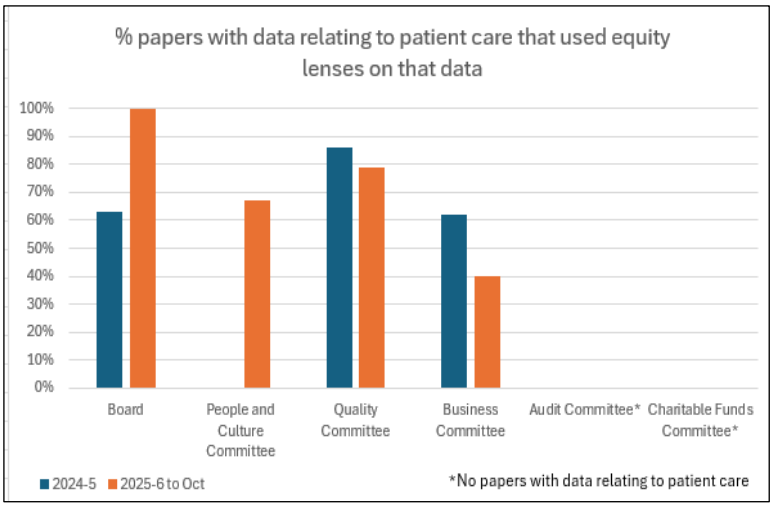
- ✓ **system-partnership priorities** both in the identification of shared priorities and working together to develop solutions: Leeds Health and Wellbeing Strategy commitment to improve the health of the poorest the fastest; Marmot; Health Equity Index (update provided in Appendix 3); Equality Delivery System (EDS); prevention; PCREF; understanding cumulative impact through EQIAs; Person-Centred Care; One Workforce Equity Training Programme

The plan seeks to continue our focus of moving from intent to action, by strengthening accountability and action for addressing inequity across the trust. It does this by identifying the objectives, owners and high-level delivery timescales to achieve our ambitions.

2.4 Governance

In 2021 LCH determined that due to the importance of the Health Equity agenda in everything that we do, Board should have direct oversight of the health equity programme. Aligned to the decision to make this a fifth strategic goal in 2023 equity risks (BAF7) are managed by Quality Committee, but delivery of the overall equity strategy does not report directly to any of the Board subcommittees. During 24.25 two of the three planned Health Equity updates to Board have been postponed or cancelled, and concerns have been raised by Non-Executive Directors regarding lack of evidenced progress. Use of the agreed Equity box on committee and Board

cover papers has been inconsistent, but with an increase in September-October since the last update provided.



It is proposed that the workstreams from the Health Equity five-year tactical plan (Appendix 2) are incorporated into reporting to the appropriate subcommittees during 25.26, with the overarching Health Equity objectives continuing to report directly to Trust Board. Committee chairs are asked to identify the equity workstreams that align with their committee areas of responsibility. This could be undertaken at the meetings between Board and Committee chairs, the Medical Director and Health Equity Lead about the use of equity data in committee papers (action, LCH Board September 2025).

3 Impact

- **Quality**

Poor quality care for people already at risk of worse health outcomes exacerbates those differences. Conversely, improving the overall quality of care can contribute to improved health outcomes. By taking an equitable approach to quality improvements, we support targeted approaches that narrow this gap and ensure that improvements that are perceived to be universal do not widen the gap.

- **Resources**

Delivery of our equity ambitions and five-year plan will not only have a positive impact on those groups at risk of poorer health outcomes, it will also contribute to overall productivity gains for example in reducing missed appointments and improving access to self-management.

- **Risk and assurance**

BAF risk 7 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.

If action to address inequity is limited to the capacity of the small specialist team (1.3 substantive WTE + 1.5WTE temporary to August 2027), it increases the risk that the organisation will be unable to deliver at the scale and pace required to reduce inequity or mitigate against worsening inequity. The five-year plan supports the development of shared responsibility and skills across the organisation, supported by a small specialist team, in order to meet our ambitions and deliver on this plan.

4 Next steps

- Finalise health equity five-year tactical plan to align with trustwide five-year priorities and results of engagement on the future of community services
- Agree responsibilities for delivery and reporting with the Health Equity Leadership Group
- Meet with Board and Committee chairs to identify the equity workstreams that align with their committee areas of responsibility and the use of equity data in committee papers
- Deliver a communications campaign to increase awareness of and engagement with agreed health equity priorities

5 Recommendations

The Board is recommended to:

- Approve the 5-year plan and note the risks to the scale and pace of delivery
- Note the areas of the plan associated with each Committee's role and governance route

Ruth Burnett and Em Campbell
Medical Director and Health Equity Lead
28 October 2025

Appendix 1: Current position and ambitions for 2031

		Where we were (2021)	Where we are now (2025-6)	In 5 years, equity is embedded (2031)
Creating the conditions for change	Governance and accountability	• Appointment of Exec Lead for Health Inequalities • Health Equity Leadership group developing as an action learning space.	• Equity is a strategic objective and the BAF includes a risk relating to equity • Exec Lead for Health Inequalities chairs Leeds Healthcare Inequalities Oversight Group and Director of Finance represents LCH • Renewed Health Equity Leadership Group meeting quarterly with senior representation across BUs and corporate teams	✓ Reporting on equity is a shared responsibility across all Committees ✓ A thriving Health Equity Leadership Group is fully engaged, has improved coordination, and is delivering change through a clear organisational direction and shared ownership of a clear plan.
	Equity within LCH strategies and plans	• Creation of LCH's first equity strategy and public commitment to identifying and addressing inequity	• As a strategic objective, equity informs annual planning • Equity is explicit within PSIRP • Equity within Quality and Value has been reviewed within Internal Audit with improvements being made to further embed equitable approaches in service redesign • Person-centred care as it applies to addressing inequity includes Accessible Information Standards, Reasonable Adjustments, Health Literacy, share decision-making and cultural conversations	✓ Equity is embedded in organisational strategy and contributing to the delivery of the NHS 10-year plan ✓ Action to identify and address inequity is embedded within annual planning cycles and contributes to overall achievement of a share equity ambition ✓ Equity is embedded within PSIRP, driving safety improvements across safety priorities ✓ Person-centred care has senior oversight, is integral to service delivery and improvement and is being measured
	Capacity and capability to take action on equity	• Temporary Health Equity Lead appointed • Learning Disability Lead appointed • Small amounts of capacity in inclusion roles in some services	• Substantive Health Equity Lead in place with 2-year Equity and LD Improvement Manager and Project Support roles • Small amounts of capacity in inclusion roles in some services with equity also being included in some other champion roles • ICB Equity fellowships provide additional capacity for equity improvements • 2-year project with Leeds Health and Care Academy to develop and test citywide equity training • Delivery of Leading Cultural Conversations training	✓ Equity is part of training and development programmes including clinical education and leadership development ✓ Ongoing delivery of One Workforce equity development programme ✓ Capacity to deliver equity has grown across the organisation through staff with dedicated inclusion and equity focus, supported by a specialist function ✓ All services are engaged with the Cultural Conversations programme and can demonstrate culturally sensitive approaches to care delivery

		Where we were (2021)	Where we are now (2025-6)	In 5 years, equity is embedded (2031)
Supporting action	Equity data	• Equity lenses in reporting available through special request to BI	• Self-service equity reporting suite in place on PIP and equity lenses are available within some trustwide dashboards • Training on using equity reports has been delivered to BU leadership and some services. • System wide work underway to develop a Health Equity Index and to determine a set of measures to apply the index for LCH • "About Me" template and associated digital patient questionnaires being developed to collect equity data and improve data quality	✓ Equity measures are included in IPR and regularly reported into committees and board ✓ Equity Index is in use as a way to track our progress on key performance indicators ✓ Improved data quality and streamlined data collection around key health equity variables through the "About Me" template ✓ Key members of the workforce have the capability to interpret relevant health equity reports and data ✓ We have equity reporting on access, experience and outcome measures
	Voice and influence	• Feedback from patients, carers and communities used to develop LCH's equity strategy, with ongoing engagement agreed as an underpinning principle to LCH's approach to equity.	• LCH engagement principles are explicit about being accessible, inclusive and active • Healthwatch and partners have been commissioned to undertake engagement work on the future of community services, with legacy work to learn how to effectively include insight from marginalised communities.	✓ We have strengthened the process of gathering and acting on patient, community and staff insights, particularly in relation to racialised and other marginalised communities. ✓ Engagement/feedback datasets are analysed by demographics
	Equity in decision-making processes	• Equity impact in service change and policy decisions based on an internal discussion and provision of a statement that equity had been considered.	• The EQIA process has been designed and revised to identify, review and mitigate risks to groups at risk of worse health outcomes. • Policy development and review include equity impact assessment • We are identifying how the HEARTT or other equity in waiting list tool, can be made applicable to community services.	✓ Consideration of equity impacts is embedded at the earliest stage of designing service chang, leading to an effective, robust formal EQIA process. Cumulative impact is measured and addressed and assurance processes in place. ✓ Equity is embedded at the heart of decision-making processes including finance, procurement and business development, ✓ Learning from testing of an equity in waiting list tool is applied more broadly across LCH

		Where we were (2021)	Where we are now (2025-6)	In 5 years, equity is embedded (2031)
Reducing inequity in access, experience and outcomes	Inequity in access	• Access data (referrals, appointment outcomes and waiting lists) are not routinely analysed for equity	• Monthly deprivation analysis of waiting times underway, with inequity escalated through performance report. • LCH policy around waiting list management and reducing missed appointments (including on opt-in/out practices) is being rewritten to address inequity • Resources on reducing missed appointments in place, citywide and LCH workshops held. Pilot to phone patients in IMD1 who have missed appointments to implement reasonable adjustments and signpost to support underway.	✓ The average length of wait is the same for patients in IMD-1, those with learning disability and racialised communities as for others and all reducing overall ✓ The missed appointment rate is the same for patients in IMD1, those with learning disability and racialised communities as for others and all reducing overall
	Tackle known inequities faced by specific population groups	• Equity strategy identifies population groups at risk of worse health outcomes and prioritises focus on deprivation and ethnicity	• Racial equity in Care group established, priorities agreed and delivery underway • Learning Disability Standards improvement work underway • Reasonable Adjustments and Accessible Information Standards improvement priorities underway • Armed Forces accreditation gained and improvement plan being delivered	✓ Continuous improvement approach embedded to Accessible Information Standards and Reasonable Adjustments ✓ Delivering improvement programmes in relation to racial equity in care ✓ Meeting the LD Standards ✓ Trauma-sensitive approaches in place ✓ Data enables identification of inequity for wider range of groups/communities. ✓ Access, experience and outcomes measured and able to be analysed for equity, with improvements routinely identified and delivered. ✓ Each Business Unit has a measurable plan and targets to address inequity in their area of work
	Prevention as a route to tackling inequity	• Prevention not included in equity strategy	• Exploring prevention as a route to tackling inequity	✓ Mapping has been undertaken around hypertension and smoking to understand existing practice in services and deliver improvement work ✓ Learning from prevention approaches is expanded to engage effectively in other priority prevention programmes

Appendix 2: Health Equity 5-year tactical plan

A. Creating the conditions for change

ID	Objective: by 2031	Lead	Year 1	Year 2	Year 3	Year 4	Year 5
Strengthening governance and accountability for health equity							
A1	Reporting on equity is a shared responsibility across all Committees		Analysis of use of equity data by committees Launch of refreshed cover report template to reinforce the inclusion of equity data	Evidence of equity consideration in 50% papers to Board Committee chairs to review equity data analysis at the end of the year and put challenge back in when missing	Evidence of equity consideration in 50% papers to all subcommittees to Board Committee chairs continue to review equity data analysis biannually and put challenge back in where missing	Evidence of changes as a result of discussion in sub-Committees and Board	
A2	A thriving Health Equity Leadership Group is fully engaged, has improved coordination, and is delivering change through a clear organisational direction and shared ownership of a clear plan.	Med Dir / Equity Team	Representation from all BUs and key departments at 75% core meetings. Agreed alignment with People Directorate priorities.	Representation from all BUs and key departments at 75% core and 50% workstream meetings. Plan feeding into both Quality and Business governance routes	Representation from all BUs and key departments at 100% core and 75% workstream meetings.		
Embed Health Equity within LCH Strategies and Plans							
A3	Equity is embedded in organisational strategy and contributing to the delivery of the NHS 10-year plan	Strategy & Planning	Launch of 5 year Medium Term plan which will have 'equity' as an underpinning thread	Continued implementation			

ID	Objective: by 2031	Lead	Year 1	Year 2	Year 3	Year 4	Year 5
A4	Action to identify and address inequity is embedded within annual planning cycles and contributes to overall achievement of a share equity ambition	Strategy & Planning	Launch of annual operational plan Development of guidance on 'strategic plans' that will replace existing thematic strategies	Continued implementation			
A5	Equity is embedded within PSIRP, driving safety improvements across safety priorities	Quality & Safety	Involvement of the patient safety partners in the falls improvement group.	Priorities confirmed through PSIRP and equity safety data. Patient Safety Partners engagement with diverse communities to inform improvements			
A6	Person-centred care has senior oversight, is integral to service delivery and improvement and is being measured	LCH PCCEAG rep	Baseline of AIS and reasonable adjustments. Interpreting and translation managed on new contract	Baseline for shared decision-making and 3Cs			
Expand the capacity and capability of the organisation to take action on health equity							
A7	Equity is part of training and development programmes including clinical education and leadership development	Prof Devlpt, People Solutions	Access to modules via LEAD programme Access to learning bursts on equity via LHCA Implementation of LHCA One Workforce: Health equity education programme	Embedding new Allyship programme The Learning and Development Quality Assurance Framework being developed by the Trust will include equity as a golden thread for all clinical training topics delivered by the Trust.	The Learning and Development Quality Assurance Framework will be rolled out and an annual review and update process established.		

ID	Objective: by 2031	Lead	Year 1	Year 2	Year 3	Year 4	Year 5
A8	Ongoing delivery of One Workforce equity development programme	Public Health	Services are engaged in the pilot delivery	Commitment to prioritise ongoing programme delivery			
A9	Capacity to deliver equity has grown across the organisation through staff with dedicated inclusion and equity focus, supported by a specialist function	Equity Team, Prof Devlpt, BU l'ship	Increase capacity and learning within services through student projects / assignments Build staff and student awareness Baseline Assessment of SBU understanding and compliance Staff Learning and development Share best practise and learning at BU and Trust level	Define Roles and Align Priorities e.g. Health Equity Champions Resource/roles identified in services and working in joined up approach to equity priorities Ensure attendance at Health Equity Groups and embed learning and development from the groups.	Embed Equity into Practice and monitor through Performance process Develop Service-Level Health Equity Plans Use Health Equity Data to inform decision making at service level. Review Staff training and Development needs	Ensure BU compliance with Health Equity strategic planning goals. Community Partnerships: Work with partner organisations to embed best practice and shared learning Evaluation using PDSA cycle	Organisational and BU Culture Shift: Recognition and Awards Embed continuous Improvement cycle
A10	All services are engaged with the Cultural Conversations programme and can demonstrate culturally sensitive approaches to care delivery	Equity Team, People Solutions	Baseline of existing engagement and impact. Quarterly delivery of training for leaders.	Introduction of trustwide cultural conversations aligned to allyship programme.	All services engaged in cultural conversations programme, impact measured	Continuous quality improvement approach	Continuous quality improvement approach

B. Supporting action

ID	Objective: by 2031	Lead	Year 1	Year 2	Year 3	Year 4	Year 5
Strengthen health equity data from collection to use in decision making							
B1	Improved data quality and streamlined data collection around key health equity variables through the “About Me” template	BI	Data quality processes including reporting , monitoring and improvement plans relevant to “About Me” roll out in place	Monitoring of data quality relating to patient characteristics, including those within the “About Me” template embedded in BAU performance processes	Data quality processes implemented for next set of equity priorities	Data quality processes implemented for next set of equity priorities	Data quality processes implemented for next set of equity priorities
B2	Equity measures are included in IPR and regularly reported into committees and board	BI	Implementation of KPIs that use the Health Equity Index to assess difference in waiting times by ethnicity, IMD, LD, armed forces and people with a disability.	Application of the Health Equity Index to the next set of equity priorities. Development of the IPR structure to allows assessment of equity to be embedded for every measure rather than separately.	Application of the Health Equity Index to the next set of equity priorities	Application of the Health Equity Index to the next set of equity priorities	Application of the Health Equity Index to the next set of equity priorities
B3	Equity Index is in use as a way to track our progress on key performance indicators	BI	Operational reporting of the Health Equity Index for waiting times by ethnicity, IMD, LD, armed forces and people with a disability available in standard waiting list reporting	Application of the Health Equity Index to the next set of equity priorities	Application of the Health Equity Index to the next set of equity priorities	Application of the Health Equity Index to the next set of equity priorities	Application of the Health Equity Index to the next set of equity priorities

B4	Access, experience and outcomes measured and able to be analysed for equity, with improvements routinely identified and delivered	BI, Dep Dir AHPs	Aligned to development of Equity Index for access and experience measures, goal based outcomes (GBO) to be implemented and reported on.	Reporting on difference in GBOs to be made available for people with a disability or learning disability, by ethnicity, armed forces status and IMD available	Further characteristics and outcomes to be added to reporting as per the next set of equity priorities	Further characteristics and outcomes to be added to reporting as per the next set of equity priorities	Outcome measures routinely used, reporting mechanisms and analysis to evidence effectiveness in clinical pathways for individuals and populations and changes made in response to these
B5	Key members of the workforce have the capability to interpret relevant health equity reports and data	BI/Equity Team	Videos to support the use of existing equity reporting in place for use by all staff. Ad hoc support with use of data available	Assessment of the organisation's need for support in using health equity data. Implementation of initial actions to improve this.	Continued implementation of actions to improve organisational capability to interpret and use health equity data. Review of actions implemented to assess their efficacy and further actions identified	Continued implementation of actions to improve organisational capability to interpret and use health equity data. Review of actions implemented to assess their efficacy and further actions identified	Continued implementation of actions to improve organisational capability to interpret and use health equity data. Review of actions implemented to assess their efficacy and further actions identified
Voice and influence							
B6	We have strengthened the process of gathering and acting on patient, community and staff insights, particularly in relation to racialised and other marginalised communities.	Pat Exp	Continued engagement with 3rd sector, actions from Healthwatch engagement paper, continue to gather broad spectrum patient feedback and service specific bespoke engagement work.	Increase outreach work to marginalised communities, including engagement work by the Patient Safety Partners.	Embed consistent approach to gather and act on the feedback to hear the voices of our community. Align to ten-year plan with shift from analogue to digital ensuring accessibility remains to all.		

B7	Engagement/feedback datasets are analysed by demographics with improvements identified and made	Pat Exp	FFT analysed by demographics	Identified themes and trends, gaps in communities feedback	Proactive engagement with identified marginalised groups to report on wider community		
Embed equity at the heart of decision-making processes							
B8	Consideration of equity impacts is embedded at the earliest stage of designing service change, leading to an effective, robust formal EQIA process. Cumulative impact is measured and addressed and assurance processes in place.	BI, Clinical Effectiveness, Strategy and Planning	Review and relaunch of Change and Improvement methodology, which will include learning from QV about considering equity from the start and throughout a change	Embed equity prompts into project initiation, business case, and case for change templates. Identify metrics for reporting on impact. Begin tracking cumulative impact across projects.	Continue tracking of cumulative impacts. Begin to develop an equity dashboard for impact. Start to identify themes in impacts and mitigation utilised. Link these to Trust wide principles.	Continue to integrate EQIA requirements into formal assurance processes. Conduct annual review of cumulative impacts and mitigation effectiveness. Share findings with stakeholders to inform future planning.	Use cumulative impact data to shape strategic priorities and resource allocation. Review C&I methodology based on feedback and evolving best practice. Publish equity impact outcomes to demonstrate transparency and accountability.
B9	Equity is embedded at the heart of decision-making processes including finance, procurement and business development.	Finance, Strategy & Planning	Equity to be a standard outcome metric in all change reporting Build into Business case training which is currently being developed. Initially rollout to BCIS.	Evidence of reporting against equity outcome metric Roll out business case training across LCH	Continued implementation - challenge any decisions that have not considered equity and change projects not reporting against equity metric	Continued implementation	Continued implementation
B10	Development of an equity in waiting list tool is applied more broadly across LCH	BI	A tool to manage equity for the people waiting for LCH care is developed and implemented.	Additional areas in which learning from implementation of the tool can be applied are identified and actions planned and implemented.	Continued implementation		

C. Reducing Inequity in access, experience and outcomes

ID	Objective: by 2031	Lead	Year 1	Year 2	Year 3	Year 4	Year 5
Working with services to reduce inequalities in access through reducing missed appointments and waiting lists							
C1	The average length of wait is the same for patients in IMD-1, those with learning disability and racialised communities as for others and all reducing overall	BU leaders, Equity Team, BI	Continued progress on IMD1 waiting times. Baseline for ethnicity established and improvement plans in place for equal length of wait. Data Analysis: Audit current waiting times Community Engagement: Consult with affected groups to understand barriers Staff Training Pilot Projects: Launch small-scale interventions	Service-Level Equity Plans. Digital Inclusion Support: e.g. tools and training for patients facing digital barriers Explore Flexible Access Models Refine Monitoring Dashboards.	Joined-Up Working: Coordinate across services to share best practices Specialist Roles: Establish inclusion leads in services Referral Pathway Review: Streamline referral processes to reduce delays for priority groups.	Measuring difference in acuity/disease progression between triage and assessment to understand how prioritisation of clinical need of patients is addressed Impact Evaluation: Assess effectiveness of interventions Refine policies based on evaluation findings and patient feedback. Staff Recognition: Celebrate improvement Co-design: Involve patients and carers in redesigning services	Identify how we move from equality of length of wait to equity in length of wait, prioritising Access equity a core part of service planning and performance metrics. Scale successful interventions across all services. Embed continuous Improvement cycle External Sharing of models

C2	The missed appointment rate is the same for patients in IMD1, those with learning disability and racialised communities as for others and all reducing overall	BU leaders, Equity Team, BI	2% reduction in IMD1 missed appointments (11.2%-9.2%) Data Audit: Analyse missed appointment rates by IMD quintile, learning disability status, and ethnicity. Barrier Identification: Engage with affected communities to understand reasons for DNAs Staff Training Pilot Reminder Systems	2% reduction in IMD1 (9.2% to 7.2%) Targeted Support and Service Redesign Flexible Booking Options Digital Inclusion: Provide support for patients with limited digital access or literacy. Community Navigators: Explore navigators to help patients manage appointments and follow-ups.	Targeted reduction to continue to bring in line with new IMD2-10 rate Implement dashboards tracking DNAs by demographic group across services. Joined-Up Working: Coordinate across services to share best practices Specialist Roles: Establish role of Health Equity Leads in monitoring access in services Referral Pathway Review: Streamline referral processes to reduce delays and confusion that lead to missed appointments	Impact Evaluation: Assess effectiveness of interventions Refine policies based on evaluation findings and patient feedback. Staff Recognition: Celebrate improvement Co-design: Involve patients and carers in redesigning appointment systems and communications.	Missed appointment equity a core part of service planning and performance metrics. System-Wide Rollout: Scale successful interventions across all services. Embed continuous Improvement cycle External Sharing of models
Tackle known inequities faced by specific population groups							
C3	Continuous improvement approach embedded to Accessible Information Standards, Reasonable Adjustments and health literacy	BU leaders, Equity Team	Identified leadership and understanding our baseline: AIS, RADF, health literacy self-assessments and identification of priorities Actions as per C2	Review and update public-facing and staff resources Actions as per C2	Embed consistent approaches Actions as per C2	Continuous improvement cycles Actions as per C2	Continuous improvement cycles Actions as per C2

C4	Delivering improvement programmes in relation to racial equity in care	Dir Nurs, People Solutions	Interpreting and translation identified leadership and understanding our baseline Anti-racism / allyship	Interpreting - Review and update public facing and staff resources	Interpreting - Embed consistent approaches	Interpreting - Continuous improvement cycles	Interpreting - Continuous improvement cycle
C5	Meeting the LD Standards	LD Lead	Meeting LD standards: RA and Oliver McGowan training	Embed Standards: Ask Listen Do	Review standards and deliver continuous improvement cycles	Continuous improvement cycles	
C6	Trauma-sensitive approaches in place	tbc	Identification of existing practice	Sharing learning and identifying trustwide commitment and approaches	Embedding consistency in approaches	Continuous improvement cycles	
C7	Data enables identification of inequity for wider range of groups/communities	BI	Reporting on waiting times for people with a disability or learning disability, by ethnicity, armed forces status and IMD available	Further characteristics and measures to be added to reporting as per the next set of equity priorities	Further characteristics and measures to be added to reporting as per the next set of equity priorities	Further characteristics and measures to be added to reporting as per the next set of equity priorities	Further characteristics and measures to be added to reporting as per the next set of equity priorities

C8	Each Business Unit has a measurable plan and targets to address inequity in their area of work	BU leader ship	Baseline audit: Assess current compliance with AIS across services & identify gaps Review staff training requirements Review patient feedback assessment tools and co-design with patients to be able to identify gaps in service provision. Trial Reasonable Adjustments in targeted services	Implement consistent systems for recording and acting on AIS needs and Reasonable Adjustments. Share tools for creating easy read, translated, and visual materials. Explore role of Health Literacy Champions Introduce routine patient feedback mechanisms	Embed AIS and Reasonable Adjustments into EPR and booking systems. Tracking of compliance through health equity dashboards Services to develop and report on improvement plans Facilitate cross-service learning to share best practice	Assess improvements in patient experience, outcomes, and service accessibility. Update guidance based on evaluation findings Celebrate services demonstrating excellence in inclusive communication. Co-Design: Involve patients and carers in refining materials and systems for accessibility.	AIS, Reasonable Adjustments, and health literacy core to service planning and performance reviews. Scale successful tools and practices across all services Embed continuous Improvement cycle Share findings externally
Exploring prevention as a route to tackle inequity							
C9	We understand existing practice in services around hypertension and smoking and deliver improvement work	Public Health Conslt	On hold for Year 1 due to lack of PH resource and capacity	Mapping around hypertension and smoking in services, identify and test improvement work	Mapping around hypertension and smoking in workforce, identify and test improvement work	Consolidate improvement approaches	
C10	Learning from prevention approaches is expanded to engage effectively in other priority prevention programmes	Public Health Conslt	On hold for Year 1 due to lack of PH resource and capacity	Align with priorities from the Prevention Diagnostic and Neighbourhood Prevention model.			

Appendix 3: Health Equity Index update

1. Background

The Health Equity Index is a strategic tool for measuring and embedding equity in healthcare performance. This tool was initially developed by the London Northwest University Healthcare NHS Trust. This London Trust, alongside Imperial College London, developed the statistical methodology that facilitates users to have a measure of equity embedded within clinical performance metrics.

The Leeds Healthcare Inequalities Oversight Group (chaired by Ruth Burnett, with Andrea Osborne representing LCH) has committed to developing the Health Equity Index for application across the system and within organisations in Leeds. This update describes the need for the index, its potential uses and envisaged application within LCH.

1.1. Purpose of the Health Equity Index

As a provider, we often struggle to answer the following questions:

1. Are we making progress on health equity?
2. How can we be assured we're not making inequity worse?
3. Where should we focus our energy, attention and resources to improve equity?
4. How are we doing on Health Equity as a healthcare system?

These questions are challenging to answer because health equity data can be complex to report and interpret. Currently, health equity data will involve examining multiple variables with multiple categories. This can make it challenging to understand the impact of intersectionality, to monitor changes or improvements over time, and to understand the significance of the differences we observe within the data. It is also inherently difficult to get an overview of progress and compare across different types of metrics.

The Health Equity Index seeks to provide a way to simplify health equity data reporting, making interpretation, comparison and tracking progress over time much more accessible to its end users.

1.2. Functions of the Health Equity Index

The health equity index analyses inequity within a measure against a range of selected variables. It provides a score between 0 (equity) and 1 (inequity). It can be applied to a wide range of clinical performance metrics to give end users a sense of equity within that measure.

Example

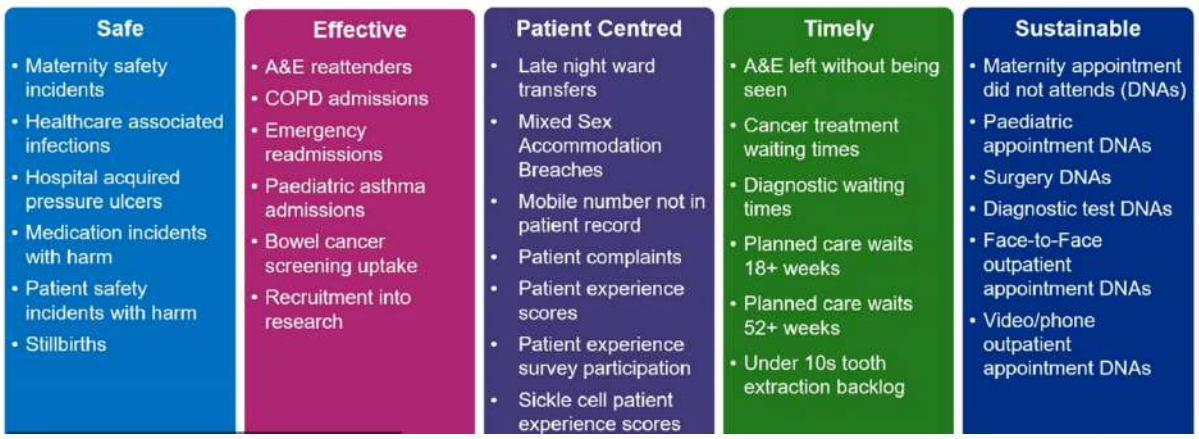
Chosen clinical performance measure: Rate of Healthcare Associated Infections

The health equity index will review a range of variables within this measure such as age, deprivation, ethnicity, learning disability status. It will look at the differences in the rate of Healthcare Associated Infections within these groups.

Health Equity Index Score: 0.6 (score 0= equity 1= inequity)

Interpretation: There is inequity within the rates of healthcare associated infection in some groups. When we look more closely at the data we can see there are much higher rates in people living in deprived communities and those with a learning disability.

The creators of the Index, London North-West Hospitals, co-created a list of 30 performance metrics through collaboration with patients, partners, and staff to which they applied the Index. Metric selection followed the principle that indicators needed to be meaningful to the audience and support organisational strategic intent. Metrics were prioritised based on the trust's ability to act and likely impact on health equity. The metrics London North-West selected to apply the Equity Index to were as follows:



London North-West then applied the Health Equity Index to these metrics (as seen in the screen shot below). At a glance, this overview provides you with the ability to see where there may be issues of greater inequity such as in patient experience survey participation.

Quality Dimension	Indicator	Equity Index (Q3 2023/24)	Detail
Experience	Late night ward transfers	0.09	Link to Sheet
Experience	Mixed Sex Accommodation Breaches	0.34	Link to Sheet
Experience	Mobile number not in patient record	0.20	Link to Sheet
Experience	Patient complaints	0.04	Link to Sheet
Experience	Patient experience scores	0.04	Link to Sheet
Experience	Patient experience survey participation	0.79	Link to Sheet

We can then go onto see a more detailed view of each indicator to understand where the equity or inequity may be arising from (see London's example below). This view shows us the overall Health Equity Index score for the face-to-face DNAs, as well as the differences between groups (deprivation, age, ethnicity) and other overall demographic data completeness. This view allows us to see in more detail where inequity may be arising and can inform action.

1.3 Benefits of using the Health Equity Index in LCH

- Simplify the interpretation of health equity data for individuals, teams, services and the trust. Empowers our workforce to build equity into business as usual.
- At a glance it highlights inequities or good practice across a range of performance metrics, prompting action.
- Supports deeper dives into equity issues, providing data and evidence for our improvement work.
- Supports the trust to track progress on health equity around a range of key performance indicators, by monitoring changes in the Index value over time. This can be done at trust, business unit, or service level.
- Can support us to consider equity within prioritisation and decision building processes.
- Strengthens our assurance processes around health equity at the trust.
- Creates a common language and approach to reviewing equity data at the trust.
- As this is a Leeds-wide initiative, it also provides a common language to review health equity as a system. This will enable us to track our collective progress on health equity and facilitate systemwide conversations on action needed to address inequities beyond the gift of LCH to address on its own

1.3. Caveats on the use of the Health Equity Index

The Health Equity Index would be an improvement in how we currently measure equity within the trust, but it is not a perfect tool. For example:

- From the index score alone, you cannot get a clear sense of scale i.e. the number of people impacted. For example, if the index score indicates there is inequity within a performance measure, it would require further investigation to understand which groups this relates to and to number of people affected.

- Although you can compare score across a range of measures, the index does not highlight whether equity within one measure is more important than another. Judgement and prioritisation still need to be applied.

- The Index will only be useful if staff understand what it is, can interpret it and use it to inform action. Skilling up key members of staff will be vital and gathering feedback on its use to inform improvement activity.

2. Development and application of the Health Equity Index

2.1 Development of the Health Equity Index across the city

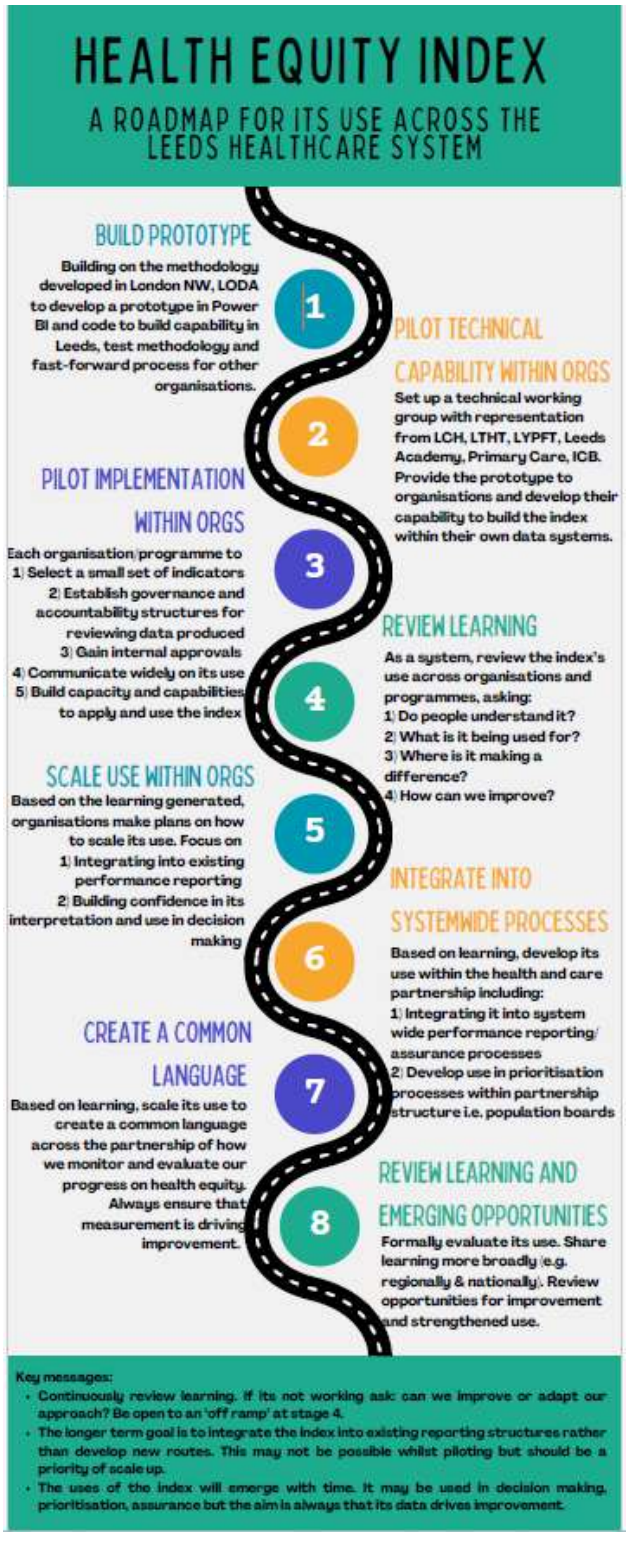
The development of the Index in Leeds is being led by the Leeds Office for Data Analytics (LODA) on behalf of the Leeds Healthcare Inequalities Oversight Group. The LODA are doing the technical work to apply the methodology for the Index, developing the code and statistical modelling, to enable this to be copied and pasted more easily into organisations. They are currently developing a prototype of the Index, learning from London North-West colleagues. The LODA are committed to supporting and upskilling Business Intelligence teams within the trusts to apply and implement the Index.

A workshop in May 2025, brought together healthcare providers, primary care and third sector colleagues across Leeds to consider the implementation of the Index across the system. It was recommended each organisation select a small set of metrics for the Index to be initially applied to test its feasibility, technical application and use.

By 2026 the project aims to achieve:

- Development of a Health Equity Index prototype that can be implemented by partners across the Leeds Health and Care System
- Development of a system-wide set of measures which can be used to monitor the progress being made on health equity across Leeds

A roadmap for its development and use is shown (right):



2.2 Development of the Health Equity Index in LCH

The process of developing the Index within LCH, and across the city, will be iterative, learning from its use and planning next steps based on these reflections.

The development and implementation forms part of the five-year tactical plan (Appendix 2). As a starting point, we propose that we apply the Index to waiting times, with reporting by ethnicity, IMD, LD, people with a disability and armed forces.

The Index will then be applied to the next set of equity priorities. The identification of key measures and patient groups required for this work has begun through the development of an equity measurement framework (Board equity paper, August 2024).

The implementation of the Equity Index project in LCH will also require:

- Collection and quality assurance of data.
- Implementation of the software tools within the LCH reporting infrastructure.
- Development of reports and dashboards to highlight the equity index.
- Monitoring and performance management mechanisms.
- Support to services to implement changes to improve equitable care.

Scoping and planning of this work are currently ongoing and timeframes for the work are being developed. The intention is for it to align with and support the development of the Integrated Performance Report.

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (9)

Title of report:	Trust Priorities – Mid Year Update

Meeting:	Trust Board Meeting Held In Public
Date:	6 November 2025

Presented by:	Andrea Osborne, Executive Director of Finance & Resources					
Prepared by:	Emma Tiernan, Head of Business Dan Barnett, Associate Director – Strategy, Change, and Improvement					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	The paper provides a mid year update on progress against the 2025-26 Wildly Important Goals (WIGs): • Support the development of the foundations of the community element of the **Neighbourhood Health Model** by April 2026 • **Reduce the backlog of people waiting** for our services in line with the national targets for 25/26 • **Transform our services through year 2 of quality and value,** for more effective service delivery that ensures equitable access and financial balance.

Previously considered by:	Business Committee

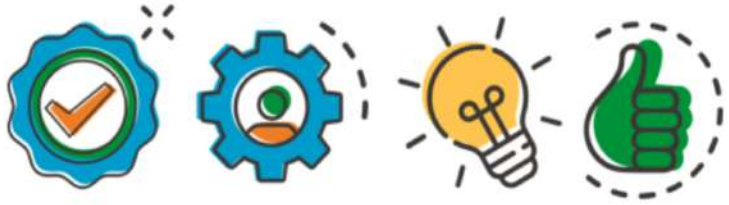
Link to strategic goals: (Please tick any applicable)	Work with communities to deliver personalised care	X
	Use our resources wisely and efficiently	X
	Enable our workforce to thrive and deliver the best possible care	X
	Collaborating with partners to enable people to live better lives	X
	Embed equity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

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

			there to include this information?	

Recommendation(s)	• The Board is recommended to note the progress made to date in 2025/26

List of Appendices:	Appendix one – Trust Priorities Mid-Year Update



Trust Priorities - Mid Year Update

Board

November 2025

LCH Vision and Strategic Goals

We provide the best possible care in every community, by:

- *Working with communities to deliver personalised care*
- *Enabling our workforce to thrive and deliver the best possible care*
- *Collaborating with partners to enable people to live better lives*
- *Embedding equity in all that we do*
- *Using our resources wisely and efficiently, both in the short and longer term*

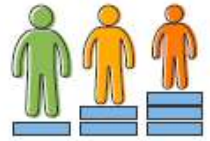
2025/26 Operational Plan - Wildly Important Goals (WIGs)

1. Support the development of the foundations of the community element of the **Neighbourhood Health Model** by April 2026

2. Reduce the backlog of people waiting for our services in line with the national targets for 25/26

3. Transform our services through year 2 of Quality and Value, for more effective service delivery that ensures equitable access and financial balance

WIGs and Outcome Measures

Wildly Important Goals (WIGS)	Outcome measures
1. Support the development of the foundations of the community element of the **Neighbourhood Health Model** by April 2026. 	TBC
2. **Reduce the backlog of people waiting** for our services inline with the national targets for 25/26. 	Missed appointments  Patient facing activity  Contacts per WTE 
3. **Transform our services through year 2 of Quality and Value,** for more effective service delivery that ensures equitable access and financial balance. 	 Financial  Access  Equity  Productivity  Quality  Workforce

1.1 National Neighbourhood Health Implementation Programme (NNHIP)

Leeds, Wakefield, and Bradford District & Craven have all been successfully accepted into the programme as pioneers.

This is a large-scale initiative designed to test, learn, and grow new approaches to improving health and wellbeing, particularly for adults living with or at risk of multiple long-term conditions. The focus is on delivering support at the neighbourhood level.

Building on existing work in the city and aligned with our Leeds Ambitions and the Leeds Health and Wellbeing Plan, the programme will be testing in 3 areas (across 6 LCPs):

- **Neighbourhood Health Hubs:** Investigating the processes, culture, assets, and team dynamics needed for integrated working in shared physical or virtual spaces.
- **Integrated Working:** Identifying key components to strengthen multi-disciplinary teams and coordinate care for targeted populations.
- **Single and Multi-Neighbourhood Providers:** Exploring models for organising integrated care under future contractual and financial frameworks, in collaboration with General Practice.
- **Establishing LCP leadership teams - ensuring appropriate LCH representation**

This programme will work alongside the **Neighbourhood Proactive Care** element of Home-First

1.2 Home-First Phase 2

Intermediate Care

- We are continuing to build on Home-First and develop our intermediate care offer

Prevention Diagnostic

- Jointly commissioned by LCC and LCH and delivered in partnership with wider health and care partners.
- Purpose – To improve the current approach to Prevention and inform system priority projects.

Workstreams - To identify key interventions and approaches to improve outcomes and reduce demand / escalation

1. LCC Adults and Health Workstream
2. Neighbourhood Prevention Workstream

Neighbourhood Prevention Workstream Findings

- Reviewed the current approach in the Leeds Neighbourhood Health Model and conducted data analysis, case reviews and deep dives
- Identified a priority patient cohort:
  - Top 5% of spend on unplanned services. Targeting this group could support 26,000 additional people.
  - Potential saving **£10-£15m**
- Most recommended interventions: Social Prescribing, Mental Health Support and Neighbourhood Networks / Enhance.
- Key Enablers:
  - Engagement: Apply the 3 C's and co-production / design to align with what works for people / carers
  - Joined-up approach: Care co-ordination, Culture and Ways of Working and enabling information sharing

1.3 Adult Business Unit

Wharfedale Short-Term Community Beds:

- Contract has been extended until June 2026, with capacity increasing from 34 to 40 beds from November to support system flow.

Community Health & Wellbeing Pilot:

- Phase 2 is now underway, focusing on delegated insulin administration and wound care.
- An evaluation is in progress to assess value for money and inform decisions for the post-pilot phase (April 2026).

Neighbourhood Clinics:

- New referral process launched on 1st September has been positively received.
- Improves patient flow, reduces inappropriate appointments, eases the burden on referrers, and enhances data collection—helping to target resources where they're most needed and better understand demand.

2. Waiting List Update

Overall Progress

- Significant reduction in patients waiting over 40 and 52 weeks across multiple services (50% reduction for patients waiting over 40 weeks, 40% reduction for patients waiting over 52 weeks)
- Targeted plans in place for services with the highest impact on the Trust's **National Oversight Framework (NOF)** score: **PND, Adult SLT, CUCS, and Podiatry**.
- Several services have **cleared all 40+ week waits**

Paediatric Neuro Disability (PND)

- Introduced **tiered triage** and engaged **locums** for autism assessments.
- Early results show slower-than-expected progress; further locum capacity and outsourcing options are being scoped.
- Forecasts show **continued growth without intervention**, but initiatives may stabilise the position.

Podiatry

- Transformation work and **opt-in process** led to discharge of over 1,000 long waiters.
- **Saturday clinics** added ~450 appointments (Oct–Mar), with high patient engagement.
- Forecast predicts **52+ week waits cleared by Nov 2025** and **40+ by Dec 2025**.

Adult SLT (Speech & Swallowing)

- Introduced **opt-in approach**, refined access criteria, recruited locums. Monitoring health equity impacts via IMD decile analysis.
- Forecast shows **52+ week waits cleared by Dec 2025**, **40+ by Jan 2026** – in review; anticipated slip due to locum servicing notice. Service sourcing alternative provision to recalculate trajectory.

2. Waiting List Update

CUCS (Continence, Urology & Colorectal)

- Streamlined pathways and appointment times.
- Piloting **PIFU (Patient-Initiated Follow-Up)** to free up capacity.
- Forecast shows **52+ week waits cleared by Nov 2025**.

Neighbourhood Therapy Service:

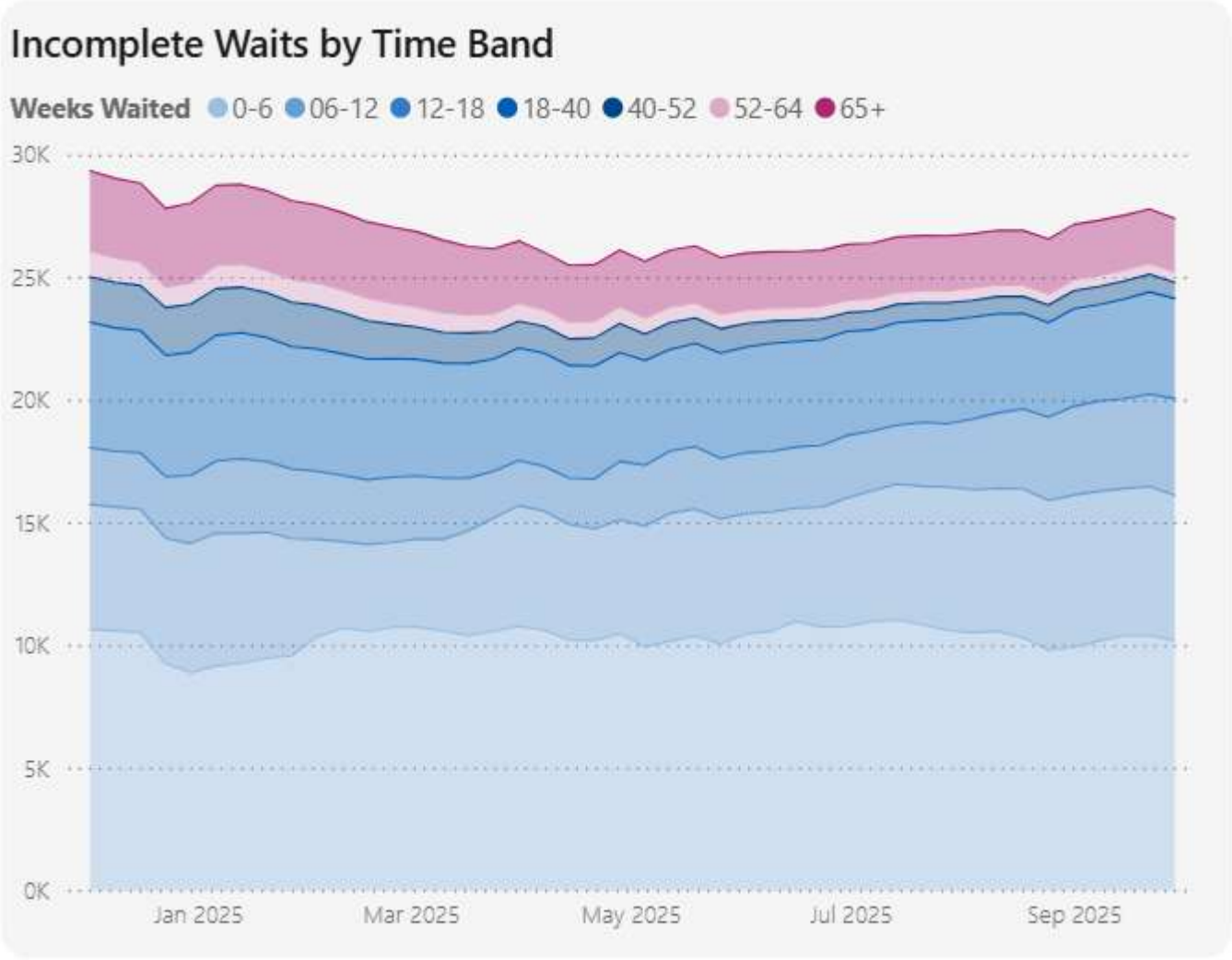
- Now operates as a standalone service
- **Waiting list reduced** by 22% since September 2024, with a 60% decrease in high priority waiters.
- **No 40+ week waiters -** only 9 patients waiting over 26 weeks (as of 10/10/25)
- **16 new posts in recruitment** and migration to a **new standalone S1 unit** being planned to improve data access and quality
- **Therapy triage MADE event** – led to training rollout, freeing up therapy staff from triage duties
- **Productivity improvement** actions underway following baseline audit

Other Notable Improvements

- **Community Dental**: Revised plans post staff withdrawal from fixed term post; weekend sessions & outsourcing being explored.
- **CYPMHS**: Reduction in ADHD and ND pathway waits; outsourcing triage under consideration.
- **Children's SLT**: Now only 6 patients over 40 weeks; aiming for 18-week waits.
- **Community Neurology, Nutrition & Dietetics, Looked After Children**: All cleared 40+ week waits.
- **MSK**: Review validation process and additional clinics being implemented.

2. Waiting List Update

1. Total number of people waiting by time bands

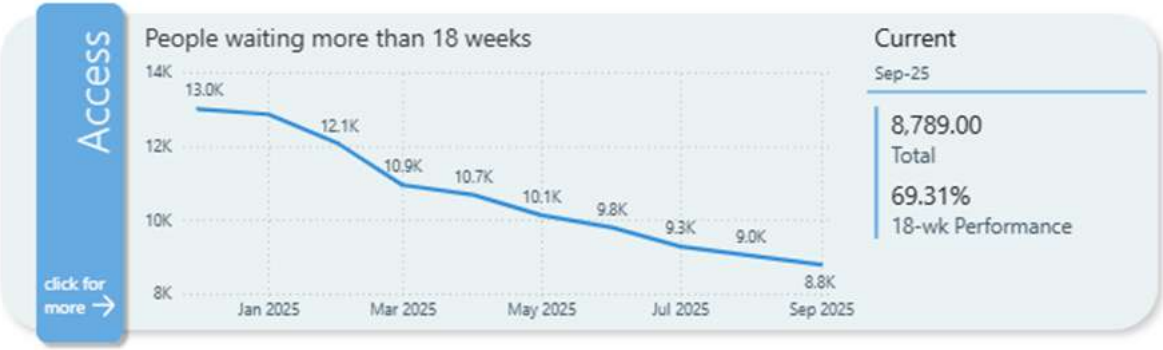


2. Missed appointment rates

2. Waiting List Update

3. Total patient facing contacts

4. People waiting more than 18 weeks



5. Contacts per WTE

3. Transform our services through year 2 of Quality and Value, for more effective service delivery that ensures equitable access and financial balance.

3. Quality and Value Programme

Overall programme update

- As at the end of September 2025, the Trust is forecasting a break-even financial position.
- The recurrent full year effect CIP is £11.2m (of a £14m target). This is offset by non recurrent savings. Reliance on non recurrent savings has reduced this year compared to last year (20% this year compared to 40% last year)

Overall Programme		YTD - £5.2m (90%) RFYE - £11.2m (80%)

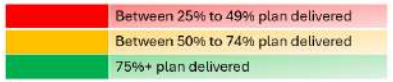
ABU		YTD - £409k (47%) FY Effect - £2.026m (98%)
CBU		YTD - £694k (74%) FY Effect - £1.408m (63%)
SBU		YTD - £2.2m (107%) FY Effect - £4.63m (93%)

Service redesigns

- This year the service redesigns underway include:
  - ABU (Proactive Care Community Matrons, Pharmacy Technicians, Palliative Care, Self Management)
  - CBU (CYPMHS, Fair Days Work across the whole Business Unit)
  - SBU (LMWS, Cardiac, Respiratory, Diabetes, CNRS) as and legacy work from year 1 that needs to go further (MSK, SLT, Podiatry, Falls)
  - ABU and SBU are progressing well and on track to achieve full year effect CIPS
  - CBU is undertaking a Fair Days Work approach across the whole Business Unit.

  Whilst progress is currently behind schedule, this is expected to ramp up by the end of the year.

Key:



3. Quality and Value Programme

Corporate redesigns

- Corporate redesigns for year 2 include Finance, Clinical Governance, Clinical Education, Administration, Leadership in Business Units.
- Underperformance in progress is offset by overachievement in Trust wide initiates

Corporate & Ops Management		YTD - £638k (49%) FY Effect - £1.432m (46%)

Estates

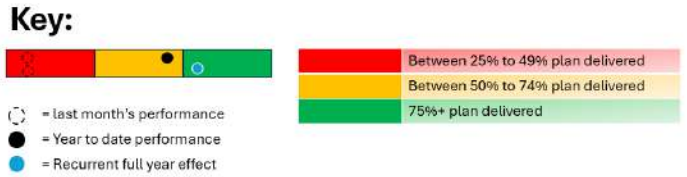
- All on track including sales of Otley HC, and review of third party contracts, review of utilisation

Estates		YTD - £250k (120%) FY Effect - £500k (100%)

Trust-wide initiatives

- Overachievement – activities include interest received, procurement initiatives, reserves

Trust wide		YTD - £976k (217%) FY Effect – £1.2m (111%)



3 Quality and Value Programme

Business Development

Short-Term Community Beds:

- Tender submitted in partnership with Leeds City Council and Leeds GP Confederation. New service will be for a single provider of Community Beds in Leeds.

MindMate SPA Transformation:

- Business case approved to improve efficiency, reduce waiting times and future proof the service.
- Proposal to subcontract operations to Northpoint, leveraging their digital triage and third-sector expertise.
- Case for change is being finalised

Leeds Weight Management Access Interface Hub:

- Business case approved by ICB (£500k) – internal governance in progress
- LCH lead provider partnering with and procuring Leeds GP Confederation to lead delivery

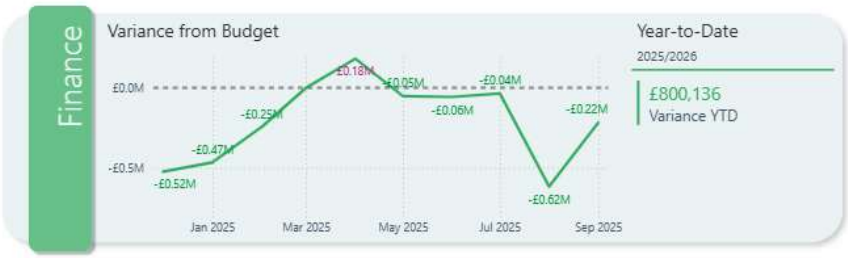
Health & Growth Accelerator Projects:

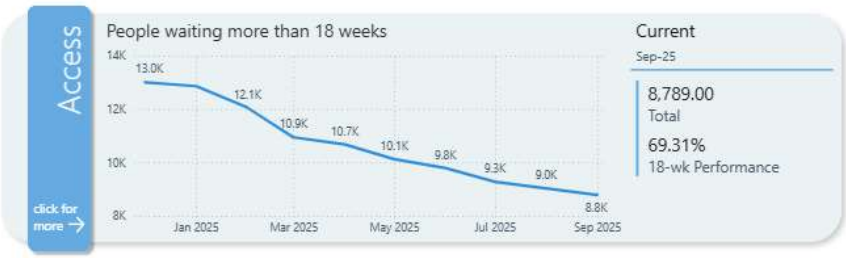
- Funding secured for Leeds MultiSystem Rehabilitation Service (£110k) and MSK (£33k); both operational since August 2025.

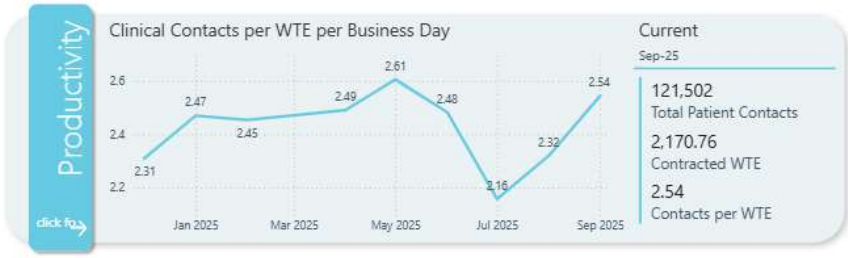
3. Quality and Value Programme

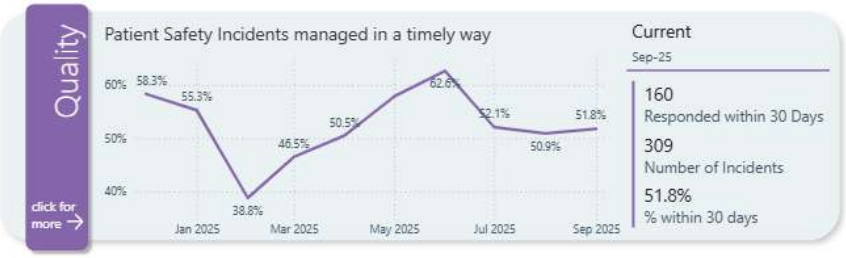
Monitoring the impact of the Quality and Value Programme

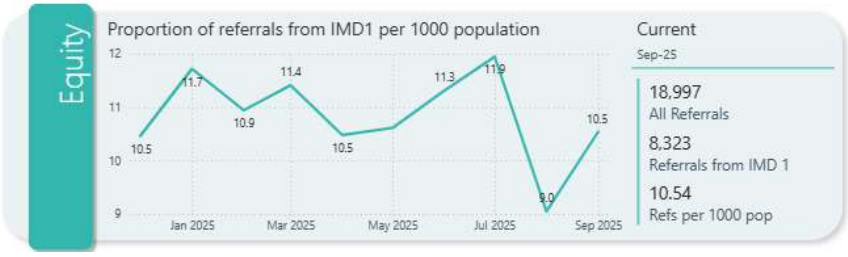
A range of quality, equity, people, and finance related metrics are regularly monitored to understand the impact of a large programme of change, such as Quality and Value, on the organsiation. These include:











Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (10i)

Title of report:	People Headlines And Strategy Update

Meeting:	Trust Board Held In Public
Date:	6 November 2025

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

Executive Summary:	This paper provides Trust Board with information on key headlines linked to the LCH People Directorate portfolio. It will be produced 4 times per year. It is reviewed and discussed at People Culture Committee prior to coming to Trust Board. Headline Areas covered in this edition of the report include: • National Oversight Framework: People elements • Nights Service Sickness Absence • Staff Support & Safety • Mutually agreed Resignation Scheme (MARS) Update • People Directorate current priorities Since the People &Culture Committee on 23 September, one update to this paper has been added, on MARS (section 2.4), confirming numbers now proceeding to departure. The paper also provides an update on the progress made against LCH Workforce Strategy (2021-2026) outcome measures to date.

Previously considered by:	N/A

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

	Embed equity in all that we do	X

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

Recommendation(s)	The Board may wish to note that the People & Culture Committee: • Noted the Workforce Headlines presented in this report • Noted the progress achieved in pursuit of the target measures set out in the current LCH Workforce Strategy.

List of Appendices:	Appendix 1: Draft / Emerging High Level Content for LCH Workforce Strategy successor Appendix 2: Workforce Strategy Progress Dashboard

People Strategy Update & Headlines

1. Introduction

This report is presented to each meeting of the LCH People & Culture Committee as a current snapshot of People & Culture headlines, priorities and progress.

Highlighted in this month's report are:

- National Oversight Framework: People elements
- Nights Service Sickness Absence
- Staff Support & Safety
- Mutually agreed Resignation Scheme (MARS) Update
- People Directorate current priorities

The report also provides details of current standing against the objectives set out in the LCH Workforce Strategy 2021-26.

The report is in addition shared with Trust Board for information.

2. People & Culture Headlines

2.1 National Oversight Framework: People elements

Sickness Absence and Staff Engagement are two of the main metrics underpinning LCH's performance results under the National Oversight Framework (NOF), whose national league tables have been released this month. Projects have been set up on both, to deliver improvements in LCH results.

The People & Culture Committee will receive a more detailed update on both projects during its September meeting, from project leads.

2.2 Nights Service Sickness Absence

Sickness absence in the LCH Nights Service was identified earlier this year as an area of concern requiring focused support to address.

Focused work took place with the team during Q1, using available data and research, to assess potential factors that could be affecting sickness absence in Nights Service; and what actions could be taken to support the service and/or address these.

A number of actions have been identified and implemented, including the introduction of an offer of regular Occupational Health assessments for staff; greater regularity of team huddles and communications; improved direct support for staff experiencing a patient death during a shift; and greater attention paid to the timeliness of Wellbeing at Work panel meetings.

Since the work was carried out and actions implemented, sickness absence has come down within the service; although long term sickness absence continues to be high and remains under close review.

At the time of writing, the Nights Service is participating in the “deep dive” review & support process as part of the LCH Sickness Absence project.

2.3 Staff Support and Safety

The Trust’s focus on Staff Support and Safety is heightened at present, in the context of the ongoing reports in the media of protests outside hotels housing asylum seekers, alongside a rise in racially motivated hate incidents.

Unfortunately, these national events are also being reflected in some of our local communities. Within LCH some colleagues have reported feeling unsafe when out in the community; and at the time of writing, one racially motivated incident has been reported. Racial abuse is not acceptable at LCH and it is not to be tolerated.

The Trust is working across its Corporate and Operational teams, to ensure that staff are supported, that risks are identified and mitigated, and that any incidents are reported in order that they can be acted on. Engagement with the Race Equality Network, Freedom to Speak Up Guardian and Trade Union colleagues is ongoing, to ensure that Trust actions meet the needs of staff.
The Trust’s existing protocols around lone working, the PeopleSafe app; raising concerns and risk & security management provide a comprehensive framework for staff safety and support.

In addition the Trust is holding a series of events for staff to raise concerns and receive advice and support; and it is looking at its messaging within the organisation and externally to ensure its position and protocols in relation to racism are clear and obvious.

2.4 Mutually Agreed Resignation Scheme (MARS)

As described in May’s edition of this report and approved by Trust Board in June 2025, the LCH MARS scheme has been running to its timetable during Q2 of 2025/26. The scheme is now drawing towards its conclusion.

Close to 100 applications for MARS were received; and 47 were approved by the Trust, at an estimated cost within the approved parameters of the Scheme, of £917,822. At the time of writing this report, NHS England is being notified of the Trust’s progress and all applicants will subsequently advised of the outcome of their application.

September’s Trust Board received confirmation of progress together with details of the Equality assessment undertaken.

Since the People & Culture Committee that took place on 23 September 2025, 5 applications have been withdrawn; and the remaining 42 have signed formal agreements with confirmed departure dates.

2.5 People Directorate current priorities

The People Directorate continues to build on the service redesign work it undertook during 2024/25, and against the 2025/26 priorities shared with the Committee in May 2025.

Work on the transformation of People Directorate services is continually balanced and readjusted alongside the Directorate's day-to-day service provision.

In particular the Directorate continues to support the Trust with

- ongoing heightened volume and complexity in HR casework, which is not expected to change in at least the medium term. The Committee will see in more detail in this month's Employee Relations and Freedom to Speak Up combined report
- organisational change processes associated with service redesign and the Quality & Value Programme
- National Oversight Framework work programmes aligned with People Directorate services and skills; specifically Sickness Absence and Staff Engagement projects.

In addition the Directorate has commenced work on the medium term (5 year) programme of People ambitions and objectives that will succeed the current LCH Workforce Strategy 2021-26; and align with the overall LCH Medium Term Plan. An early indicator of high level content is at ***Appendix 1***.

3 Workforce Strategy Delivery Progress

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

The RAG rating key is as follows:

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

Overall, work on the Workforce Strategy continues to progress in line with the stated plans. The majority of targets remain on track and RAG-rated green; with a number of targets already achieved. Progress on sickness absence is not currently following the trajectory expected at the outset of this strategy, with sickness levels at LCH and countrywide higher than in previous years. A focus project to address sickness absence is underway at the Trust.

3. Conclusion

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

4. Recommendations:

The Board may wish to note that the People & Culture Committee:

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

Laura Smith / Jenny Allen; and Ann Hobson

Director of People; and Transformation Lead

16 September 2025 / updated for Trust Board 27 October 2025

Appendix 1: Draft / Emerging High Level Content for LCH Workforce Strategy successor

Appendix 2: Workforce Strategy Progress Dashboard

This table provides an overview of all the measures within the Workforce Strategy and their current Rag status

Theme	Measure	Rag Status	Theme	Measure	Rag Status
Resourcing	Bank Fill Rates increase by 10% and active bank capacity increases by 20% Master Vendor Agreement: Work is underway with the NOECPC as part of the Yorkshire & Humber Community & Mental Health Cluster to move towards a collaborative Master Vendor model for LCH's use of agency Nurses and HCAs. This will help control agency costs for these staff groups.	**Completed**	**Organisational Design**	Resourcing plans are in place for each Business Unit and refreshed annually. Primarily undertaken at service level and linked to Q&V programme, in addition to annual organisational planning round	**Completed**
	Turnover is below 13%, with stretch target of 11%	**Completed**		The overall LCH Workforce Plan reflects system partnership approaches to specific pathways, careers or roles see above	**Completed**
	Vacancy fill rates achieve 90%, with more applicants for hard-to-recruit roles than in 2020/21. Filling of International recruits. Some recent successful filling of consultant vacancies. Focus for 2025/26 - Smaller number of essential vacancies, to reduce overall workforce size	**Superseded**		e-Rostering is fully implemented, enabling systematic skills and capacity planning by services	**Completed**
	Range of advertising and marketing options is increased, with regular targeted campaigns for high priority roles / services. Focus for 2025/26 - Increased range reduced and dialling back in response to changed organisational need & priorities Flu Campaign: The Temporary Staffing Bank have been working closely with the School Immunisation team to support their Winter Flu campaign, which will help deliver 117,000 vaccines to 330 schools. The TSB team have led an internal recruitment push in recent weeks which has significantly increased the pool of bank workers available to support the campaign	**Completed**		Hybrid Working is fully embedded, supporting and informing the design and delivery of LCH approaches to Estates, Sustainability and Digital	**Completed**
	Recruitment Service offer is clearly specified, with associated KPIs regularly monitored and achieved	**In progress**		A new LCH approach to Flexible Working is developed and introduced, with some form of flexible working taken up by >50% of LCH staff	**Completed**
Leadership	Quarterly and National Staff Survey results evidence overall improvement of at least 5 percentage points in staff experience of their leaders, with areas implementing Leadership Development action plans seeing specific improvement in scores – Only reportable annually from Staff Survey results, the Quarterly Pulse survey does not ask those questions now Preparations are underway to launch this year's Staff Survey, which includes a comprehensive Comms plan and message from the CEO.	**In progress**	**Inclusion**	14.5% of the LCH workforce have a Black, Asian & Minority Ethnic background, increasing from 10% in 2021 and working towards 18% by 2028 Due to a non-mandatory field within the new recruitment system that enabled candidates to by-pass this declaration route, we saw a deterioration in our BME staff. This has now been resolved, and new recruits are being contacted to update EDI information. We expect to see improvements October/November	**On target**

	New managers have attended an LCH Leadership Essentials module, or provided evidence of recent equivalent training with a previous employer LEAD Programme There is now an annual cohort of Leadership apprenticeships in place Currently exploring internal delivery of the Mary Seacole Programme	**Superseded**		LCH talent management programme cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career Bespoke work is undertaken such as Interviewing support and techniques with the REN group	**In progress**
	Executive Team performance in Committee and Board settings reviewed by external audit partner, informing Well Led action planning and individual development plans	**Completed**		Staff Survey results evidence reduction of at least 50% in the gap in discrimination experience of disabled and BAME respondents, with aspirations towards complete closure of the gap. Whilst the overall trend for BME staff has shown a narrowing of the disparity gap, for staff with a disability, the disparity gap remains (Based on WRES and WDES staff survey results 2019-2024) Each of the staff networks has an Executive Ally. This year, as part of the new People Directorate re-structure, we now have a People Consultant aligned with each of the staff networks, who are actively involved, such as participating in the Pride event	**Improving**
	LCH talent management programme cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career. Focus for 2025/26 - targeting existing development offers BME Talent Development Programme took place during 2025 and this year the focus is on supporting and developing those delegates to thrive	**Completed**		100% of new starters and middle managers have been offered training in LCH's approach to Inclusion via the LCH Leadership Essentials course. Now focused on LEAD programme, and Skills Boosters, targeted to services going through organisational change; and 25/26 focus additionally on where areas of need are identified and New Manager Induction Launching an Allyship campaign with associated Inclusion learning Continuing to deliver cultural conversations to Managers and staff which are well received	**Superseded**
Wellbeing	Our "lead indicators" from the Staff Survey around staff engagement, motivation, and support from line managers, improve year on year between the 2021 and 2024 Staff Surveys. 2024 engagement scores dipped back to 2022 levels, but other scores maintained. Focus work is being undertaken in response to the NoF requirements around our Engagement score	**In progress**	**System Partner**	A minimum of 4 recruitment or training exercises per year, on average, are carried out collaboratively with ICP or ICS partners	**On track**
	Absence due to stress / anxiety / depression is reduced, with overall annual sickness below 5% by 2025. Sickness back to 2021 levels of 6.5%, some way off 5%	**In progress**		The GP Confederation has a full suite of pay, terms & conditions protocols	**On track**

	The Director of Operations and the People Director are leading sickness panels to work with managers to gain insight to the challenges they are facing with sickness and to provide additional support where required (team level analysis).				
	Long term sickness absence rates return to target levels of <3.5%, with a stretch target of 3% Data is showing sustained increase in long term sickness absence – Focus of much attention Trust-wide (see note above re – sickness panels) and NoF requirement around sickness levels	**In progress**		LCH staff in multiple services are working beyond LCH's organisational boundaries in support of LCH and system goals	**Completed**
	Staff reporting that LCH takes positive action on HWB rises by 5% This is taken from annual national staff survey – will need to await results of next annual staff survey around this.	**Improving**		LCH staff join ICP and ICS colleagues in undertaking collaborative and system leadership training opportunities	**Completed**
	Health & wellbeing conversations are embedded as a regular part of appraisal and employee / leader conversations, supported by LCH leadership training	**Completed**			
Foundations	Service specification with KPIs is in place for Resourcing, Workforce Information and HR A new people dashboard has been created enabling you to see either high-level or granular detailed data at a glance, around the Well-Led measures	**In progress**	**Foundations**	Core KPIs including "time to recruit;" "average length of formal ER case" are met and within benchmarked norms	**In progress**
	A co-produced Organisational Training & Development offer and approach is in place, in partnership with QPD	**Completed**			

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	**Report to:**	Trust Board 6 November 2025
Date of Meeting:	23 September 2025	**Date of next meeting:**	25 November 2025

Introduction

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

Alert	Action
1. *Diabetes Development – Health Equity Data* Limited progress over five years in embedding automated equity reporting within diabetes projects. Further work is underway to strengthen data use and reporting	RB to bring a citywide report in January 2026
2. *Patient Story (March 2025) – Adult Safeguarding / Patient Experience* Committee requested assurance that a clear process exists for managing complex patient experience cases and outcomes.	SS to prepare a report on complex cases to provide assurance due January 2026
3. *Clinical Patient Safety Training – Assurance Paper* A paper on clinical training has been requested to provide assurance on current arrangements and improvements. The paper is being reviewed through QAIG and Q&V Transformation and will be presented to the next Quality Committee	LU paper being brought to next QC
4. *QAIG – Key Issues for Escalation* The AAA report was not finalised in time for the Committee meeting. The Committee Chair expressed frustration at the delay in receiving the report.	LU to bring retrospective report to next QC
5. *Quality and Value – Equality Impact Assessment (EQIA)* Committee noted limited assurance regarding understanding and use of data in EQIA processes to inform decision-making. Further work required to embed robust data analysis across the organisation.	SP/DB/RB Further update to be presented to the Committee in January 2026.

Advise

- *Police Custody – Halifax Improvement Plan*
  The Committee received an update on the improvement plan following an inadequate Quality Walk and a Regulation 28 notice at Halifax Police Custody.

Committee Escalation and Assurance Report

Progress has been made, with improvements recognised by Police Service inspectors. Key risks remain around vacancies, sickness, and support for a non-FME model. A further Quality Walk is scheduled for October 2025, with outcomes to be reported via QAIG.

- Performance Brief – This was a review for data in August 2025. All elements were discussed in Safe, Caring, Effective and Responsive. Discussion points around.
- *Winter Planning – Flu* - Robust plans in place for the 2025–2026 staff flu vaccination campaign.Covid-19 vaccinations not offered by the Trust as per NHS England policy; staff supported to access via their GP.
- Mortality: Data narrowed for audit requirements; full detail to be included in annual report.
- Patient Safety: Conflicting information with Mortality report on deaths attributable to Trust care to be investigated.
- IPC BAF: Improved assurance on FIT testing; new partial compliance identified on water and ventilation—further assurance to be provided in next report.

Assurance

Safeguarding and IPC Annual Reports

- Safeguarding: Future reports to include data on equity impact (e.g. Mental Capacity Act) and clearer articulation of key risk areas.
- IPC: Training compliance at 91%; strengthened collaboration with the Director of Public Health; FIT testing now in a more assured position.

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 newly 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** **See above comments in report**
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	16 (extreme)	Reasonable	• QAIG AAA report – no report provided • EQIA Q&V report – limited assurance

Committee Escalation and Assurance Report

to preventable harm, poor patient outcomes, and a diminished patient experience.			
Risk 2 Failure to respond to increasing 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	• National Oversight Framework – limited assurance • EQIA Q&V report – limited assurance • PSIRF discussion deferred to November
Risk 3 Failure to implement the digital strategy. 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.	12 (high)	Reasonable	N/A
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	N/A
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.	12 (high)	Reasonable	N/A

Author:	Lynsey Ure/Ian Lewis
Role:	Executive Director of Nursing and AHPS/Committee Chair
Date:	21/10/2025

Agenda item:	2025-26 (12)

Title of report:	Infection Prevention and Control (IPC) Annual Report 2024-2025

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

Presented by:	Lynsey Ure, Executive Director if Nursing and AHPs					
Prepared by:	Liz Grogan: Deputy DIPC and Head of IPC					
Purpose: (Please tick ONE box only)	Assurance ☒		Discussion		Approval ☒	

Executive Summary:	To inform the LCH Quality Committee of the achievements within Infection Prevention and Control during 2024-25 and provide assurance of the overall compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, in line with the 10 criterion. The report provides an overview of the collaborative work throughout the Leeds system, as part of the cooperation partnership agreement with Leeds City Council.

Previously considered by:	Quality Committee 29th 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?	Data around HCAI is provided within the report for example MSSA and some of the activities we undertake within the service around system work and engagement with underrepresented communities, with specific emphasis on our upstream approach to support those living in the most deprived communities, having a greater risk of infection and

				increased usage of antibiotics.
	No	☐	Why not/what future plans are there to include this information?	To develop more on staff equity as part of the IPC Annual Report.

Recommendation(s)	• Note contents of the report and approve publication.

List of Appendices:	• The Leeds Community approach to IPC • Celebrating what we do • External system work • IPC Board Assurance Framework

Executive summary

The report covers the period 1st April 2024 to March 31st, 2025, and provides information on:

- Compliance with the outlined criterion of the Health and Social care Act 2008.
- Healthcare Associated Infections (HCAI) statistics and surveillance.
- IPC activities undertaken within the organisation and collaboratively with partners across the healthcare economy inclusive of the cooperation partnership agreement and additional commissioned services.
- Description of the (IPC) arrangements including governance structure.
- Forthcoming IPC programme 2025/26.

The following are key elements of the infection prevention activity and performance during the period of April 2024 to the end of March 2025.

- The Trust has had zero meticillin-resistant *Staphylococcus aureus* (MRSA) assigned bacteraemia cases during the year; however, learning has been identified through the Patient Safety Incident Response Framework (PSIRF) process.
- The Trust has had zero assigned *Clostridioides difficile* case during the year, however learning has been identified through the Patient Safety Incident Response Framework (PSIRF) process.
- The Trust has had zero assigned *Escherichia coli* (E. Coli) gram negative bacillus bacteraemia case during the year; however, learning has been identified through the Patient Safety Incident Response Framework (PSIRF) process.
- The Trust has achieved 91% of all staff members being up to date with statutory and mandatory Infection Prevention and Control training for level 1 and level 2.
- The Trust achieved 49% of front-line staff vaccinated against influenza, which whilst is a decrease on last year's percentage, we have continued to be top community provider in West Yorkshire Integrated Care System (ICS) which emphasises the reduced level of uptake regionally.

Main issues for consideration

- Continued expansion to the 'Cooperation Partnership Agreement' between LCH and LCC for IPC provision and restructuring of the IPC Service.
- Successful implementation of the Patient Safety Incident Response Framework (PSIRF) and collaborative work with provider organisations.
- The continuation of surveillance of HCAI's including methicillin-resistant *Staphylococcus aureus*, *Clostridioides difficile* and *Escherichia coli.*
- The continuation of evolving health inequalities throughout the population we serve that impact on the health promotion in relation to IPC.
- Continuation of the collaborative working that IPC have made with partners across the city and wider, inclusive of the Partnership Cooperation Agreement with Leeds City Council and the support in relation to adult social care within the system.
- The continuing difficulties that the team face in achieving the 90% target for the seasonal staff influenza programme.
- Work completed around antimicrobial resistance, sustainability and sepsis prevention.

Recommendations

Quality Committee is recommended to note the contents of this report and approve its publication

NHS
Leeds Community Healthcare
NHS Trust

Infection Prevention and Control (IPC)

Annual Report

2024 – 2025

Figure 1: Images of IPC Conference, Sepsis Awareness, Breeze Events, Winter Vaccination Programme.

Report compiled by Head of IPC and Deputy DIPC with contributions made by members of the IPC Team.

Executive Summary

This document forms the Infection Prevention and Control (IPC) annual report on Healthcare Associated Infections (HCAI) within Leeds Community Healthcare NHS Trust (LCH).

The publication of the IPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability, in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance.

The aim of this report is to provide information and assurance to the Board that the Infection Prevention and Control Team (IPCT) and all staff within the Trust are committed to reducing HCAI's and that LCH is compliant with current legislation, best practice and evidenced based care in line with Care Quality Commission (CQC) criterion and the Health and Social Care Act (2008, 2022) and the National Infection Prevention and Control Manual (NIPCM, 2022).

Key Achievements 2024/2025

During the past year the Trust has maintained and achieved in the following areas:

- Continuing compliance with the CQC criterion relating to Infection Prevention and Control (IPC) and Board Assurance Framework.
- Hugely successful collaborative working across the healthcare system and working towards the Partnership Cooperation Agreement with Leeds City Council.
- Continued funding capacity from Leeds City Council to deliver the Cooperation Partnership Agreement.
- Increased activity with the winter vaccination programme of work for influenza. We vaccinated 49% of frontline staff overall with a noted reduction of 9% uptake from 2023/2024. Despite this reduction, the Trust achieved the highest rate of staff flu vaccination in the West Yorkshire Integrated Care Board (ICB) area.
- Digitalisation of Fit Test App with Coreshare that has been started and is due to be finished 2025/2026.

Key Risks

- Major infection/outbreak/pandemic – this is a risk for any service. There were several outbreaks of infection this year throughout the healthcare economy including measles, and 'High Consequence Infectious Diseases' (HCID) such as MpX, and Avian Influenza.
- Assurance around effective cleaning in line with the National Cleaning Standards from third party organisations where LCH provide healthcare services (Risk 1066).
- Assurance around Water Safety, Ventilation and the Built Environment.
- Funding risk from Leeds City Council in relation to the cooperation agreement.

Key plans for 2025/26

The IPC programme aims to continuously review and build on existing activity. This is driven by local needs, whilst incorporating and complying with the latest Department of Health (DH), UK Health Security Agency (UKHSA) and relevant strategy and/or regulation(s). Key priorities for 2025/25 are as follows:

- Collaborate with the Leeds Healthcare economy on the implementation of a work plan to reduce the number of Gram-negative E. coli bacteraemia and aim to reduce incidence by 10% in accordance with Department of Health and NHS England. We continue to maintain a zero tolerance to preventable healthcare associated infections such as MRSA *and Clostridioides difficile (C.Dif)*.
- Continue education on the standards relating to antimicrobial stewardship guidance in line with the UK's five-year national action plan.
- Co-ordinate an occupational winter vaccination campaign and improve uptake by 5%.
- Continue to promote knowledge and compliance with hand hygiene practice and other standard infection control precautions through education, increased audit activity, risk assessment and planned action in relation to environmental or cleanliness issues.
- Work collaboratively across the Leeds Healthcare Economy to support staff to identify correct detection, reporting and management of sepsis; with an emphasis on improving awareness of sepsis signs, symptoms and management.
- Continue support and guidance in relation to key risks identified; provide assurance in line with the national cleaning standards and build upon pandemic preparedness with LCH emergency planning.
- Amend the terms of reference for the governance of the IPCG, with the DIPC chairing the group from April 2025.

Cooperation Agreement with Leeds City Council main deliverables 2024/25:

- To deliver a safe, integrated and effective system of IPC in place for the wider community across Leeds
- To ensure LCH is meeting its statutory obligations regarding Infection Prevention control as detailed in the Health and Social Care Act (2008)
- To establish and maintain effective partnerships ensuring a robust, flexible and responsive IPC across LCH and wider community of Leeds
- To deliver a timely and effective response to outbreaks or incidents of infectious disease as directed by the outbreak control team
- To support a year-on-year reduction in Health Care Associated Infections (HCAI) both within LCH provided services and the wider community healthcare economy, in line with locally / nationally agreed performance targets
-
- To deliver a continued improvement in IPC standards both within the wider community healthcare economy and LCH managed activities.
- To enable both parties to work with partners across the whole health and social care economy to reduce and manage incidents and outbreaks of infection with the intention of reducing the adverse impacts of HCAI and communicable disease both to the individual and wider community
- To work flexibly and ensure the ability to respond to emerging infections and health care associated infections in line with national policy and guidelines
- Increase capacity and capability of existing LCH Infection Prevention Service to ensure there is sufficient capacity to implement contact tracing alongside partners in the system and provide expert resource and safely manage outbreaks in the Leeds community.

- Manage local outbreaks of Covid-19, influenza and other infections in complex settings (for example, care homes/ schools / hostels) in line with system partners.
- Collaboratively provide direct infection prevention and wider support to complex groups and households.
- Provide preventative, proactive training, advice & guidance (e.g., care homes, schools/ workplaces, hostels) regarding infection control.
- Conduct local engagement & intelligence gathering (e.g., Voluntary Community Sector/ LA front-line e.g., home carers).
- Participate and play a lead role in system wide discussion around roles and responsibilities in relation to Covid-19 and other outbreaks of infection of concern such as influenza
- Increase the provision of Infection Prevention and Control (IPC) training (increased frequency and additional training requirements including PPE, COVID specific topics, new updated evidence) to care homes using innovative ways of ensuring delivery.
- Monitor and report monthly on numbers of training and evaluations in addition to the core contract.
- Increase the provision of IPC training to homecare and other community settings such as luncheon clubs using innovative ways of ensuring delivery.
- Continue the development and deliver an IPC package for schools and early year's settings and engaging with existing work across the city.
- Provide IPC expertise to the management of covid-19 outbreaks, influenza outbreaks and other infections of concern which are likely to be higher post pandemic.

Cooperation agreement priorities for 2025/26

- Zero tolerance to preventable HCAI's and reduction in numbers in line with NHS England /DH threshold - both within LCH provided services and the wider community healthcare economy
- Strengthening the strategic focus on the four key challenges to prevent, recognise and manage pneumonia including community acquired pneumonia, urinary tract infections (UTIs), sepsis and AMR.
- To support the wider care home economy aspiration to improve the quality of care provided to older people.
- Prevention in Specialist Inclusive learning centre (SILC schools): support wider education preventable measures in collaboration with LCC
- Education and training development
- Provide Infection Prevention leadership and expertise in outbreak and pandemic system planning
- Provide infection prevention leadership and expertise in the management of infectious disease outbreaks

1. Background

This report is a requirement under the 'Code of Practice' of which Criteria 1 states *that 'the nominated Director for Infection Prevention and Control (DIPC) is to prepare an annual report on the state of healthcare associated infections HCAI) in the organisation for which he or she is responsible and release it publicly.'* This report has been produced by the Head of Infection Prevention and Control and Deputy DIPC on behalf of the DIPC.

Leeds Community Healthcare NHS Trust recognises the obligation placed upon it by the Health Act 2006, (updated 2008, 2012, 2015 and 2022), that the prevention and control of infection continues to be a high priority for the Trust. There is a strong commitment throughout the organisation to prevent all avoidable HCAIs. In addition:

- Reporting requirements for the annual report are pre-set by the Department of Health.
- The Trust has registered with the CQC as having appropriate arrangements in place for the prevention and control of healthcare associated infections.

1.2 Infection Prevention and Control Board Assurance Framework (BAF)

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains the responsibility of the organisation and all registered care providers must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the 10 criteria outlined in the Act. The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format (Appendix 4)

The compliance rating column allows for the selection of a RAG rating for each criterion:

Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
Criterion 3	Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance
Criterion 4	Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion
Criterion 5	Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.
Criterion 6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
Criterion 7	Provide or secure adequate isolation precautions and facilities
Criterion 8	Provide secure and adequate access to laboratory/diagnostic support as appropriate
Criterion 9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections
Criterion 10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them.

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for Infection Prevention and Control. The DIPC has overall responsibility for the control of infection and this role is undertaken by the Executive Director of Nursing and Allied Health Professionals (AHPs) and was taken over by the Deputy Director of Nursing in August 2024. The DIPC attended the Trust Board meetings with detailed updates on infection prevention and control and escalations as required and from August 2024 escalations were made to the Executive Director of Nursing and AHP's and the Chief Executive.

The Trust Infection Prevention and Control Group (IPCG) is held quarterly and is chaired by the head of IPC and Deputy DIPC. IPC performance and concerns are escalated at the quarterly 'Quality Assurance Information Governance' (QAIG) meeting. The IPC service is provided through a structured annual programme of work which includes expert advice, audit, teaching, education, surveillance, policy development and review as well as advice and support to staff, patients and visitors. The main objective of the annual programme is to maintain the high standard already achieved and enhance or improve on other key areas. The programme addresses national and local priorities and encompasses all aspects of healthcare provided across the Trust. The annual programme is agreed at the IPCG. The proposal for 2025/2026 is for the DIPC to chair the IPCG and for this to be moved to a committee meeting, with an escalation report to go to Quality Committee.

The 'Partnership Cooperation Agreement' and annual IPC plan will be monitored through quarterly cooperation review meetings with a governance structure in place, as well as the Infection Prevention and Control Committee (IPCC) and the Quality Assurance and Improvement Group (QAIG). Figure 1 outlines several internal and external IPC related meetings.

Quarterly Meetings	**Monthly Meetings**
IPCG (LCH)	Clinical and Corporate Policy Group (CCPG)
Attendance at HCAI Meeting (Citywide)	
Attendance at Health Protection Board (LCC led)	**Annual**
Cooperation Review Meeting (LCC/LCH)	IPC Annual Report for approval
Attendance at Quality Assurance Information Governance (QAIG) LCH	IPC Annual Plan for approval
Attendance at Health and Safety Group (LCH)	Cooperation Agreement Governance Annual Review (LCC/LCH)
Attendance at Water Safety Group (LCH)	
Antimicrobial resistance (LCC/ICS)	

Figure 1: Governance Meetings

The IPC Board Assurance Framework has been completed by the Head of IPC and shared with Quality Committee and the Board on a six-monthly basis. Gaps in compliance are highlighted with clear actions in addition to the annual programme of work.

Performance

2.1 Surveillance of Healthcare Associated Infections (HCAIs)

This section of the annual report provides insight into the current Healthcare Associated Infection (HCAI) burden and actions taken to improve practice and patient safety. The following organisms are subject to NHSE mandatory reporting: Meticillin-resistant Staphylococcus aureus bacteraemia (MRSA), Meticillin-sensitive Staphylococcus aureus bacteraemia (MSSA), Clostridioides difficile, and Gram-negative bloodstream infections (Escherichia coli, Klebsiella species, Pseudomonas aeruginosa).

Although there are no specific government reduction targets for community care organisations for the incidence of MRSA and CDI, LCH has worked within locally agreed targets for a number of years. These targets included no more than 2 cases of MRSA bacteraemia and 3 cases of CDI being directly attributed to LCH, where a multiagency review identifies learning from Patient Safety Incident Response Framework (PSIRF) in care that have directly contributed to the infection episode and themes are identified.

2.2 Introduction of Patient Safety Incident Response Framework (PSIRF)

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents,
- Application of a range of system-based approached to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

PSIRF replaces Root Cause Analysis and Post Infection Reviews. It involves the application of a range of system-based approaches to learning from patient safety incidents including healthcare associated infections.

2.3 MRSA

The purpose of the PSIRF is to deliver zero tolerance on MRSA blood stream infection (BSI), to identify how each case of MRSA Blood Stream Infections occurred and identify any learning that may prevent infection reoccurring in the future.

During the reporting period, nine MRSA BSI cases were classified as Community Onset - Community Associated (COCA), reflecting an increase of six cases compared to the previous year.

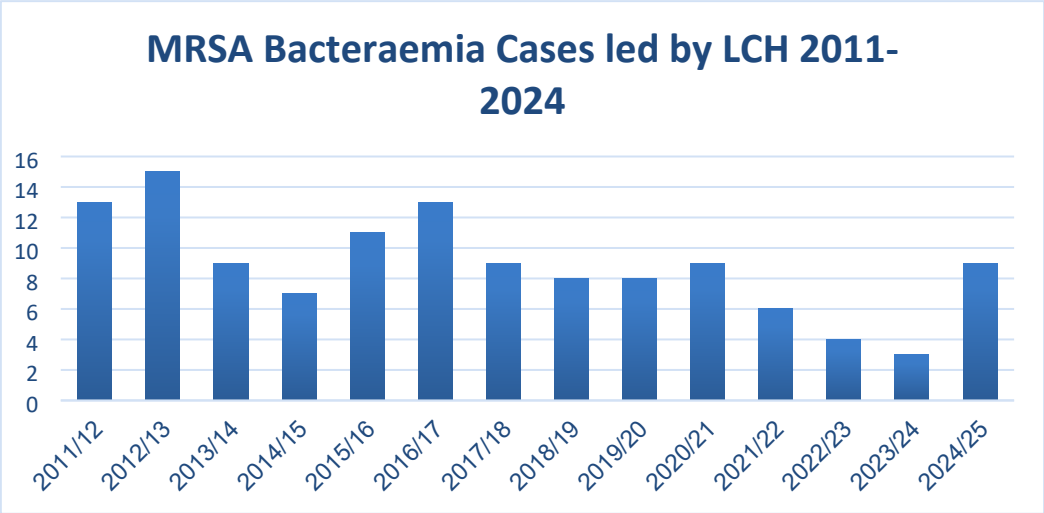


Fig 2: Annual MRSA Bacteraemia cases identified within 48 hours of admission to Secondary Care (2011 – 2025)

Two of the MRSA BSI cases involved the same patient, with the MRSA bacteraemia recurring six months after the initial episode due to ongoing infection- spondylodiscitis with associated epidural abscess. The recurrence of the MRSA bacteraemia did not necessitate a repeat investigation, as no new opportunities for learning were identified. The Community IPC team conducted eight post-infection reviews following the PSII framework, with the two bacteraemia's from Q4 still being reviewed.

None of the six completed MRSA BSI cases have been attributed to LCH and all are considered to be unavoidable. Most of these cases originated from the skin, either from a suspected minor cut or injury or confirmed skin damage and cellulitis. However, when the point of entry was not confirmed, the source of the bacteraemia was documented as unknown. Four of these bacteraemia's progressed to invasive infections: two developed osteomyelitis of the leg, one developed empyema and one developed spondylodiscitis. Including the two cases still under review, three deaths occurred following the identification of the MRSA bacteraemia.

Out of the eight MRSA BSI cases, five were identified to have LCH involvement. Three of these cases were known to Leeds Community 0-19 service as involving children and young people of 18 years of age and under, who have been supported by the service as part of the healthy child pathway. Notably, in all three cases, the isolated MRSA strain was a PVL (Panton-Valentine Leukocidin) strain. The other two cases had received care by the LCH CUCS and the Podiatry team, respectively.

Positive learning was identified from the PSIRF investigations and shared with the with the service involved.

2.3 Clostridioides difficile (CDI)

All community apportioned CDI cases identified as Community Onset, Community Associated (COCA) or Community Onset, Indeterminate Associated (COIA) are reviewed by the LCH IPCT. The IPC team provides all patients, who have been sampled by the GP, with a CDI information leaflet and identifying card to share their status with health care professional. Where prescribing deviates from Leeds Health Pathways, the Leeds Branch, West Yorkshire ICB Medicines Optimisation Team will also review the case and liaise directly with the respective GP practices.

A rapid review is undertaken where the episode of infection is identified as part of an outbreak, when the patient is identified within an LCH inpatient area, or when CDI is a contributing factor (noted as 1a,b,c of the death certificate) in the death of the patient.

There were 86 community-apportioned CDI cases during the reporting period. This represents an increase of 26 cases compared to 2023/24, which recorded the lowest number of community-apportioned CDI cases since 2015.

	Quarter 1 2024 – 25			Quarter 2 2024 – 25			Quarter 3 2024 – 25			Quarter 4 2024 – 25			Year Total
	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
COCA	2	4	3	13	8	2	8	6	4	5	5	2	62
COIA	2	3	4	1	3	0	0	2	2	3	2	2	24
Total Community attribution (COCA + COIA)	4	7	7	14	11	2	8	8	6	8	7	4	86
Cases attributed to LCH	0	0	0	0	0	0	0	0	0	0	0	0	0

Fig 3: C. Dif Cases during 2024/25

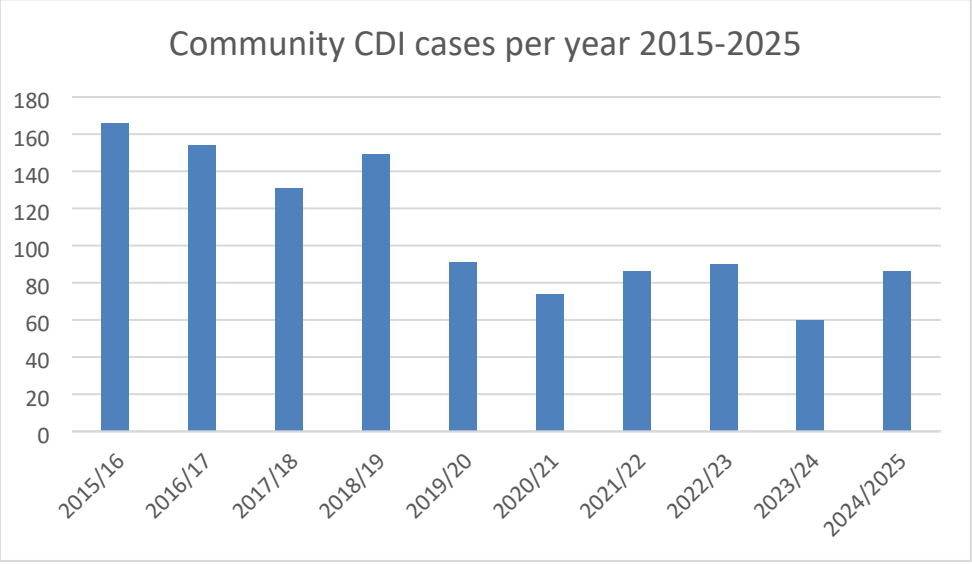


Fig. 4: Community onset CDI cases identified each year 2015 – 25

Following the implementation of the revised RCA process, 33 community-apportioned CDI cases were identified as requiring further investigation- 31 had LCH involvement and 3 were care home residents. None of the cases were attributed to LCH, however system wide learning was identified and shared with relevant areas.

2.4 Gram Negative Blood Stream Infections (GNBSI)

LCH continues to work towards the national ambition of reducing the number of healthcare-associated GNBSI by 50% by 2024 as per The UK's five-year national action plan (HM Government, 2019, 2022).

	Quarter 1 2024 – 25			Quarter 2 2024– 25			Quarter 3 2024– 25			Quarter 4 2024– 25			Year Total
	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Community E. coli cases	23	35	32	39	41	50	43	33	31	35	30	36	428
Community Klebsiella cases	10	8	7	9	11	9	10	10	14	6	5	7	106
Community Pseudomonas cases	0	2	0	2	3	2	2	2	0	0	2	2	17

Fig. 5: GNBSI Cases 2024/25

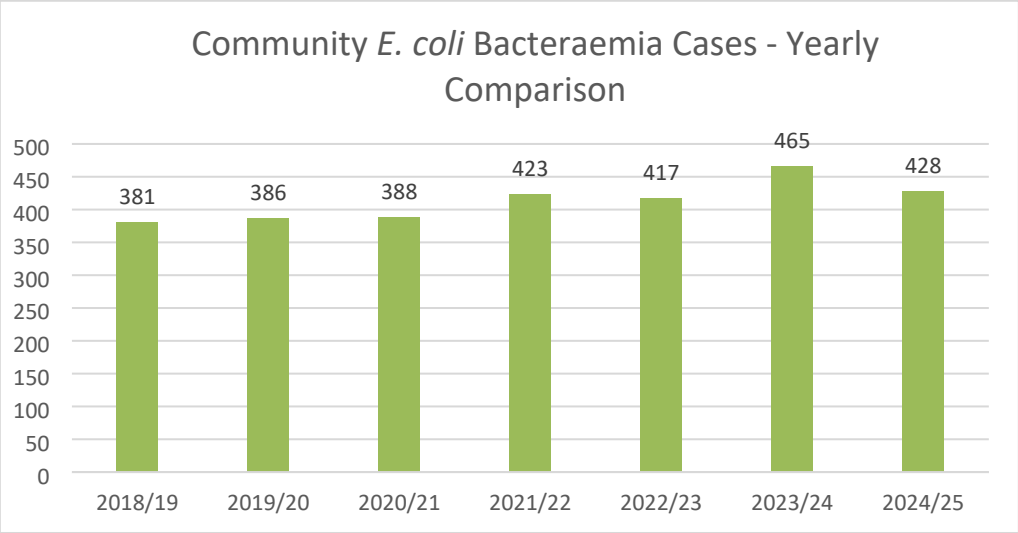


Fig. 6: E. coli combined figures 2023/25.

All community onset community acquired (COCA) E. coli BSI cases are subject to some information gathering (likely source, geographical location, age, community care involvement). Any E. coli BSI cases where a patient has died and E. coli is listed as either 1a or 1b on their death certificate, and the patient is known to either LCH services or a resident of a care home, undergo further investigation.

A total of 428 E. coli BSIs were reported which is 14 fewer than the previous year, alongside 106 Klebsiella spp. BSIs and 17 Pseudomonas aeruginosa BSIs.

2.5 Discussions and Actions of HCAI activity

- Throughout this year, the IPC team has continued investigating MRSA BSI cases using PSII documentation. A key aspect of this process has been the involvement of the patient and their family, allowing them to ask questions and provide feedback related to the incident. This has contributed to improving the quality of care provided.

- Over the past year, the patient safety staff within the IPC team were invited to attend PSIRF training sessions organized by the Health Services Safety Investigations Body (HSSIB) to help build the skills necessary for their role.
- PSIIs conducted in 2024/25 have continued highlighting concerns that signs of patient deterioration are being missed. In response, the LCH Community Sepsis and Deteriorating Patient Nurse has started working with LCH community services to improve the recognition of sepsis signs and symptoms, and this work will continue.
- During the summer months of 2024, LCH IPC colleagues supported the Breeze events taken place across various areas in the city to promote key IPC messages, including hand hygiene to prevent infections, AMR, sepsis, *E. coli* infections and the importance of hydration -especially during the summer-, awareness of measles and pertussis. As these were family-friendly events, there was an opportunity to engage young children, who particularly enjoyed the hands-on experiment with pepper and water, and pregnant women, emphasising the importance of vaccination during pregnancy.
- Over the past year, the IPC team has responded to outbreaks of CPE and VRE identified in wards at LTH NHS Trust by supporting patient discharges to community care settings. The IPCT provided advice to community settings on safe patient management, using individualised risk assessments to help prevent the transmission of these multidrug-resistant pathogens.
- Two COCA MRSA BSI cases identified this year were within the IVDU community. These incidents have highlighted an opportunity for the IPC team to work more closely with support services such as Forward Leeds, which assist people who inject drugs. The focus will be on preventive initiatives to reduce both MRSA BSI and other healthcare-associated infections. An IPC training session for Forward Leeds took place on 13th May 2025.
- This financial year, three cases of MRSA bacteraemia were caused by PVL strains, resulting in severe infections. Sadly, one patient passed away following the identification of the infection. Initial discussions took place with the community microbiologist and UKHSA consultant to improve communication and timely notification of PVL-positive cases to the Community IPC team and clarify roles and responsibilities around decolonisation follow-up. UKHSA has confirmed that the national guidance on PVL *Staphylococcus aureus*, initially published in 2008, will be reviewed in 2025. Further discussions were held with the LTHT IPC team to look at initiatives to improve PVL *Staphylococcus aureus* education and raise awareness among healthcare professionals and the public.
- Over the past year, the connection between the LCH and LTHT IPC teams has been re-established, with regular six-weekly catch-up meetings scheduled since November 2024. These meetings have been helpful for sharing learning from HCAI PIRs, discussing cases that require joint investigation, benchmarking processes such as PSIRF, and providing updates on infectious disease issues affecting both hospital and community settings (e.g. PVL infections, scabies, measles and multidrug-resistant organisms). The meetings also offer the opportunity to plan joint projects focused on improving education and raising awareness about various pathogens.
- As highlighted by the local GNBSI figures and the national AMR strategy, there is a continued need to focus on preventive efforts to reduce the incidence of these infections. In response, the IPC team has decided to relaunch the Gram-Negative Reduction Group in collaboration with colleagues across the system. The first meeting took place in April 2025.
- Some projects scheduled for this year, such as developing an MSSA reduction plan and supporting the Leeds Primary Care guidelines review, have been postponed due to increased workload pressures within our team caused by prolonged staff absences. Similarly, the completion of the NHS Fellowship undertaken by an IPC colleague last year, which focuses on preventing UTIs in menopausal women, has been delayed until March 2026.

2.6 Leeds Health Care Record / PPM+

The reporting of laboratory specimen results from Leeds Teaching Hospitals is informed via the Leeds Care Record (LCR) – PPM+. All MRSA positive, E. coli and CDI positive samples for patients in the LCH community setting are reported to the IPC team on a daily basis through this electronic platform.

Each result was processed by adding a high priority alert/reminder on SystmOne. An IPC information task was sent to any LCH services currently involved with the patient, identified by any services with an open referral. The result was flagged up to the patient's GP by either a task on SystmOne, or a telephone call to those using a different healthcare record system, requesting that the patient be reviewed in light of the result. If the patient was a resident in a care home or nursing home the facility was contacted to inform of the result and offered appropriate infection control advice. GPs were signposted to the MRSA decolonisation guidance, available at Leeds Health Pathways.
Leeds Care Record is a joined-up digital care record which enables clinical and care staff to view real-time health and care information across care providers and between different systems. It is a secure computer system that brings together certain important information about patients who have used services provided by their GP, at a local hospital, community healthcare, social services or mental health teams.

Primary Care Collective Action has seen a number of tasks referred to primary care being returned with a refusal to treat. As a service we have been working with Leeds Teaching Hospitals (LTHT) IPC team to identify a different process, ensuring that the patient remains at the centre of care delivery and that decolonisation and patient safety is not compromised.

2.7 Communicable Disease Control (CDC)

The CDC Team consists of 3 nurses fulfilling 1 WTE role and is based with Leeds City Council's (LCC) Environmental Health Food and Health Team. The team's purpose is to investigate, act and report on all individual cases and larger outbreaks of notifiable gastric diseases within the population of Leeds.

The team investigate, confirmed and suspected food poisonings and coordinate outbreaks of viral gastroenteritis within any establishment including Care Homes, Childcare settings, Schools, Day Centres, food premises, etc. Following a risk assessment, we might be required to visit premises who report outbreaks of gastrointestinal illness, people's own homes, and hospital wards if necessary. To provide information regarding specific illnesses, collect information and complete questionnaires to try to establish the source of the illness and where necessary, arrange faecal samples for cases and contacts for clearance and screening. The team work closely with partner agencies including Leeds City Council and UK Health Security Agency (UKHSA).

There were 259 reports of suspected food poisoning which were reported electronically, via the Food Standards Agency (FSA), or LCC self-service reporting systems, slightly less than last year's figure of 300. All suspected food poisoning reports are reviewed each day by the CDC nurse to detect any potential food poisoning outbreaks, and cases are responded to accordingly. Of the 259 reports of illness, 45 required follow up action from the CDC nurses which may have been by email, telephone contact and referral to Environmental Health Officers where necessary.

The overall number of positive isolates was slightly higher than 2022/23 and 2023/24, 1180 compared to 1113 and 1053 respectively. The table below incorporates the confirmed positive isolates identified via faecal testing at local laboratories and Colindale Central Surveillance Centre.

Organsim	Number of cases 2023-24	Number of cases 2024-25
E.coli (STEC)	18	16
Hepatitis A	5	7
Cholera	1	3
Typhoid/Paratyphoid	10	12
Cryptosporidia	87	59
Shigella	29	28
Salmonella	105	113
Campylobacter	781	866
Listeria	2	0
Giardia	73	69
Yersinia	2	4
TOTAL	1113	

Fig 7: Organisms identified through Notification of Infectious Disease Reporting 2023-24 with a comparison to 2024-25.

Positives isolates are all contacted by telephone to offer advice, information and completion of a questionnaire which is disease specific. Any connection between cases is reported to the Environmental Health response officer for further discussion/investigation as this may indicate an outbreak or poor food hygiene practices at establishments.

2.8 Significant outbreaks with IPC response

Internal to LCH

Adult Business Unit	Gastrointestinal Outbreaks: 3 reported across Meanwood, Morley, and Yeadon Neighbourhood Teams, affecting staff. Respiratory Outbreaks: 2, including one influenza outbreak at Wharfedale Recovery Hub, affecting both patients and staff. Covid-19 Outbreak: 1 outbreak in the Morley nursing team in June 2024.
Children's Business Unit	Respiratory Outbreaks: 3 in total. Two at Hannah House (1 Covid, 1 flu), and 1 Covid within the CAMHS Crisis Team affecting staff. Gastrointestinal Outbreaks: 3, including at Hannah House, CAMHS Team at the Reginald Centre, and CCN Nursing Team at a SILC site.
Specialist Business Unit	Gastrointestinal Outbreaks: 2 reported in young people's detention centres. Both were reported to IPC and managed with short durations. Respiratory outbreak: 1 reported in the Podiatry admin team

All were quickly managed with IPC guidance. IPC provided several visits to assist with PPE protocols where required and were managed swiftly with minimal disruption.

External to LCH

During 2025 the IPCT responded to a significant outbreak for measles, MpX and Avian Influenza across the Leeds system, working collaboratively with UKHSA and LCC. These infections required subject matter expertise, with proactive and timely responses to vaccination, contact tracing and relevant control measures to reduce the impact and containment of the infections. For each of these specific pathogens we received outstanding feedback from regional and national colleagues in relation to our response.

During 2024/5 the IPC team has managed and supported with 29 Covid-19 outbreaks within care home settings throughout Leeds. This activity compares to 75 Covid-19 outbreaks reported in the previous year.

During the report period, a total of 30 outbreaks of Influenza were reported (see fig below). This represents a significant increase from the previous year, where 6 outbreaks were identified. This reverse correlation between the behaviour of COVID 19 and Influenza A (see fig 9), could relate to the significant transmissibility of the strains of Influenza A circulating this year. As in previous years, some issues were identified in relation to the mobilisation of Influenza and Covid-19 antiviral medication and review work is planned with LCC and the ICB to ensure a timely and robust response from Primary Care services during outbreak situations.

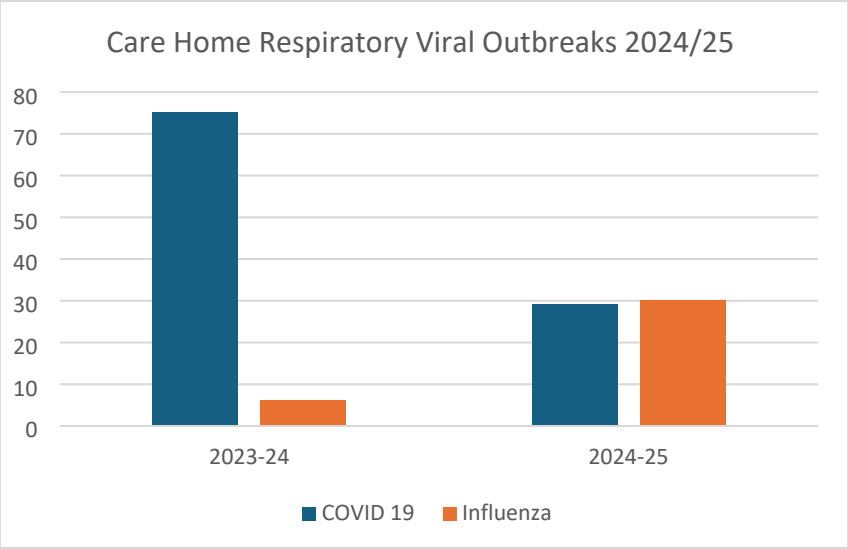


Fig 8. Care Home Influenza Outbreaks Leeds Care Homes 2023-24-2024-25

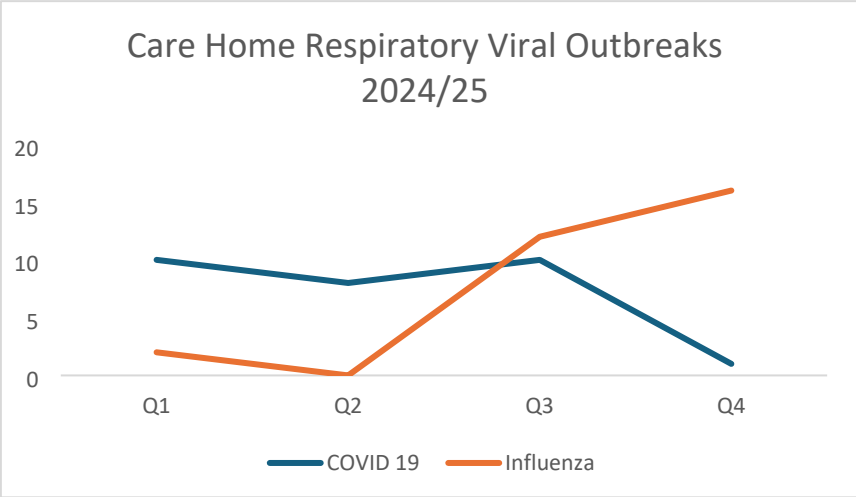


Fig 9. Care Home Respiratory Viral Outbreaks

Scabies: 6 outbreaks were reported during the year. This was the same as in the previous year and mirrors a noted national increase in cases. IPC team provided bespoke advice and site visits. The subject of scabies featured in the first IPC newsletter to be created for care homes in Q1 2025-6.

Measles: In 2024-25, the increase in measles cases across England has been notable, with 2,911 confirmed cases, marking the highest rate since 2012. The outbreak started in Birmingham and spread to London, with smaller clusters reported in other areas. Leeds experienced a significant outbreak in a small area of the city with high levels of deprivation. The IPC team worked with the school immunisation service, the local authority and other system partners to respond with bespoke vaccination and support for families who often lived in households of multiple occupancy and had low vaccination rates. Despite a decline in case numbers after mid-July, local outbreaks persisted in certain regions.

Hepatitis A vaccination: In April 2024 a small cluster of Hep A was identified in a Leeds Primary School. The IPC team working collaboratively with the school's immunisation team and attended the school over 3 days. Vaccinations were administered to 37 staff and 131 children across 6 classes and 2-year groups. This collaboration ensured timely vaccination of those at risk and ensured that the scheduled vaccination work of school immunisations could continue, otherwise routine immunisations may have had to be postponed with a future impact.

Clade 1b MpX: In November the IPCT supported with the vaccination of contacts from a positive MpX case identified in Leeds, which at the time was recognised as a high consequence infectious disease, and therefore required subject matter expertise and support in a timely manner. This case was travel related, returning to student accommodation in Leeds. UKSHA managed the contact tracing and isolation of the case and contacts, the IPC team managed vaccinations for 8 identified contacts. 2 of the contacts required an interpreter to deliver the vaccine safely. One declined the vaccine and one accessed vaccination via LTHT. This incident brought challenges with the potential risk to the wider community being of high consequence. The case and contacts were managed safely and effectively using the team Leeds approach.

Clade 1 Mpox has since been reclassified and no longer meets the criteria of a HCID. Mpox remains a public health emergency of international concern and is still an urgent notifiable disease. IPC will continue to collaborate with the team Leeds approach. UKHSA have identified LCH as a regional site for vaccination against the disease.

2.9 Incident Reporting – Datix

All incidents or near misses occurring in LCH must be reported through Datix® system. Those categorised under Infection Control, Sharps, or Environment (including clinical waste, domestic waste, unsafe environment), are reviewed by both a team leader/manager within the reporting area, and a specialist reviewer from the IPC team.

There were 47 incidents reported during the reporting period. This is a small increase on the total reported in 2022/23 (43).

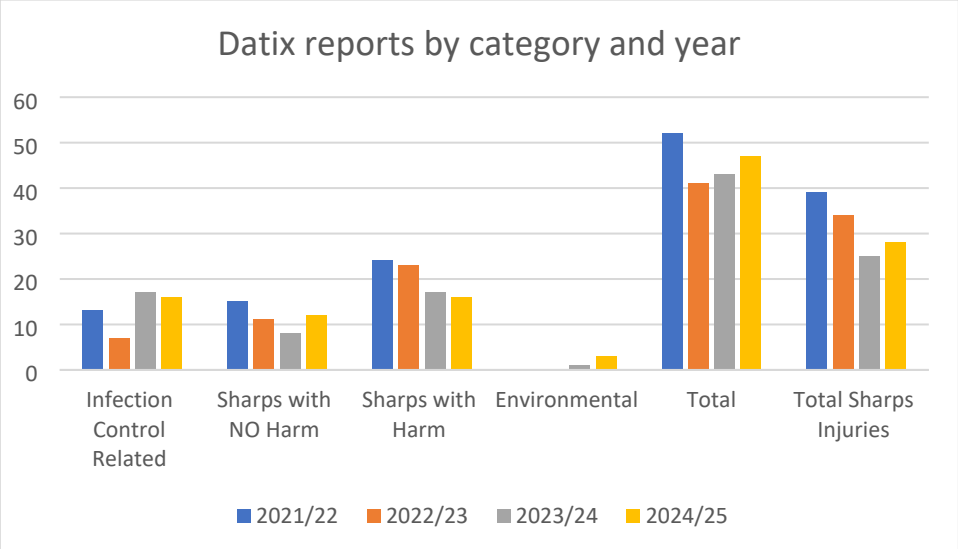


Fig. 10: Incidents in 2021/25 per category

Incident type	Q1	Q2	Q3	Q4	Total
Total Sharps Injuries (breakdown below)	4	8	7	9	28
Sharps with no harm	1	5	3	3	12
Sharps with harm	3	3	4	6	16
Infection control related incident*	7	2	4	3	16
Environmental	1	0	2	0	3
Total IPC related Datix reports	12	10	13	12	47

Fig.11: Distribution of incidents reported in 2024/25 by quarter (table).

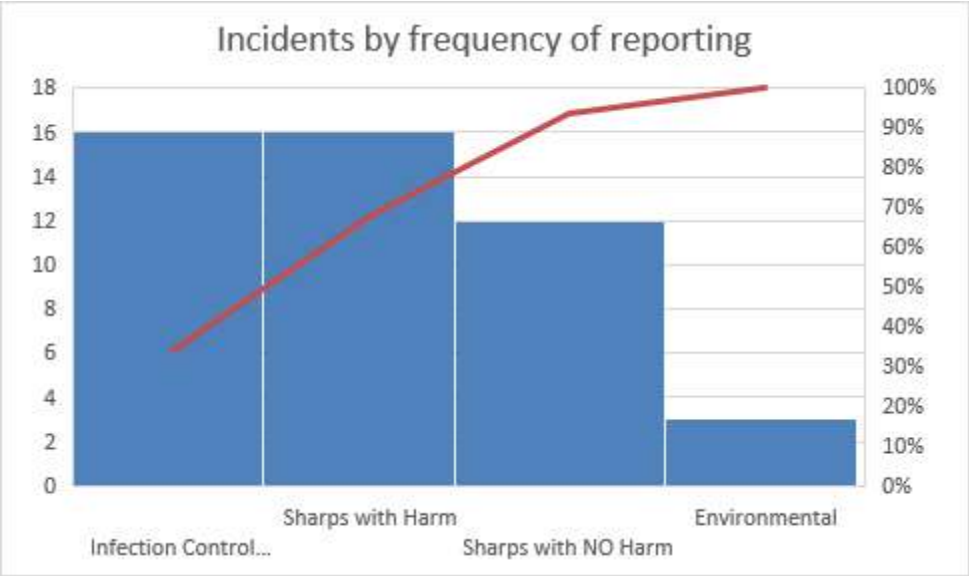


Fig 12. Pareto chart demonstrating the most frequently reported categories 2024-25.

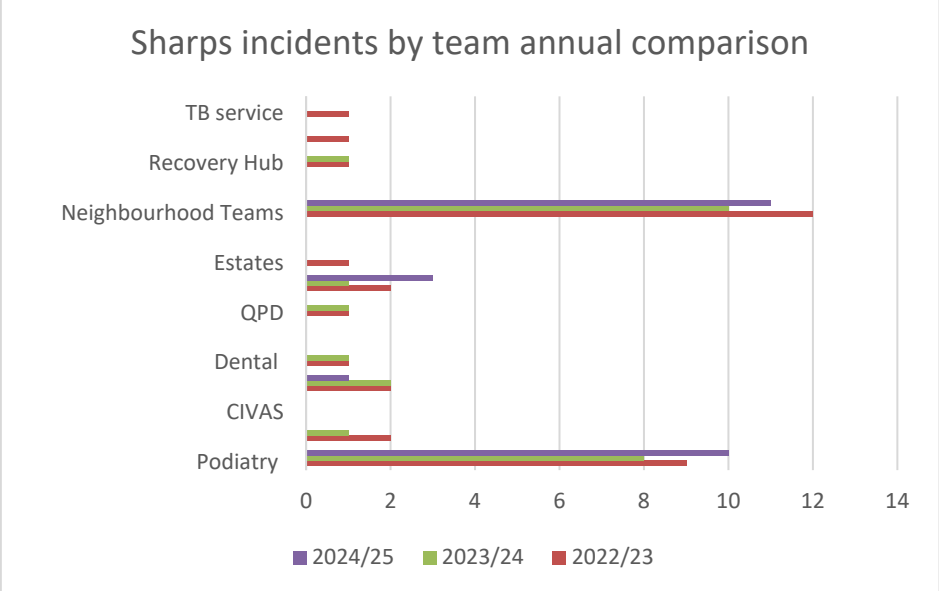


Fig. 13: Annual comparison of sharps incidents reported by team 2023-2025

Reporting of incidents is an important aspect of a positive safety culture; therefore, a reduction in incidents, especially those with no harm reported should be viewed with caution. No harm incidents present important learning opportunities, and therefore when conducting incident reduction work, those both with and without injury will still be targeted as the team works towards reducing all incidents. Sharps injuries, with and without harm remain the highest reported incidents annually on Datix, although a small reduction in incidents with harm is noted for the period 2024/25. The theme of safety devices not in use for patient's own medications (e.g., insulin pens) persists and is challenging to address where the medications are prescribed for and kept by the individual receiving them. All staff reporting sharps incidents are contacted by the IPC team and offered advice and support, ensuring that the policy for the management of needlestick injuries is followed.

The podiatry team remain high reporters of no harm sharps incidents which mainly relate to single use blades being accidentally returned to central reprocessing rather than being disposed of at the point of care. A Hierarchical Task Analysis session took place to review in detail the processes around blade management in podiatry; this resulted in some changes to

the standard operating procedure, to support staff in improving checks following each clinical episode, and when disposing of CSSD. Incidents will continue to be monitored closely to understand if this intervention has resulted in the necessary improvements.

Environmental incidents continue to be under reported and the team often become aware of these via health and safety colleagues.

2.10 Headstart

The IPC team continues to provide a specialist service for the management of head lice infestations within the community. The service offers advice, support, and treatment in cases of persistent head lice infestation, to families with social services involvement and when the carer of a child is unable to complete treatment due to a disability or condition. The main sources of referral come through health visitors and school nurses, with additional referrals via social workers, schools, community paediatricians and GPs.

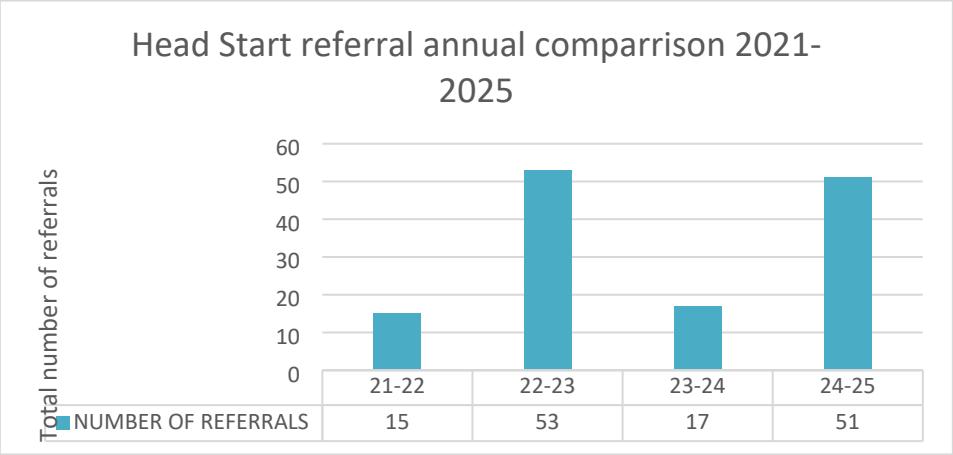


Fig. 14: Head start referral annual comparison 2021-25

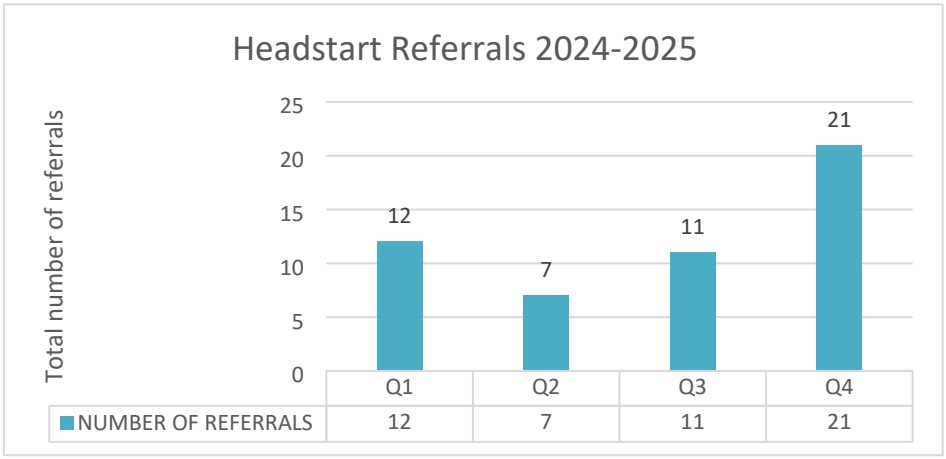


Fig 15: Head start referrals 2024-2025

The Headstart service has seen fluctuations in referrals throughout the year, with 51 referrals received this year.

2.11 Hand Hygiene Audits

LCH teams complete a quarterly hand hygiene audit for a quarter of their team using the standards for hand hygiene linked to the 5 moments and PPE.

The IPCT have worked on the tool to ensure it is compliant with the health and social care act, but also to understand levels of assurance and how these reflect day to day practice. Challenges ensuring correct practice, procedure and techniques can be influenced by to the community environment, however, this is not specific to our Trust and work is underway to provide the best assurance. The IPCT is looking to ensure that the process provides accurate assurance using a digital approach for all clinical and frontline staff to complete to improve the quality of results and the user experience.

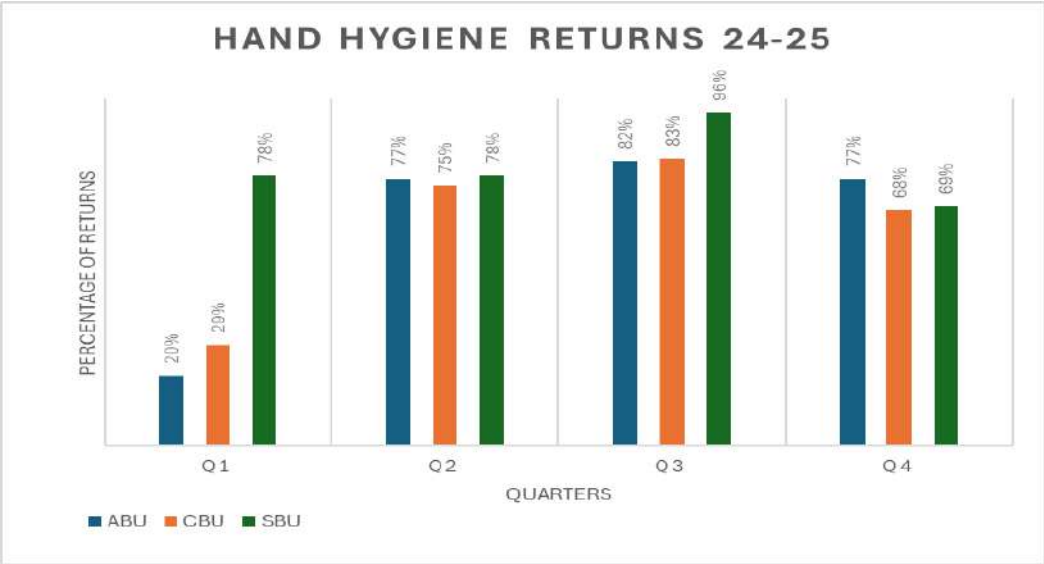


Fig.16: Hand hygiene audit returns for each business unit 2024-2025

Development work started in quarter 4 to move the hand hygiene audits into a digital capacity on Microsoft Teams, with the vision being for 2025/26 that all clinical and frontline staff will complete a hand hygiene audit in this way, which will essentially improve overall compliance and provide insight into key topics of learning for example: glove awareness, when to wash your hands etc.

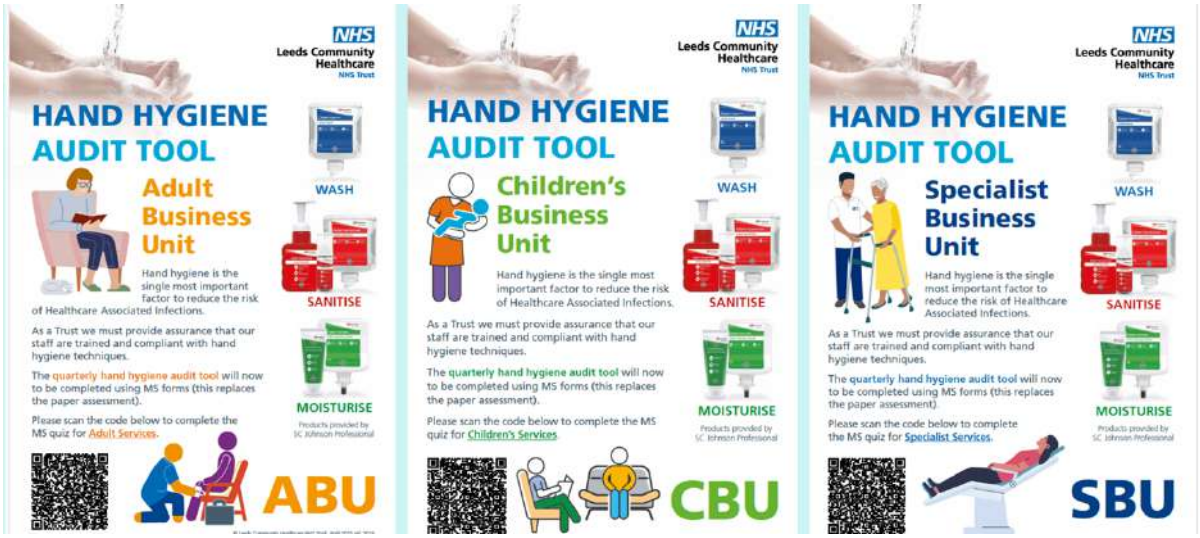


Fig.17: Hand hygiene audit tool as displayed on the Oak

2.12 Mattress audits

Mattress audits are completed quarterly at Hannah House and Wharfdale – Heather and Bilberry Wards, during 2025 – 2024. These have been completed and identified actions implemented.

2.13 Documentation audit for Wharfedale Hospital – Heather & Bilberry wards

Heather and Bilberry Wards at Wharfedale Hospital rely on IPC information included in the referral form from the transferring agency prior to accepting a patient transfer. This information is critical to enable nursing staff to conduct a risk assessment and make informed decisions on bed allocation, including the need for side rooms, ensuring the safety of patients, staff and visitors.

An audit was designed to evaluate whether IPC information is consistently received from transferring agencies, its accuracy and timeliness, and to identify any delays in its provision. A sample of 11 patient records were randomly selected over a 2-week period in August 2024.

All 11 records sampled confirmed receipt of the inter-health care transfer form. All 11 forms were sent by Leeds Teaching Hospitals Trust (LTHT) and included IPC information. 10 out of 11 forms were fully completed. 1 form was missing key IPC information.

Learning identified from the audit:

- This audit reflects strong IPC practices at Wharfedale, with staff consistently receiving and utilising IPC transfer information to inform care planning and patient placement, further enhancing patient safety.
- Staff demonstrated awareness of the need for accurate IPC information prior to admission, which is essential for effective risk assessment and prevention of infection transmission.
- Wharfedale staff found the new audit tool easy to use, supporting reliable and efficient data collection.
- Repeat audit in 12 months to monitor ongoing compliance and identify areas for further improvement.
- Feedback to LTHT regarding the single omission to reinforce the importance of complete transfer documentation.

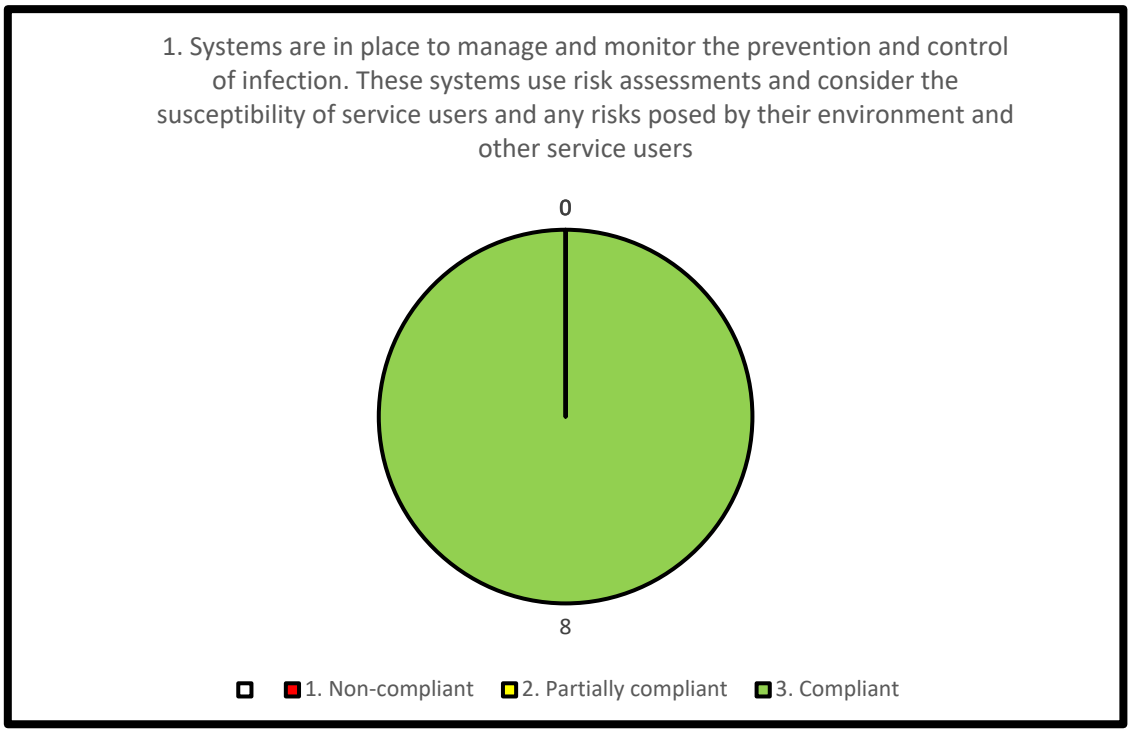


Fig. 18: BAF compliance to Criterion 1

Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

3.1 Implementation of the National Cleaning Standards

In November 2021, Leeds Community Healthcare NHS Trust (LCH) was required to implement the new NHS national cleaning standards, with full implementation by May 2023. Within LCH this requires us to fully implement the standards within the buildings we own/ clean (including tenant areas) and to ensure that our landlords have implemented the standards in the buildings where LCH is the tenant.

The audit team consisted of members of the Domestic services management team, Ops support manager and IPC staff. The audits consisted of a mixture of FR4 (clinic room) and FR6 (office) areas in line with national guidance. The results were captured on to the spreadsheets provided by NHS England and followed the guidance around blended scores.

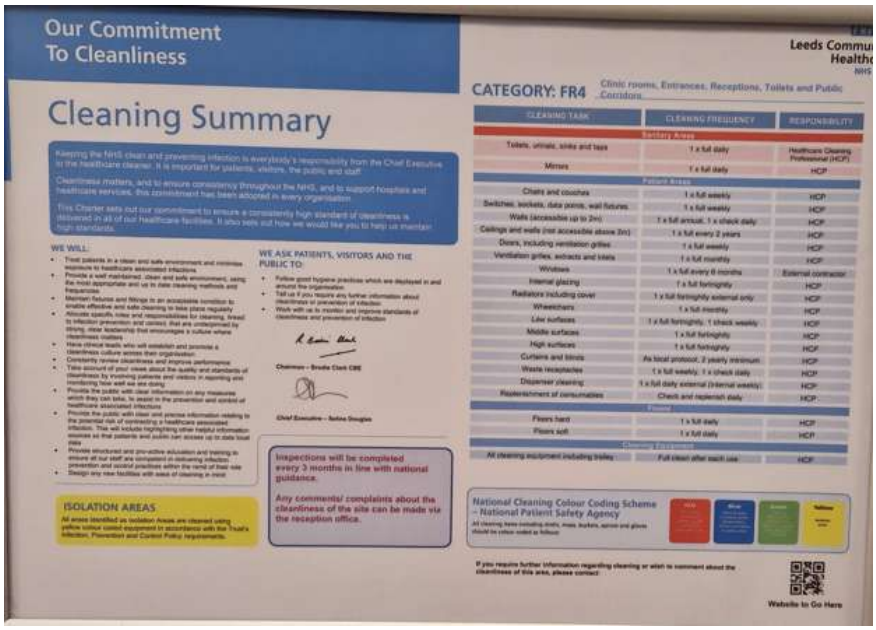


Fig. 19 and 20 example of scores on the doors

The current % average score across all sites is 88%, which for our clinical rooms is a 5-star rating. This obviously also exceeds the target for the blended scores (including FR6 areas). The cleaning standards group has refocused several times in the new year to ensure that improvement plans were in place for the sites that did not achieve 4- or 5-star ratings. The 2 sites identified below standard have been identified as Burmantofts and Morley; both have action plans for improvement and will be overseen by the cleaning team. There will also be further work carried out to prepare for the efficacy audits and annual review.

Site	FR category	Audit frequency	Target (%)	No of rooms audited	Target calculation	Max score	Actual score	% score	Stars
All sites	FR3	1 monthly	90	5	450	86	85	0.99	
	FR4	3 monthly	85	81	6885	1209	1071	0.89	
	FR6	12 monthly	75	67	5025	775	661	0.85	
	FR Blended		81						
	Total			**153**	**12360**	**2070**	**1817**	**0.88**	**5 star**

Fig. 22: Cleaning standard scores

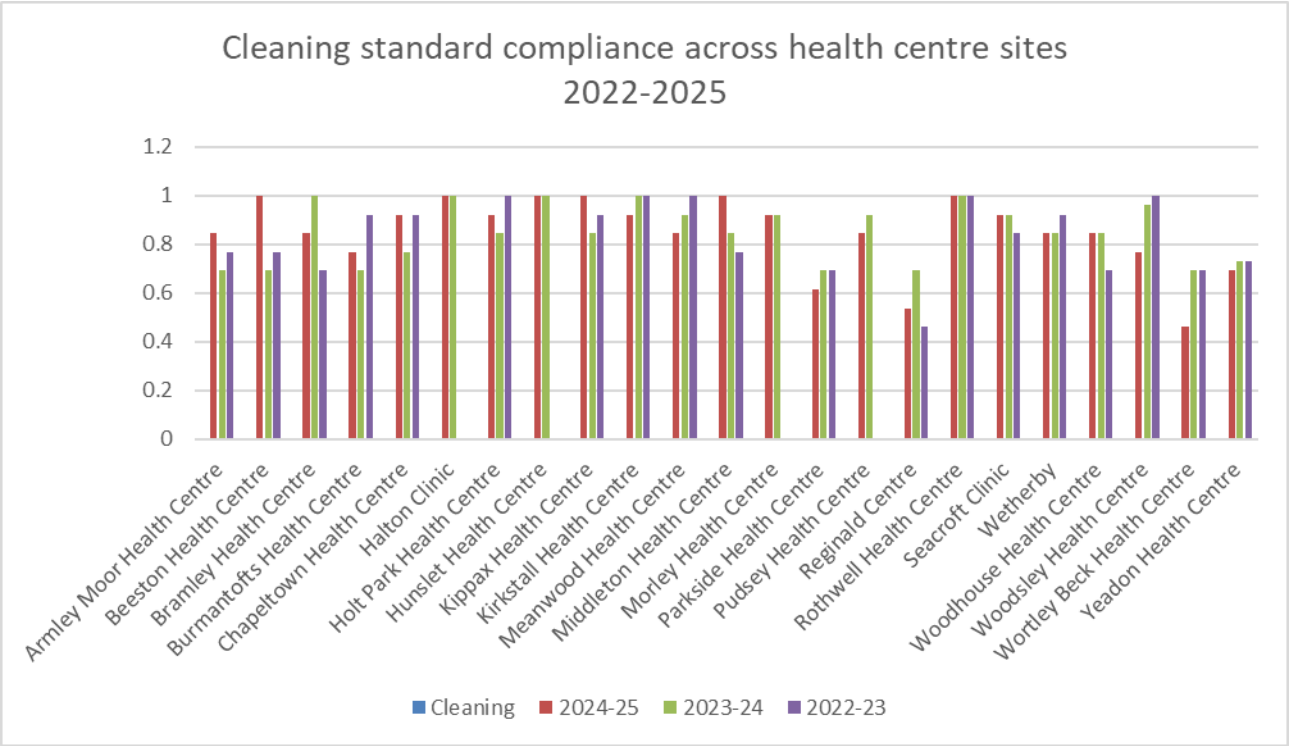


Fig. 23: Cleaning standard compliance across Health Centre sites 2022-2025

3.2 Environmental Audits

Auditing is a requirement of the Health and Social Care Act 2008, Code of practice for registered providers on the prevention and control of health care associated infections and related guidance. The code states that registered providers must audit compliance to key policies and procedures for infection prevention.

Data from the LCH auditing activity is used to applaud good practice, identify concerns and themes which are used to improve LCH environments, services and staff performance. These improvements will reduce the risk of transmission of healthcare associated infections to patients, staff and visitors.

3.3 Audit activity 2024-2025 – LCH premises

Data from the LCH auditing activity is used to applaud good practice, identify concerns and themes which are used to improve LCH environments, services and staff performance. These improvements will reduce the risk of transmission of healthcare associated infections to patients, staff and visitors.

During the 2024-2025 period a total of 52 out of 53 LCH premises were audited which comprises of 26 Health Centres and 27 other sites as listed below.

- 26 Health Centres
- David Beevers Day Unit - Dental Suite
- St George's Centre for Musculoskeletal (MSK) and Children's Outpatients
- Leeds Assisted Living Centre
- Leeds Sexual Health Service (Beeston)
- Hannah House Respite Unit for children with complex health needs
- Wetherby Young Offenders Institute (WYOI) and Adel Beck Secure Children's Home (HMPs)

- 12 Police custody suites in South, East and West Yorkshire
- 4 Specialist inclusion learning centre (SILC) schools.
- 3 Recovery hubs
- 1 MSK unit: Wharfedale Hospital
- Wharfedale Hospital – 2 in patient areas

During the report period the total average compliance score for LCH premises was 92.7% with a range of 83% to 98%. Of the 26 health centres audited only one scored below the 85% pass score (Yeadon HC: 83%). This compares to 3 sites below the 85% mark in each of the previous 2 years.

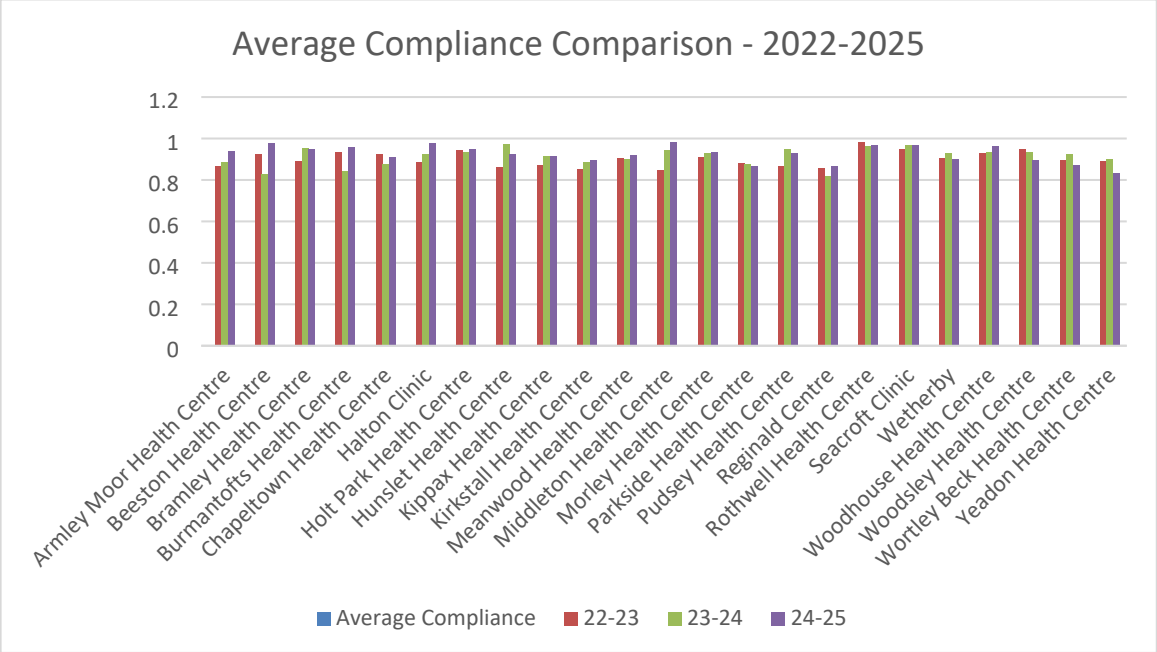


Fig 24: Average compliance comparison across all health centres 2022-2025

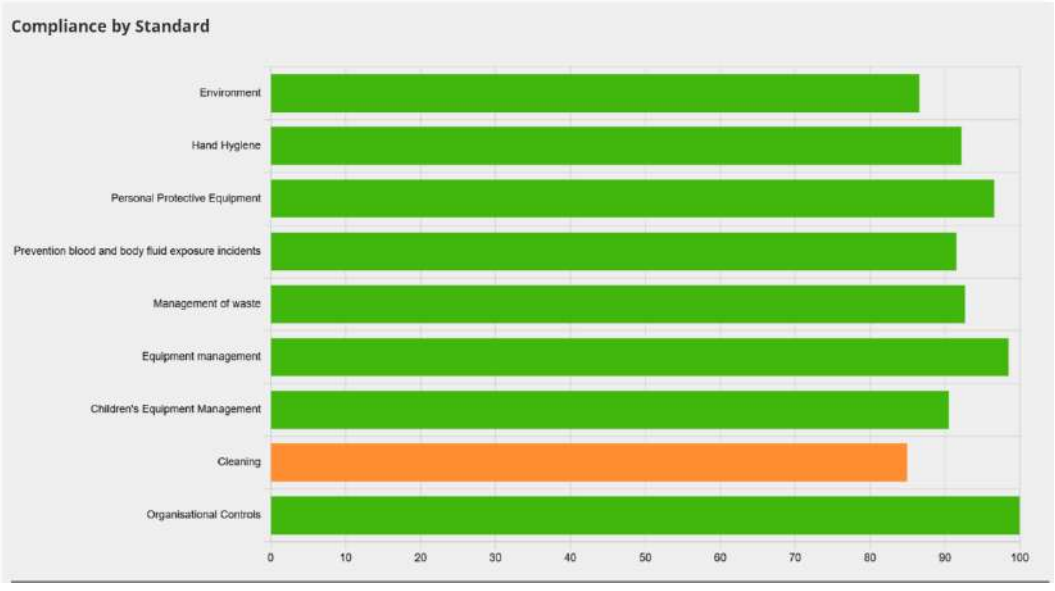


Fig. 25: Overall compliance to the different standards. Fig.20: most common issues identified

3.4 Integrated Wound Clinic Audits

During the 2024–25 period, the IPC team conducted 23 environmental audits across various healthcare settings. These included clinics directly managed by LCH as well as community-based hubs operated in partnership with voluntary organisations.
Of these 23 audits, 12 were conducted as part of the annual IPC audit programme. 11 of the sites audited were GP practices or community-based hubs, reflecting the broader scope of this year's audit activity.

Most audited sites achieved compliance scores exceeding 83%, demonstrating a high level of adherence to infection prevention and control (IPC) and environmental standards.

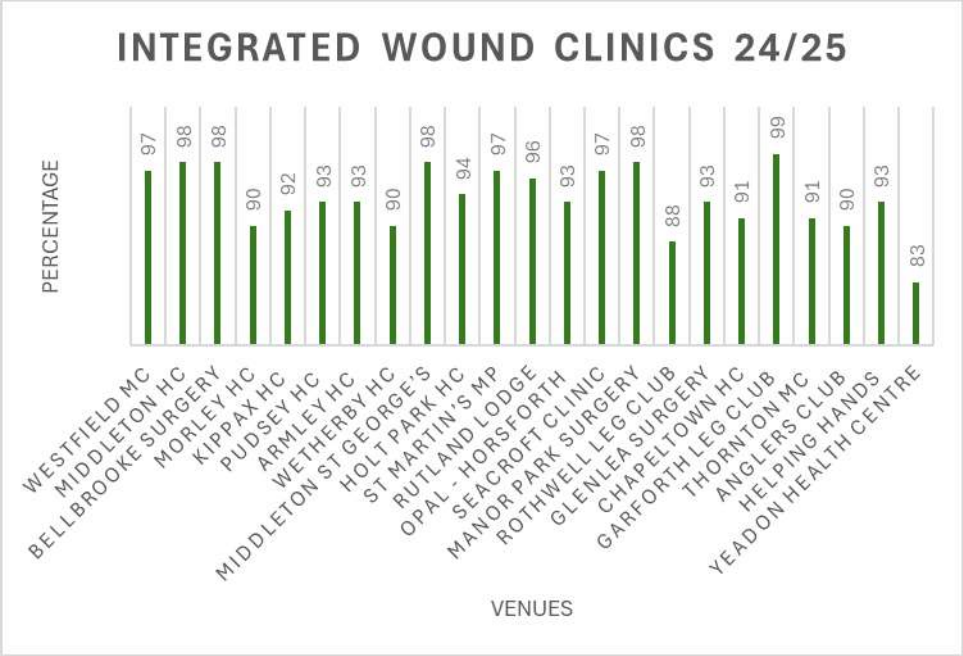


Fig. 26: Integrated wound clinic audit percentage 2024/2025

3.5 Patient Led Assessment of Care Environment (PLACE)

Leeds Community Healthcare NHS Trust had a responsibility to undertake an assessment at Hannah House, which is a purpose built self-contained 'home from home' style facility which provides planned or emergency short break care for children with complex health needs.

During October and November 2024, a group of patient representatives and members of the Youth Board visited and completed PLACE inspections at Hannah House and the two Leeds Community Healthcare (LCH) rehabilitation units, Billberry and Heather based at Wharfdale Hospital.

For the 2025 PLACE Programme, the LCH Facilities and Estates Team will be took over coordination of the inspection process. The primary focus of the assessment activity was to review the condition and cleanliness of the care environment as well as elements relating to privacy, dignity, wellbeing, food quality
disability and dementia care (Wharfdale only).

Results and comparison to 2023 PLACE inspections:

PLACE Domain	Hannah House Score	
	2023	2024
Cleanliness	97%	97%
Privacy, Dignity and Wellbeing	98%	88%
Condition, Appearance and Maintenance	96%	88%
Disability	82%	73%

PLACE Domain	Wharfedale Score	
	2023	2024
Cleanliness	100%	100%
Combined Food	81%	94%
Privacy, Dignity and Wellbeing	93%	91%
Condition, Appearance and Maintenance	98%	98%
Dementia	84%	77%
Disability	81%	85%

Fig. 27 and 28 PLACE Scores for Hannah House and Wharfdale

3.6 Waste, water and ventilation management

There is a waste manager in post for LCH who takes the lead with support from IPC on ensuring that as an organisation we are consistent with HTM:07:01, which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal. A waste and ventilation report comes to the IPCG and escalations can be raised through QAIG and the HSG.

Under the Terms of Reference, a six-monthly Water Safety Group meets which is chaired by the Senior Estates Manager. The aim of the group is to provide the framework to ensure that the Trust complies with current legislation and best practice guidelines for control of water quality and water systems across the Trust. A water engineer/specialist is contracted by LCH to provide subject matter expertise. During 2024/25 there was a period where no water safety meetings were held, which was escalated by the governance routes to the DIPC and a plan was put in place to be establish.

3.7 Central Sterile Services Department (CSSD)

The Assurance visit took place in May 2024, to Steris at Tameside. Members of dental, podiatry and IPC attended. The process was observed; however no formal audit tool is in place to capture assurance. Work is ongoing to ascertain the formal contractual arrangements between LCH and Steris. Contractual meetings were taking place prior to the covid pandemic but these have not restarted. We do have a certificate of accreditation that the company meet the correct ISO standard STERIS Certificate ISO 13485:2016 which is current.

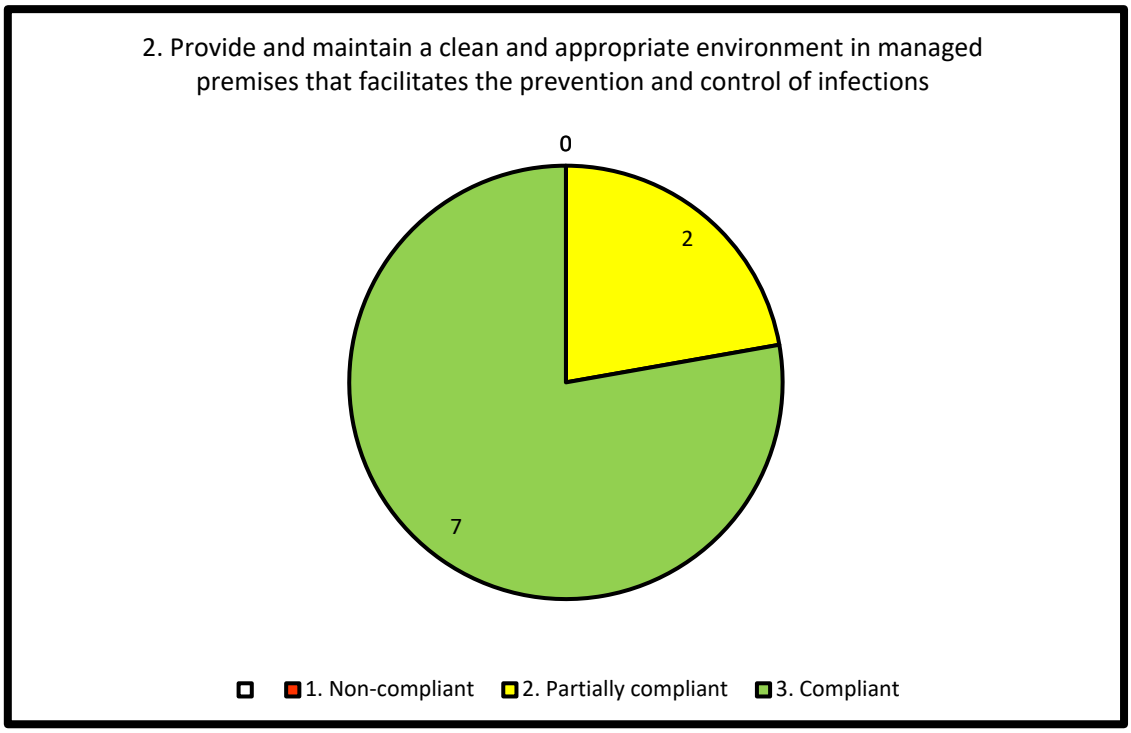


Fig. 29: BAF compliance to Criterion 2.

Partial Compliance elements:

There is evidence of compliance with National cleanliness standards including monitoring and mitigations. Whilst there is assurance for LCH, we have limited assurance for third party locations around cleaning compliance, such as Wetherby Young Offenders, Adel Beck, Custody Suites and St Georges Centre. This has been captured on the risk register.

There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in Health Building Note: 00-09.This is to be built into the IPCG and HSG to provide assurance of compliance with the relevant Health Technical Memoranda.

Criterion 3	Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance.

4.1 Antimicrobial Resistance

Antimicrobial resistance is a global public health threat, and the UK has responded to this global campaign with a series of National Action Plans and national surveillance of antimicrobial resistance patterns with key aims around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics. Leeds Sexual Health generally accounts for the majority of oral antibiotics prescribed within LCH (average 86%) per quarter.

An AMR Flash report is jointly written between the Head of Medicines Management and the Head of IPC for the IPCG and QAIG meeting that provides a highlight of the antibiotics prescribed and the reactive IPC elements that are implemented. LCH works collaboratively with West Yorkshire ICB AMR Groups which incorporates a number of elements including oral hygiene, sustainability, sepsis and blood stream infections.

AMR features as part of the National IPC Week in October 2025, where the IPC team provide key messaging as well as part of the Golden Threads Conference which was held in October 2025.

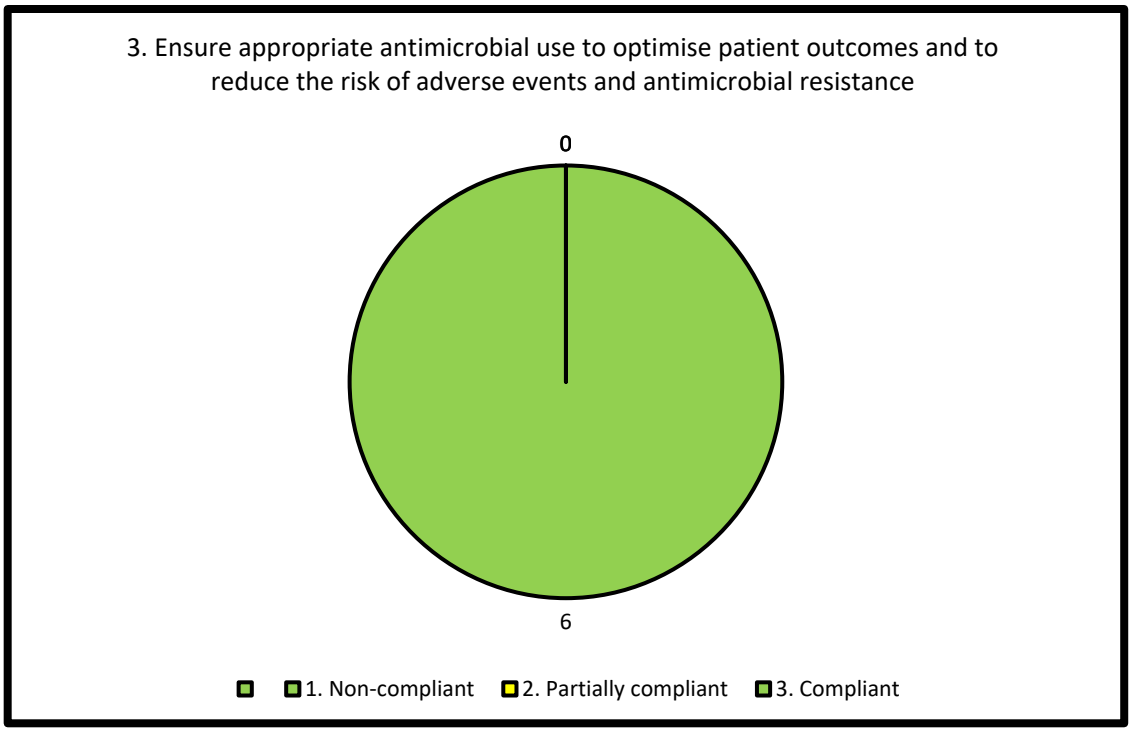


Fig. 30: BAF compliance to Criterion 3.

Criterion 4	Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion.

5.1 Conferences and awareness campaigns

Hand Hygiene Campaign May 2024

Fig. 31: 5 Moments of Hand Hygiene

For World Health Organisation, World Hand Hygiene Day 2024-25, the IPC team worked with a graphic designer in house to adapt the standard 5 moments of Hand Hygiene poster to be more reflective of the work and challenges faced in community care settings. These now include posters for visiting patient's homes, provision of talking therapy, with updates to the graphics for couches and beds reflective of LCH branding. They are all available via the IPC page on the Intranet.

5.2 IPC Week October 2024

The IPC Team celebrated a different aspect of infection prevention during October 2024, featuring different topics of engagement with staff and the public; topics included hand hygiene, sepsis, influenza and antimicrobial resistance.

5.3 IPC Oak Web Page

The LCH IPC web page provides a broad selection of information and resources to staff members, including winter vaccination, policies, hand hygiene resources, NPSA Safety Alerts, sharp safety, device related IPC measures etc. This is frequently updated to reflect the changing priorities of IPC and feature weeks.

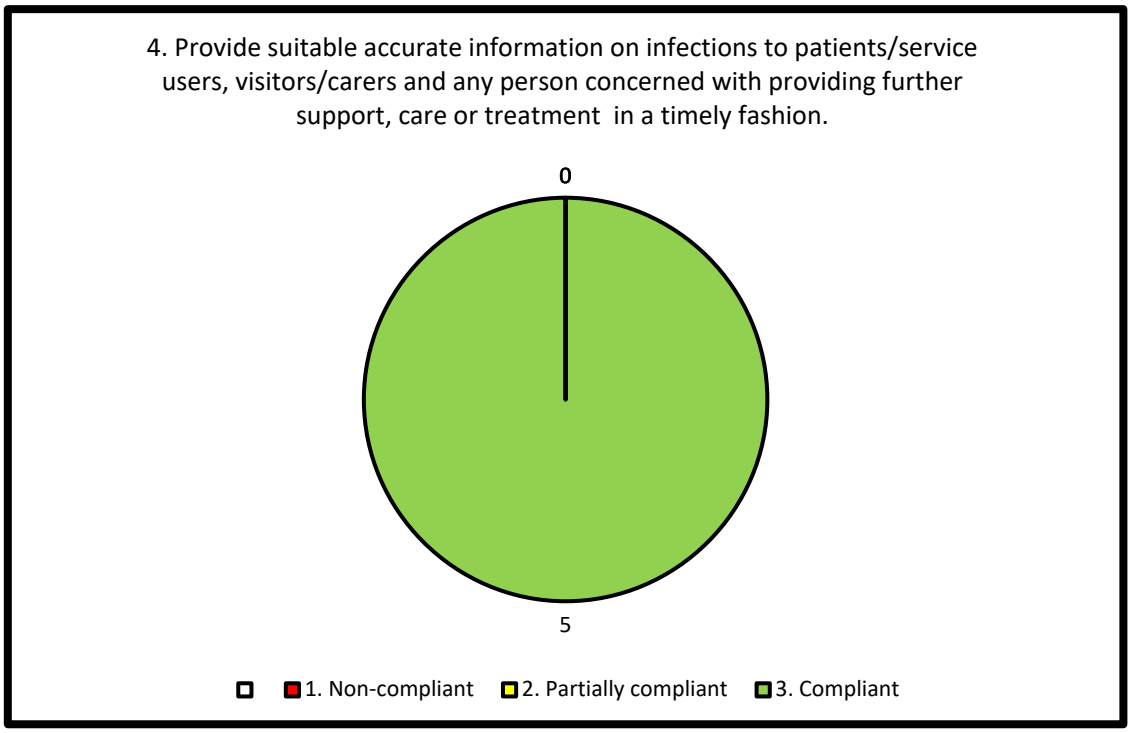


Fig 32: BAF compliance to criterion 4

Criterion 5	Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.

6.1 Outbreak management and surveillance software

LCH IPC Team is alerted either from the laboratory on an electronic system (PPM+) or by the UK Health Security agency (UKHSA) agency for specific infections. The list is reviewed daily by a reactive IPC nurse, which allows appropriate management of infections and potentially infectious patients in real time to reduce the risk to others.

LTHT IPC team continues to use an electronic platform called IC-Net which provides an enhanced surveillance system, and the Head of IPC is working with LTHT to consider options around whether this can be utilized by community to improve system wide surveillance.

IPC have supported with numerous outbreaks during 2024-25 internally and externally to LCH as part of the cooperation agreement. A log of outbreaks is captured by both gastrointestinal outbreaks and those related to respiratory infection.

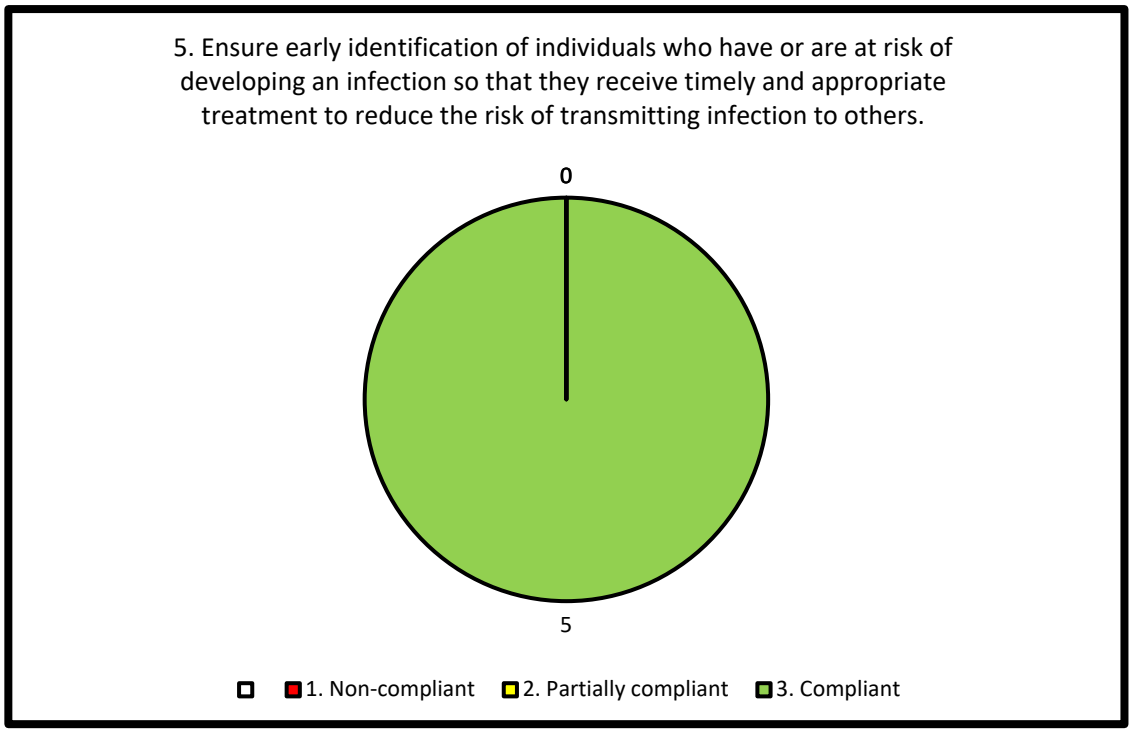


Fig. 33: BAF compliance to Criterion 5.

Criterion 6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

7.1 Statutory and Mandatory Training

The Health and Social Care Act (2008) identifies the importance of effective education and training for all staff members. There is an IPC e-learning package that meets the requirements and is mandatory for all staff at levels 2 and 3.

Training compliance rates were on average 91% at year end and this demonstrates no change from the previous report period 2023-2024. However, compliance with level 1 training had increased marginally.

Bespoke training has been delivered to the cardiac team, with a planned session for the diabetes team, rescheduled for Q2 2025-26. The training objectives were set by the teams with IPC updates provided.

During 2024/25 LCH launched the use of the NHS England E Learning for Health (ELFH) out of hospital IPC training for specific services that deliver domiciliary care.

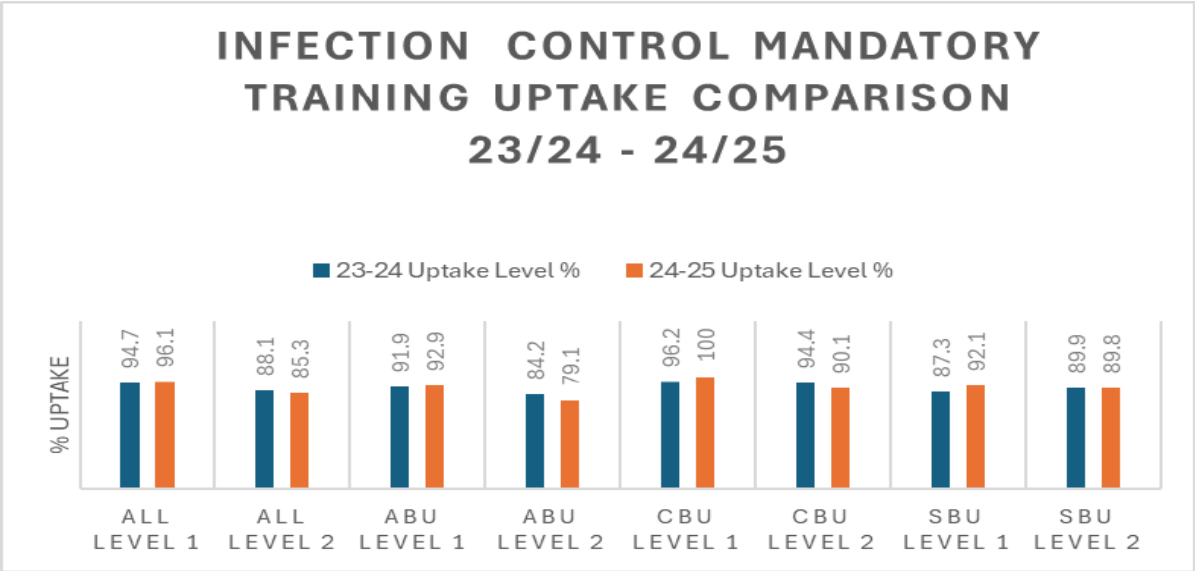


Fig. 34: IPC Mandatory Training uptake 2023-2025

7.2 Student placements

The IPCT had 16 learners allocated to the team throughout the year, 6 from Leeds Beckett, 10 from Leeds University. First, second, and third-year undergraduate nursing students, were supported on placement with the majority spending 2 weeks with the team. The following comments have been made by students through the Practice Assessment Record and Evaluation (PARE)(), completed within 2 weeks of conclusion of the placement experience.

The team have 96% positive feedback, which is an increase from 90% in 2023/24. Behaviour and Values are well evaluated at 100% and the comments made by students demonstrate the positive experience they have. We received excellent feedback as exampled below:

> All the team are incredible and have so much knowledge, always thoroughly answering my questions, welcoming me to the team and allowing me to get stuck in.

> Really welcoming and felt like part of a team - Dave went through the codes and gave me a tour which may seem like something small but on my first day I was very nervous but by Dave being great it really helped me.

> It is a very different type of placement from the rest, as it is not clinical and there is no patient contact, but despite this there is a lot to learn in terms of different health care associated infections within the community, but would be difficult to get skills signed off

> The ipc community team are absolutely fantastic, would recommend it as a placement for all learners to experience, the team are wonderful at engaging and including learners into the team and facilitating a thorough and insightful experience.

7.3 IPC Team Development - Education and team building

- Team members attended the Queens Nursing Institute Aspiring Leader Programme.
- The team has had engagement with the Infection Prevention Society (IPS) for continuous professional development and the 'Institution Membership' was purchased, to support education, learning and networking.
- A team member has contributed to a student nursing textbook, writing a chapter on 'Professionalism and the Nursing and Midwifery Council' due to be published by Elsevier in 2025.
- Positions of responsibility: The Head of IPC is a member of the CNO's IPC Shared Decision-Making Council representing community care.

7.4 Fit Testing

Following the update of the National Infection Prevention & Control Manual (NIPCM) to include Transmission Based Precautions, it recommends filtering face piece (FFP) respirators must be worn when caring for patients with known or suspected airborne infections or when performing aerosol generating procedures.

During the reporting period, the IPC Team have completed 89 Fit Tests for LCH staff. There are currently 168 staff members in LCH with an up-to-date Fit Test (completed within 2 years). All quantitative fit testing is currently undertaken by the IPC team. Members of some teams in the Trust such as Leeds Sexual Health Service, Neighbourhood Nights and Wharfedale have equipment and training to carry out qualitative fit testing for staff in their locality. The IPC team remains responsible for holding the records for staff fit tested in this way.

As outlined in the BAF, LCH have limited assurance on the accuracy of staff fit tested and how this is recorded. A review of the LCH process for Fit Testing going forward is required and how this is recorded to enable clinical team managers to access their level of compliance and to keep a more accurate up to date record and overall improve assurance in the BAF.

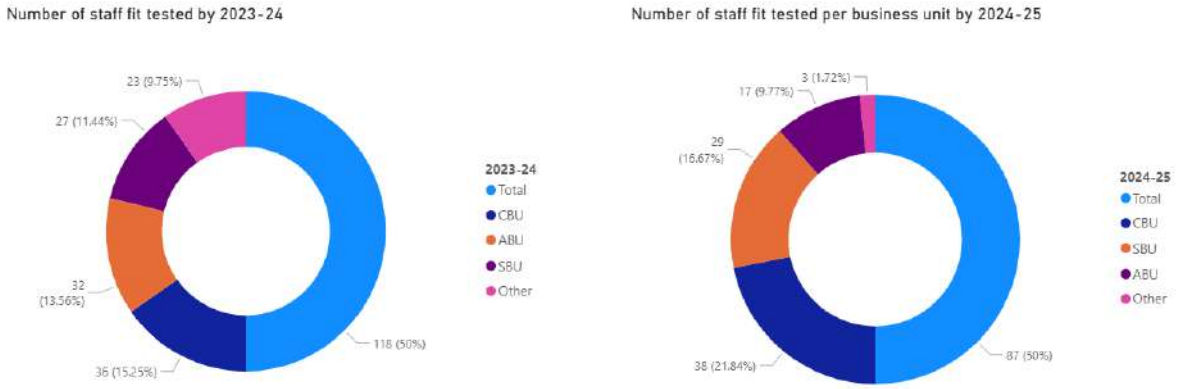


Fig 35: Fit testing comparison 2023/24 and 2024/25

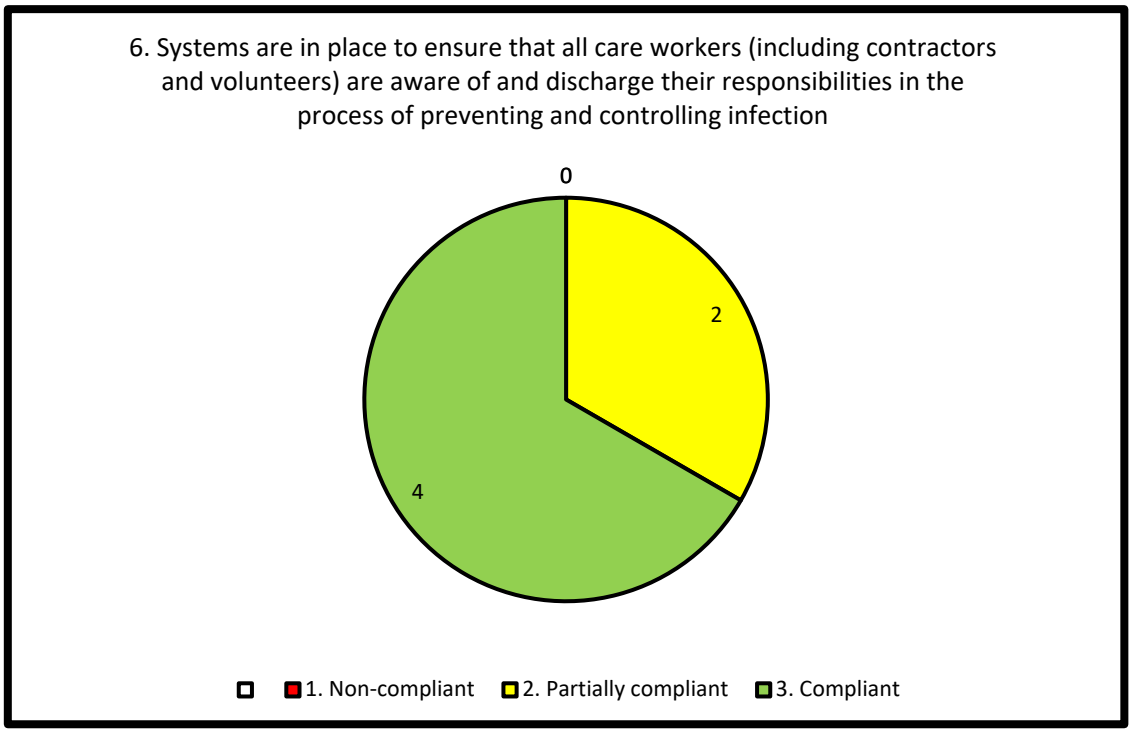


Fig.36: BAF compliance to Criterion 6

Partial Compliance elements:

That all identified staff are fit-tested A record is kept currently however this is not aligned to staff profile as per Health and Safety Executive requirements and that a record is kept: for example on ESR and therefore does provide limited assurance to the board. There are plans to move this towards an app-based approach for all frontline clinical staff which will be launched in 2024/2025.

If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently: there are a number of clinical interventions such as aseptic technique and catheterisation where clinical staff do not currently undertake any form of regular assessment.

Criterion 7	Provide or secure adequate isolation precautions and facilities

8.1 Isolation Facilities

LCH inpatient areas such as Wharfdale and Hannah House continue to provide isolation facilities (side rooms) should these be required for patients with specific infections that require isolation as per relevant policy. Patient that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed. The result of this clinical risk assessment should determine patient placement and the required IPC precautions. Clinical care should not be delayed based on infectious status.

Patients can be cohorted together in bays, if there are two or more patients with the same condition for example, a gastrointestinal outbreak or a respiratory infection. All decisions are to be clearly documented in the patients' electronic records.

During 2024-25 the IPC Team have supported with outbreaks at Hannah House where the isolation facilities were utilised.

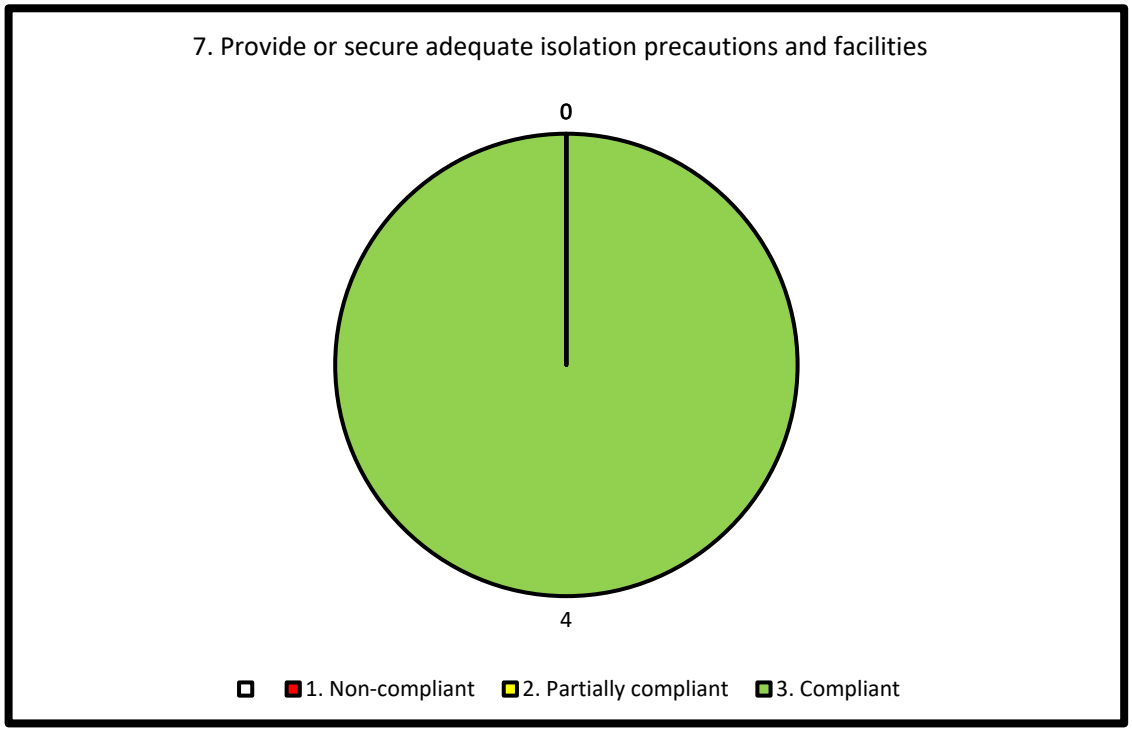


Fig. 37: BAF compliance to Criterion 7.

Criterion 8	Provide secure and adequate access to laboratory/diagnostic support as appropriate

9.1 Microbiology Provision

LCH has a dedicated contracted microbiology service with Leeds Teaching Hospitals NHS Trust, which provides a 24/7 service with UKAS (United Kingdom Accreditation Service) accreditation. A microbiology consultant is available 7 days a week with core contracted

hours via Leeds Integrated Care Board (ICB) to provide specific support and advice. The service provides support with IPC Patient Safety Investigations as well as policy and guideline updates. All results for specific organisms such as MRSA, CDI, E. coli, influenza etc, are reported via PPM+ which is then accessed by the IPC Team and reiterated to clinicians on measures required via the SystmOne electronic patient record.

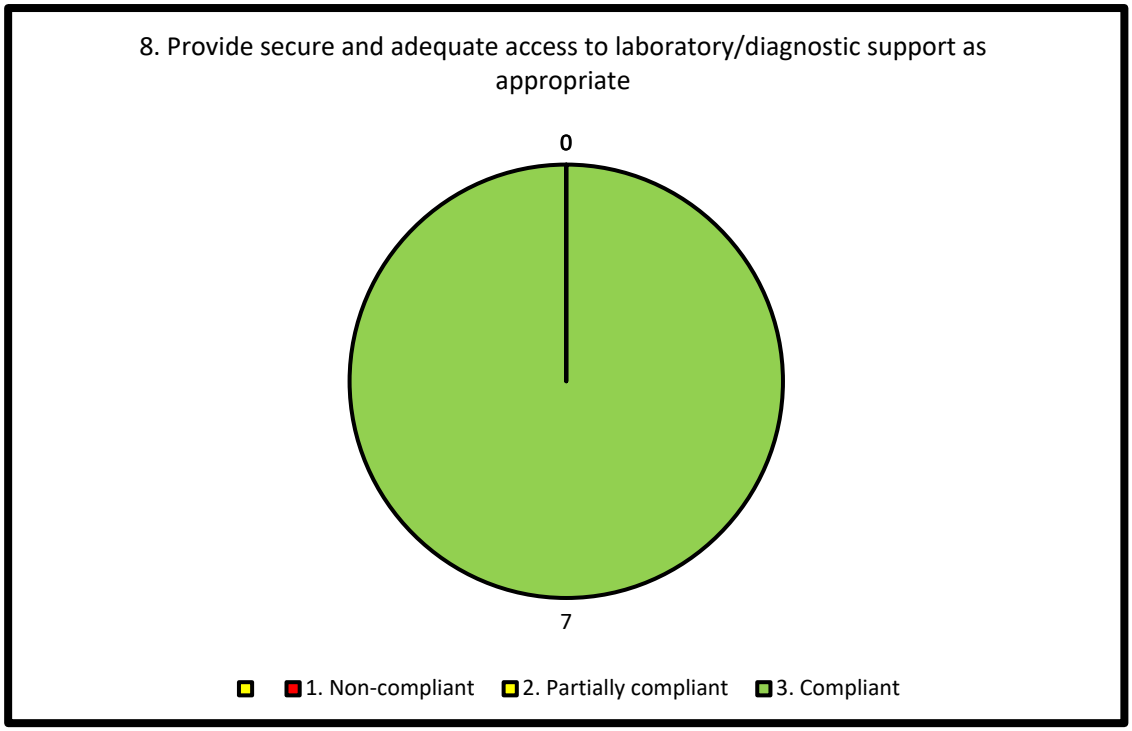


Fig. 38: BAF compliance to Criterion 8.

Criterion 9	Have and adhere to policies designed for the individual's care and provider that will help to prevent and control infections

10.1 Policies and guidelines

The overarching policies are written in line with the Trust Governance policy which outlines requirements for responsibility, audit and monitoring of policies to provide assurance that policies are being adhered to. Both policies and the manual are available for staff to view on the Trust intranet as well as the Leeds Healthcare Pathway website. The IPC team have a rolling programme of policies which require updating each year. All policies updated this year have incorporated the National IPC Manual.

- Aseptic Non touch Technique (ANTT) Policy
- Clostridium Difficile
- Diagnostic & screening Procedures including safe sampling, handling and transportation of specimen's policy
- Food Safety
- Guidelines for the management of Headlice
- Guidelines for the management of Animals in the community in-patient health care premises
- Guidelines for the management of Scabies
- Guidelines for the management of Toys in the community

- Healthcare waste
- Infection Prevention and Control overarching policy
- Isolation policy and procedures for LCH trust in patient areas
- Linen and Laundry Management Policy
- Local Decontamination of reusable medical equipment
- Management of communicable disease outbreak within the community setting
- Management of Patients with Meticillin Resistant staphylococcus Aureus (MRSA) in the community and social care settings
- Prevention and control measures for specific infections in the community
- Prevention and management of multi-resistant bacteria (Including Carbapenemase producing Enterobacteriaceae (CPE) Glycopeptide Resistant & extended spectrum Beta-lactamase
- Respiratory Virus Policy
- Standard Precautions Policy (includes hand hygiene, PPE & management of spills within the community
- Transmissible Spongiform encephalopathy: Prevention of cross infection incidents policy

During 2024/25 the IPCT have led on the development of the 'Management of the Deteriorating Patient' policy which is due to be launched in July 2025.

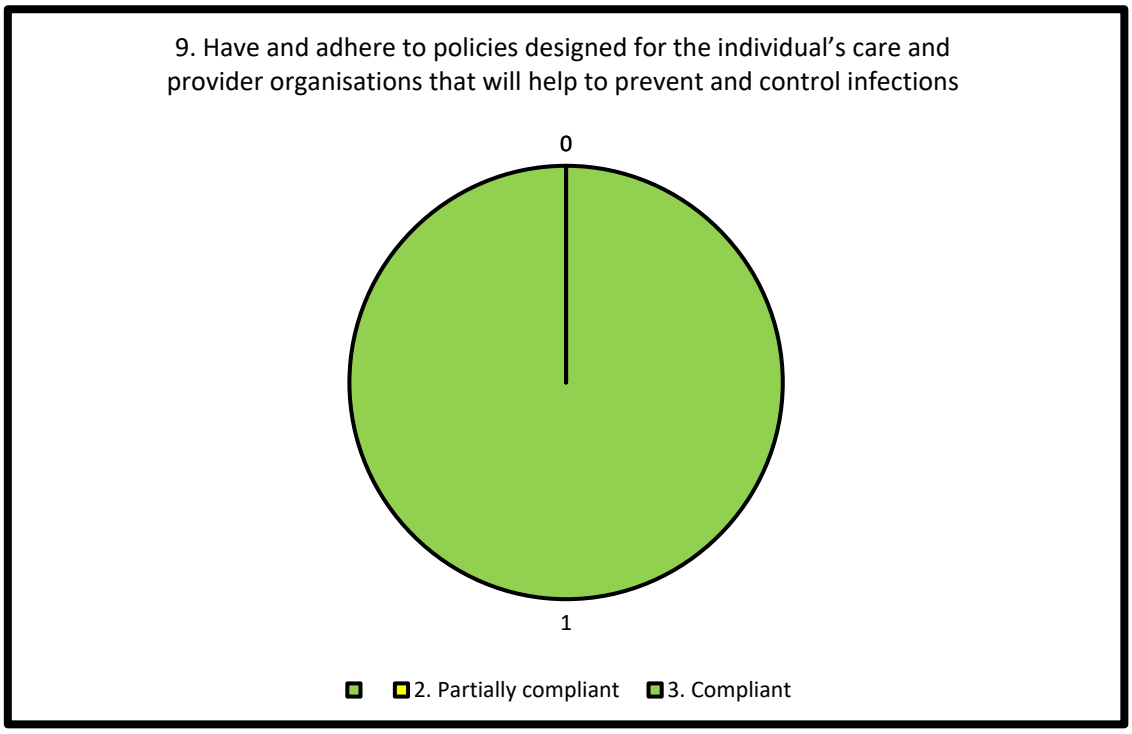


Fig. 39: BAF compliance to Criterion 9.

Criterion 10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

11.1 Staff health

LCH commissions South West Yorkshire Partnership NHS Trust to provide the Occupational Health Service. Staff who have had an occupational exposure are referred promptly to the relevant service for example: GP, occupational health, or accident and emergency. Staff understand immediate actions for example, first aid, following an occupational exposure including reporting the process, and this is prominent of the IPC web page. A system included in the hand hygiene audits monitors the management around skin health (COSHH Regulations). This includes regular skin checks to identify any occupational dermatitis.

11.2 Seasonal Staff Winter Vaccination Campaign – Covid-19 and Influenza 2024/2025

The Code of Practice (2012) for the prevention and control of healthcare associated infections (HCAI) emphasises the need for NHS organisations to ensure that its frontline health care workers are free of and protected from communicable infections (so far as is reasonably practical). Influenza is a highly contagious illness which can be serious, particularly for older people or those with other health conditions.

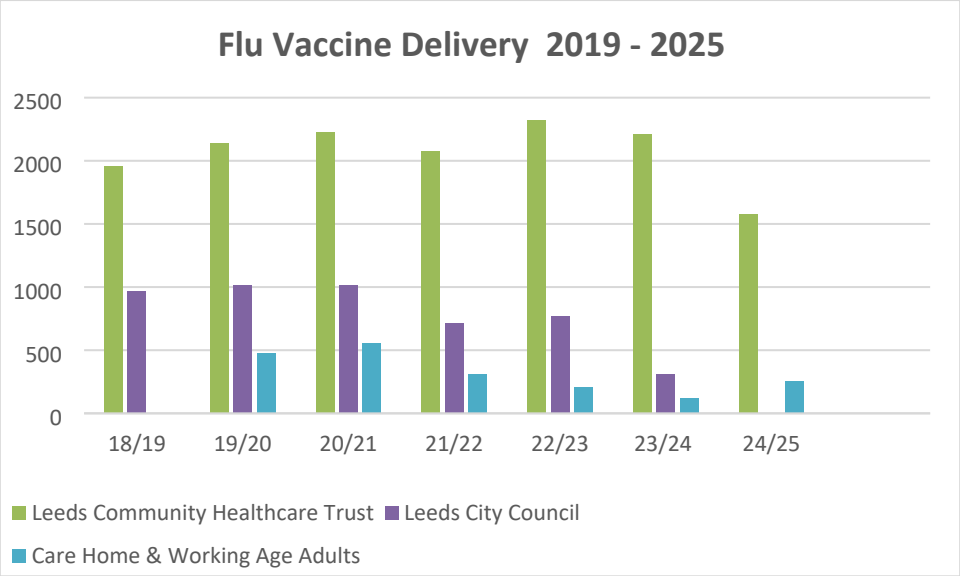


Fig. 40: Influenza Vaccines administered 2019-24.

The Joint Committee on Vaccination and Immunisation (JCVI) revised the eligibility criteria for the 2024/25 programme and for the first time since its introduction, health and social care staff were not within the recommended eligible groups to receive the Covid-19 vaccine, although for the duration of the programme NHSE continue to fund the vaccine for NHS staff. In line with this approach the Trust took the decision not to offer the Covid 19 Vaccine to staff as part of the LCH winter vaccine programme, but to promote access to the vaccine via their GP or pharmacy.

The JCVI advised starting the 2024 /25 flu vaccination programme for most adults at the beginning of October 2024.

A total of 1575 out of 3854 staff were vaccinated at Leeds Community Health Care Trust. This included staff who had informed the team they had received the vaccine elsewhere such as via their local pharmacy and GP. This total equates to 49% overall with a noted reduction of 9% uptake from the previous year 23/24. Despite this reduction, the Trust achieved the highest rate of staff flu vaccination in the West Yorkshire ICB area.

A health and social care worker targeted video was made, to dispel any myths and improve awareness of why vaccinations are important to improve patient and staff safety. A staff story was also made into a video.

Fig. 41: Winter Vaccination Video

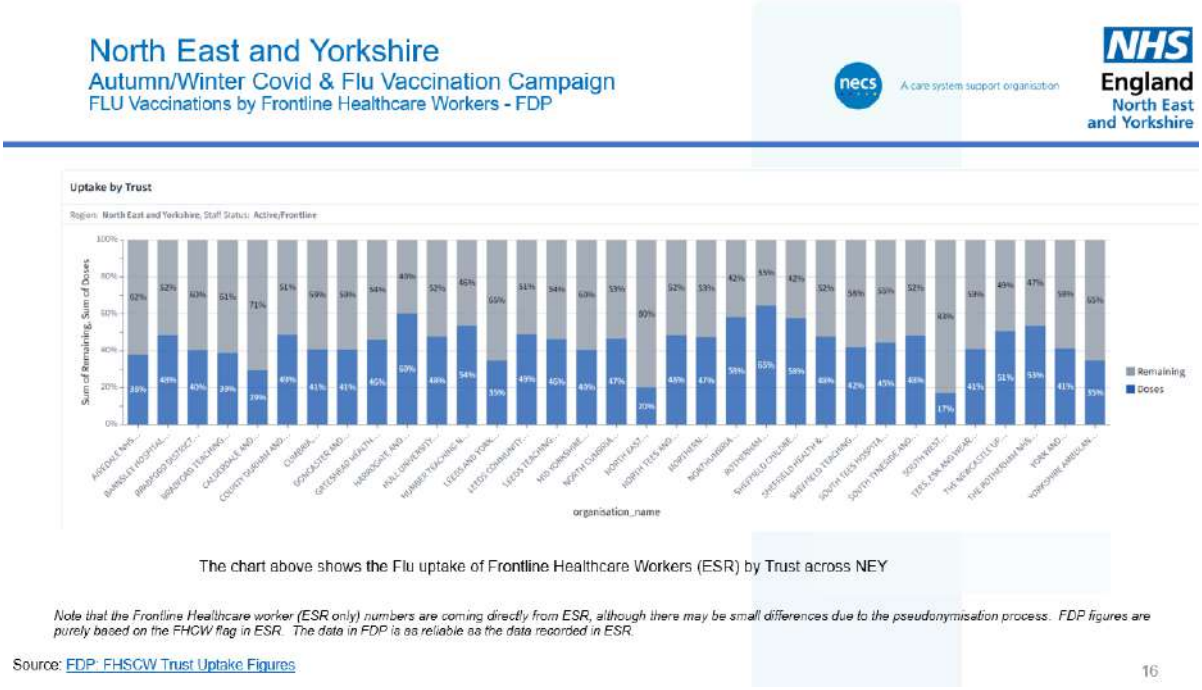


Fig. 42: NEY Autumn Covid and Influenza Campaign per trust (frontline workers)

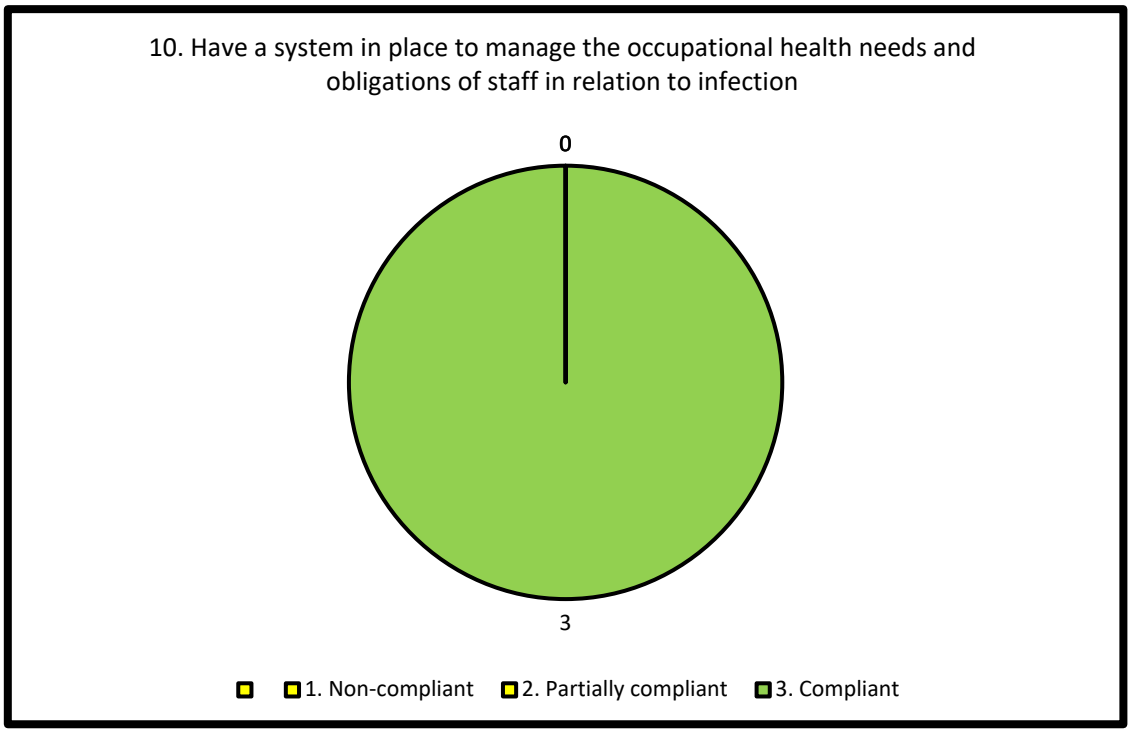


Fig. 43: BAF compliance to Criterion 10.

12. IPC team structure and celebrations

- There are currently 16 members of the IPC team which equate to 14.2 WTE, which includes adult, children, and learning disability nurses.
- The team has continued to work at an enhanced capacity with an uplift in funding from Leeds City Council in line with the cooperation partnership agreement.
- IPCT were congratulated by the National UKHSA team for our contributions and response to the MPX case in Leeds identified in November 2025.
- Senior officials Jennie Harries and Susan Hopkinson have been keen to understand more about the IPC provision in service and as a result of this an Infographic was produced. Appendix 1.

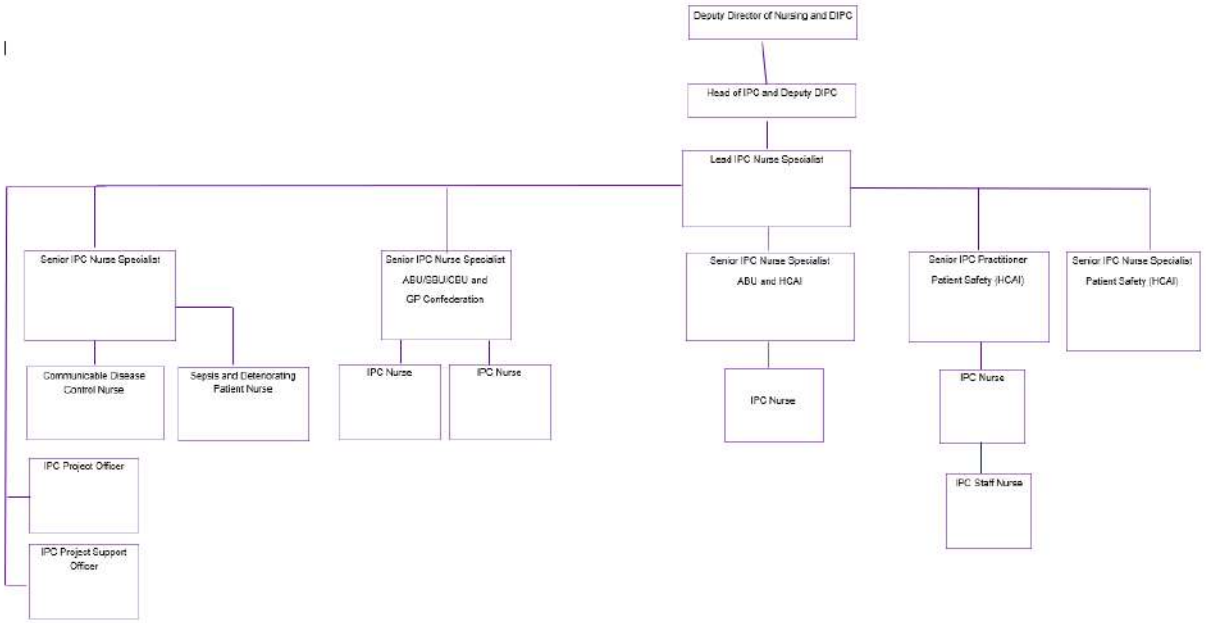


Fig. 44: IPC staffing structure

13. Challenges and forward plan 2025/2026

Forward Plan 2025 - 2026

- Outcome measurement of the services we provide, outlining the impact to the system.
- Align fit testing to the newly devised Core Share App – Fit Test Hub and promote shared organisational responsibility.
- IPC will continue to be a high priority for the Trust and the team have set out an ambitious but flexible programme of work over 2025-26.
- Building on pandemic preparedness for future potential outbreaks of novel viruses and update emergency planning resilience.
- Embed work around antimicrobial resistance, building on collaborative work with the West Yorkshire ICB incorporating core principles around data, education and sustainability and the impact on climate change, in line with the UKHSA National Action Plan.
- Continue to focus our attentions around the collaborative citywide HCAI Improvement Group including MSSA's and GNBSI's.
- Education and development of IPC team and implementation of the core competencies from the Infection Prevention Society (IPS).
- A focus around Quality Improvement to be implemented by IPC in relation to auditing, hand hygiene compliance, fit testing and HCAI Surveillance.
- Continue to build engagement with the ICS for West Yorkshire for IPC.

Challenges for 2025-26 will include:

- Achievement of the HCAI objectives with specific emphasis on the gram-negative agenda and CDI.
- LCH Cost improvement and the Quality and Value programme.
- The uncertainty around new and emerging infections and pandemic preparedness.

Cooperation agreement priorities for 2025/26

- Zero tolerance to preventable HCAI's and reduction in numbers in line with NHS England /DH thresholds - both within LCH provided services and the wider community healthcare economy
- Strengthening the strategic focus on the four key challenges to prevent, recognise and manage pneumonia including community acquired pneumonia, urinary tract infections (UTIs), sepsis and AMR.
- To support the wider care home economy aspiration to improve the quality of care provided to older people.
- Prevention in Specialist Inclusive learning centre (SILC schools): support wider education preventable measures in collaboration with LCC
- Education and training development
- Provide Infection Prevention leadership and expertise in outbreak and pandemic system planning
- Provide infection prevention leadership and expertise in the management of infectious disease outbreaks

14. Conclusion

It is noted that overall LCH is compliant in the majority of areas of the Health and Social Care Act (2008,22) 10 criterion. Where there are areas of partial compliance there is an action plan in place for 2024/25, and any significant risks have been added to the risk register.

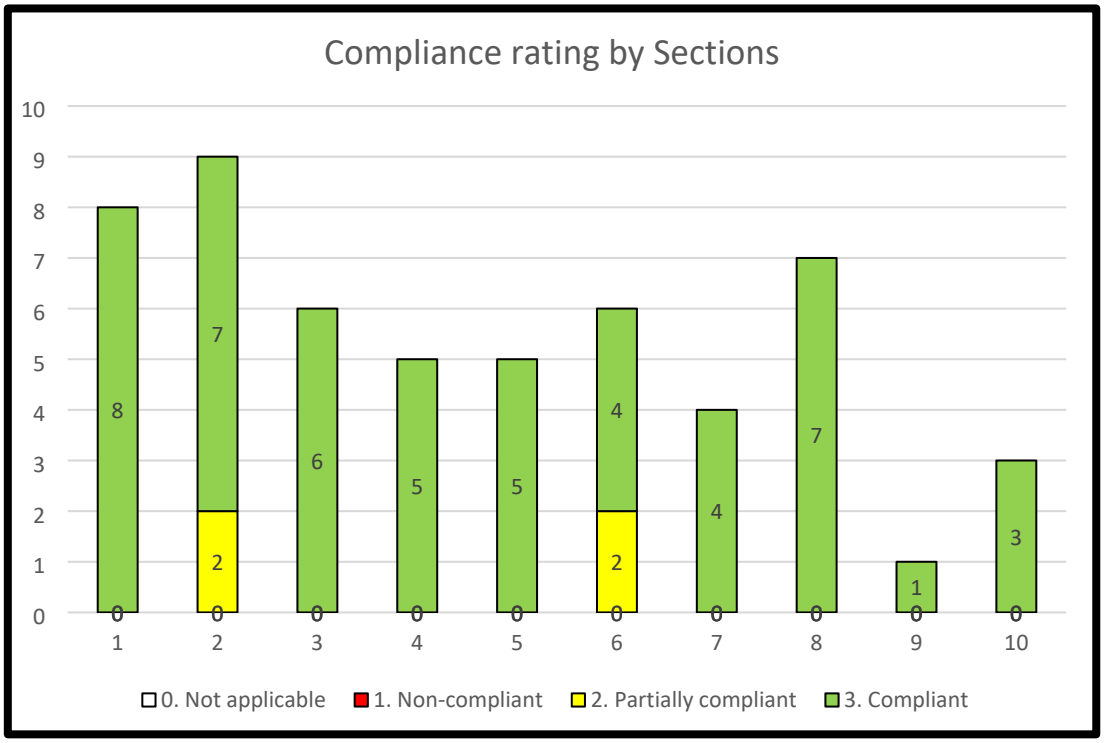


Fig.45 Overall compliance with the Health and Social care Act (2008)

It is evident that 2024-2025 has proven to be a very successful year for the Infection Prevention and Control team within LCH. We have delivered successfully on the Fifth fiscal year of the enhanced 'Partnership Cooperation Agreement' with Leeds City Council, which has now seen a permanent uplift in funding from public health monies.

This report demonstrates the continued commitment of the Trust and evidence successes and service improvement through the leadership of a dedicated and proactive IPC team. It is also testimony to the commitment of all LCH staff dedicated in keeping IPC high on everyone's agenda. The year has continued to be dominated by undulating world of infection and the IPC Team workload increased dramatically as a result. Keeping staff and patients safe was priority during this time, as well as the system wide working through the city of Leeds.

15. Recommendation

Quality Committee and the trust Board is asked to note the contents of this report including areas of noncompliance for information.

16. References

- [Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)]

- [NHS England » National infection prevention and control]

Appendix 1: The Leeds Community approach to IPC

UKHSA IPC poster v2.pdf

Appendix 2: 'Celebrating what we do'

- **Hand Hygiene Audit Tool Trial**

In Quarter 3, the IPC Team developed a Microsoft Form to collect hand hygiene audit data. A pilot trial was launched with four teams within the Children's Business Unit to test the tool and provide feedback. The participating teams included:

- Inpatient services at Hannah House
- Specialist Inclusion sites in schools
- Children's Continuing Care/Health Short Breaks
- The Children's Community Nursing Team

This approach enabled the IPC Team to evaluate the tool's effectiveness across a variety of community healthcare settings. The trial proved to be highly successful and, as a result, was extended into Quarter 4 with the same four teams. Going forward into 2025-26 this tool has been replicated for each business unit and will be rolled out to the whole organisation on 5th of May to celebrate World Hand Hygiene Day.

- **Skin Cleansing: Hexiprep and Hexihub:**

The IPCT worked in collaboration with SBU colleagues, previously worked on a trial for an alternative skin cleansing product. The aim, initially, was to increase sustainability, with a cost saving benefit to LCH. The product was successfully briefly introduced, however, was withdrawn due to production issues. The project was revisited this year whenthe IPC team subsequently identified that a plethora of products were available with products being used, often interchangeably for skin cleansing and for devices. This led to further work reviewing the evidence around appropriate skin cleansing, with the main aim to improve patient safety, by clear consistent messaging for all staff and simplifying product choice for clinical staff reducing confusion.

The products launched earlier this year with simplified messaging, no skin cleansing required for visibly clean skin for venepuncture and simplified messaging for product use:

- Blue is for skin use.
- Green is for environment and equipment

Further work is required this year to monitor effectiveness of the messaging, work with procurement to remove alternative options and evaluate cost benefits for LCH.

- **Clinical Forum Involvement**

IPC attend the quality meeting and SBU Clinical forum which is specifically with Clinical Heads of Service held quarterly.

- **CUCs Champions**

A collaboration between the CUCS team and IPC, for the training and development of CUCS champions has commenced. One day with 2 sessions has taken place with themes including hand hygiene, the deteriorating patient, sepsis and aseptic technique covered. The day received positive feedback from all those involved with further sessions planned and further developed.

- **Procurement**

IPC have supported the Children's Community Nursing Team on procurement of suitable products for managing cystotomy cares. Collaboration with colleagues in NHS Supply Chain on previous projects has enabled links to be made to appropriate personnel in a timely manner to facilitate provision of products when supply has been sparse. Spending time within teams where IPC have links, enable a rich, sound understanding of the workload and challenges faced by clinical staff, whilst also enabling a subject matter expert to provide advice and guidance.

- **Quality Improvement**

In March 2025 IPC presented the prefilled saline syringe project at a 'Making Stuff Better' session. The project enhances patient and staff safety, reduces waste, saves time and money. The product was trialled by the Children's Community Nursing Team and positively

accepted into practice. The use of the syringes has been implemented into the IV guidelines for Adults and Children. IPC collaborated on a presentation on prefilled syringes alongside colleagues from the Children's Community Nursing Team at the Infection Prevention Conference in October 2024.

- **Collaborative work with Podiatry**

Following an increase in sharps incidence reported via **Datix**, relating to the non-removal of blades. This year has seen an increase with 2 blades returned in each of the first 3 quarters and one in quarter four, totalling seven. Last year there had been a reduction with a total of 2 blades returned. A working group has been established where podiatry, IPC and senior quality leads met and carried out a hierarchical task analysis. Actions have been identified with a follow up meeting planned. Work will continue to monitor the incidents, identify common themes, and move towards a sustained reduction in incidence.

Appendix 3: External system work

Cooperation agreement – Leeds City Council

Achievements

- HP / IPC framework developed to identify future priorities according to the cooperation agreement: enhancing.
- Winter respiratory preparedness work and wider outbreak planning: support system flow and IPC education across settings, and occupational winter vaccination programme.
- System response for Measles, MPX and Avian Influenza: positive feedback from UKHSA around effectiveness.
- Healthcare associated infection (HCAI) system support and implementation of Patient Safety Incident Response Framework.
- System response delivering the AMR National Action Plan.

Priorities for 2025/26

- Zero tolerance to preventable HCAI’s and reduction in numbers in line with NHS England /DH threshold - both within LCH provided services and the wider community healthcare economy
- Strengthening the strategic focus on the four key challenges to prevent, recognise and manage pneumonia including community acquired pneumonia, urinary tract infections (UTIs), sepsis and AMR.
- To support the wider care home economy aspiration to improve the quality of care provided to older people.
- Prevention in Specialist Inclusive learning centre (SILC schools): support wider education preventable measures in collaboration with LCC
- Education and training development
- Provide Infection Prevention leadership and expertise in outbreak and pandemic system planning
- Provide infection prevention leadership and expertise in the management of infectious disease outbreaks

Care Home Environmental Auditing – Commissioned through the cooperation agreement with LCC.

Over the report period, the IPC Team have coordinated and delivered a structured audit programme for the Leeds Care Home economy. The purpose of this activity is to appraise care home environmental standards and compliance with the criterion standards outlined in the Health and Social Care Act. The activity also fosters a collaborative working relationship with care settings with an overarching aim to improve whole economy compliance standards.

A total of 153 registered care homes/ working age adult (WAA) units have been identified within the Leeds area and these have been subject to a rolling two yearly “face to face” audit activity. The audit process provides an effective means of appraising and assuring IPC standards within the local economy and through quality improvement strategies, collaboratively working with individual homes, to improve environments and infection control practices in line with legal and best practice requirements.

Within the report period a total of 80 care home audits have been completed with 5 care homes requiring follow up reviews to provide supportive input and collaborative quality improvement activity.

The care homes are audited against 10 compliance standards:

- Environment
- Hand hygiene
- Personal protective equipment
- Prevention of blood and body fluid exposure incidents
- Management of waste
- Organisational controls, (policies, risk assessments etc)
- Urinary catheter Management
- Mouthcare
- COVID 19 Management

The IPC Team are committed to continuing the collaborative working philosophy and to further assure and enhance infection prevention standards within the area. Key priorities will include:

- To continue the IPC audit programme with a total of 83 settings requiring auditing. In addition to ensure follow up audits are completed in areas where medium and high-risk compliance was noted
- Continue IPC advice, support and guidance to all social care providers, including working age adult services
- Continue to attend relevant meetings, including Care Home System Meeting and Outbreak control meetings
- Continue to monitor, collate and report data in relation to outbreaks of respiratory illness and other agents such as scabies. Separate arrangements are in place to manage outbreak of enteric illness. Modified data collection tools have been provided to enhance data collection for the forthcoming year
- Disseminate new guidance and evidence as required and utilisation of the Care Home System Working Group bulletin
- Continue and enhance engagement with the Domiciliary Care sector both for educational and potential assurance purposes
- Develop a 3 monthly newsletter focusing on current issues and updated information for dissemination

Many advances and areas of improvement have been achieved over the 2024-25 period. The profile of IPC continues to be raised through the multiple initiatives delivered.

External Training Provision

The IPC Team have provided enhanced education and training within the wider care economy of Leeds. The initial primary focus of this project was to work with care facilities providing both nursing and residential care, Working Age Adult Care Teams, Third Sector providers, Domiciliary Care Providers, Mental Health Providers, and the local authority Adult Social Care Team.

During 2024/25 a total of 92 face to face training sessions were facilitated by the team. In addition to this were several virtual workshops and bespoke training opportunities. Bespoke IPC training was also delivered to the LCC care teams at Merrion House. These included mandatory update and induction training.

Training was also provided to Domiciliary Care Agencies and sessions for staff with
The primary content of the sessions included:

- Enhanced understand how infections impact on individual clients and their families and staff, including signposting to available supportive web material
- Real time overview of infectious agents circulating and infection prevention and control challenges at the time of the training
- Exploration of the key elements included in Standard Infection Control Precautions and transmission-based precautions
- Demonstrate compliance with basic hand hygiene practice
- Revisit the appropriate use of PPE and correct donning/ doffing procedure
- Understand best practice in relation to management of waste; single use items; laundry
- Management and body fluid exposure
- Development of strategies for staff to positively influence safe practice and become IPC champions within their respective care settings. Philosophies related to role modelling and leadership
- Importance of early detection of deterioration and the “soft signs” of sepsis
- Responsibility in the prevention and management of antimicrobial resistance and challenges faced from AMR
- Sessions were also delivered to address specific issues highlighted in audit activity. These have ranged from PPE usage, environmental cleaning, water safety and Legionella control, respiratory outbreak management, etc
- The sessions were delivered in a variety of formats, including Power Point, Virtual and workshop style. Feedback from sessions was comprehensively positive, with free text comments including.

Appendix 4: IPC Board Assurance Framework

IPC BAF QC March 2025 V2.0.docx

Key line of enquiry (partial compliance)	Risk of partial compliance	Mitigation
2.1 There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard**	The being that we do not have full assurance from external partners on cleaning activity for example: Leeds City Council for St Georges	Continuation of short life working group to be in place with Estates to discuss assurance from external partners and areas of concern that are escalated from IPC

contract these setting will have locally agreed processes in place).	and Ministry of Justice at Wetherby Young Offenders.	Environmental and Cleaning Audits.
2.4 There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	This is with specific reference to the water coolers within LCH premises. All of our water systems are now up to date. Some water coolers have been removed from non LCH locations. Working with LYPFT. New Water cooler in place.	This is in reference to the internal mechanics of the device that require flushing through via external contract. Health and Safety Group aware and this is being led on by Estates and Facilities. Mitigation is that the outer of the machine is cleaned and that there is water testing in place.
2.5 There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	The risk being that we are unaware of some of the planned maintenance with external partners, which may impact compliance with HTM in the Built Environment as well as provision of services.	This is now in place for LCH premises and is listed on the agenda for the IPCG. Audits are shared by IPC to Estates and Facilities – non-compliant areas reaudited 3 monthly.
6.5 That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	A rolling training programme is made available for staff who require fit testing for FFP3. Inaccuracy in the detail of the fit testing record due to it being stored on an excel document, for example if staff leave or are on long term sick. We would meet compliance with HSE (Health and Safety Executive), however NHS England recommended during the Covid-19 pandemic for this to be stored on a programme such as ESR.	A locally held excel document is stored within IPC, however it does not provide individuals or teams the ownership. Plans have started to move this towards an app-based approach which will be launched in 2025/26.
6.6 If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard, and the staff member has completed a competency assessment which is recorded in	There is a risk about the assumption that staff are not having regular updates or checks to ensure practice is in line with current evident base. There is also a concern that due to	Staff self-declare competencies and work in an autonomous manner under their relevant codes of practice. Bespoke training can be provided by specific teams such as CUCS, CVAS and IPC.

their records before being allowed to undertake the procedures independently.	limited assurance there is a concern that we are not able to prevent avoidable HCAI's e.g. accurate aseptic technique, insertion and maintenance of catheters.	

Report compiled by Head of Infection prevention and Control and Deputy DIPC, with contributions by members of the Infection Prevention and Control Team.

Leeds Community Healthcare NHS Trust

Agenda item:	2024-25 (13)

Title of report:	Safeguarding Annual Report 2024/25

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

Presented by:	Sheila Sorby, Interim Director of Nursing & AHP's					
Prepared by:	Lynne Chambers, HoS Safeguarding					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	√

Executive Summary:	This report provides an overview of safeguarding activity, achievements, and ongoing challenges within LCH over the past year. The Trust continues to prioritise the safety and wellbeing of all service users, ensuring robust systems are in place to identify, respond to, and prevent harm.

Previously considered by:	Quality Committee

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

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

Recommendation(s)	

List of Appendices:	0

Safeguarding - combined Annual Report 2024/25

1 Introduction

The Combined Safeguarding Annual Report is to provide LCH Quality Committee and LCH Board with a brief overview of the Safeguarding achievements, challenges and ambitions for 2024/25. The paper was shared with safeguarding committee 19/08/2025 and was approved by quality committee, 23/09/2025.

2 Current position/main body of the report

The safeguarding annual report outlines the key achievements for 2024 and key ambitions for 2025 for all the sub-sections of safeguarding and the wider team, including:

- Safeguarding Adults
- Prevent
- Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Dementia
- Safeguarding Children
- Specialist Child Protection Medical Services
- Sudden Unexpected Death in Infancy and Childhood (SUDIC)
- Children Looked After and Care Leavers
- Learning Disability
- Child protection

3 Impact

The impact of our annual report as a critical document is that it can impact various aspects of our safeguarding service's operations, from strategic planning and compliance to stakeholder engagement and public confidence. It serves as both a reflective tool to assess past performance and a forward-looking guide to drive future success.

Quality

The quality of an annual report, especially in a healthcare/safeguarding context, is crucial and as such, reflects the professionalism, transparency, and effectiveness of the team and the organisation. In summary, the quality of our annual report is determined by its ability to effectively communicate the organisation's performance, challenges, and future direction in a clear, transparent, and strategic manner.

Resources

Capacity within the team has been an ongoing issue over the past few years this is due to staff turnover, staff mental well-being and a whole service review for the CLA team. This has now been resolved and recruitment to 4.5 new posts is ongoing. We were also successful in recruiting a clinical psychologist to the support the team's mental well-being. We have been able to maintain the service, however the CLA and adult team have been on business continuity by staff being flexible and supporting each other across the whole team.

Risk and assurance

In LCH, safeguarding, risk management and assurance are paramount to protecting vulnerable individuals and upholding the highest standards of care. We employ a rigorous risk assessment process to identify potential safeguarding concerns, allowing us to take proactive measures to prevent harm. This includes regular training for staff to recognise signs of abuse and neglect, clear reporting pathways, and robust procedures for managing incidents. Our assurance framework involves continuous monitoring, internal audits, and external evaluations to verify that safeguarding policies and practices are effective and compliant with legal requirements. These processes ensure that we maintain a safe environment for all individuals under our care and provide confidence to stakeholders that safeguarding is a top priority in our organisation.

Equity

LCH actively works to ensure that all individuals, regardless of race, gender, socioeconomic status, or other characteristics, have equal access to opportunities, resources, and support. This commitment is reflected in LCH recruitment and hiring practices, where we strive to build a diverse workforce that

mirrors the communities we serve. We provide ongoing training on unconscious bias and cultural competency to ensure that our staff are equipped to deliver services that respect and meet the unique needs of every individual. Additionally, we have established clear policies and procedures to address disparities and remove barriers to access, regularly reviewing and adjusting our practices to promote fairness and inclusion across all levels of our organisation. Through these efforts, we aim to create an environment where everyone feels valued, respected, and empowered to thrive."

4 Next steps

LCH remains committed to safeguarding, making strong progress in policy, training, and multi-agency collaboration. While challenges such as Prevent and Serious Youth Violence continue to demand attention, the Trust is focused on supporting staff, strengthening partnerships, and embedding safeguarding across all services to ensure safe, high-quality care.

5 Recommendations

LCH Board is recommended to note the contents of this report and approve its publication.

Name of author/s:
Lynne Chambers
Wendy Brown
Rachel Watkins
Angela Dillon
Gemma Dalby
Julie Wilson

Safeguarding - combined Annual Report 2024/25

15/10/2025

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 6 November 2025
Date of Meeting:	24 September 2025	**Date of next meeting:**	29 October 2025

Introduction

Quorate meeting. Robust discussions held by the Committee. Presentations included an overview of the Community Beds tender with an extraordinary meeting of the BC to be planned subsequently, to review the tender, given the urgency of the bid response timescales. Welcome news on the Neighbourhood Health programme acceptance. The Committee also welcomed guests from the Single Care Record scheme to understand the overall positive impact it is making.

Alert	Action
Digital Printing some progress towards a working solution. Assurance was requested following an issue with the reconciliation process for the digital letters. It was unclear if the issues with the process had caused any patient safety risks. BC Chair to raise to the Quality Committee Chair.	Investigation into any patient safety risks given issues with the reconciliation process.

Advise

- Neighbourhood Model Update – Committee noted that Leeds had been accepted onto the National Neighbourhood Health Implementation Programme (NNHIP). Areas involved and main focus topics were outlined. Work continuing on prevention and diagnostics to review patterns of unplanned care across the system, with the key areas identified as improving infrastructure, expanding community mental health services, and increasing the capacity of low-level care navigators to strengthen neighbourhood networks. Proactive care work with Primary Care Networks was ongoing to identify highest risk or escalating risk individuals.
- Business Development Strategy – Community Beds tender was discussed, and an extraordinary Business Committee meeting scheduled for 13 October to approve the bid prior to Board ratification and submission (16 October).
- Child Health Information Service (CHIS) – a 12 month contract extension was approved at the request of the commissioning Lead for Public Health Services, and the Trust has commenced initial work in preparation for the tender exercise.
- Performance Report – update received on deteriorating waiting lists position, with key areas of risk highlighted. Balance between splitting focus on waiting list initiatives and ensuring sustainable activity to meet demand, was acknowledged.
- Update on 52+ weeks waiting list recovery plan – current position outlined and individual service recovery plans shared. Detailed report to be received November 25. Paediatric Neuro-disability service was area of greatest challenge – Committee supported the proposed application of non-recurrent resources and approved the service's financial plan. The Committee sought assurance on the other waiting list plans and actions.
- Service focus - Active Recovery Single Care Record (SCR) Scheme, with Reablement Team colleagues. Challenges and benefits highlighted and lessons learnt would be collated. An implementation evaluation report was expected from the ICB in October 25.

Committee Escalation and Assurance Report

Assurance

- Q&V – The Committee noted the strong mid-year point with £10.36m of its £14m savings target identified. A Corporate workstream deep dive had provided assurance regarding red-rated areas, particularly admin services, and would be revisited again during the latter half of the financial year. Interdependencies between the corporate workstream and digital and estates developments were noted. Assurance was provided that there were sufficient non-recurrent mitigations in place for the digital workstream, and a number of initiatives were being reviewed due to the digital letters being a key component of the digital programme. The ongoing impact on staff was suggested as a possible spotlight area at the next People & Culture Committee.
- Procurement Strategy – all staff now embedded into new roles and monthly contract review meetings continuing. Internal audit to be carried out during Q3.
- Finance Report – on track to deliver full-year forecast, the forecast recurrent CIP had improved during the month to £10.3m and confidence growing through the Quality and Value programme that the recurrent target would be fully achieved. Committee to receive an update in October regarding impact of digital letters programme following a review.
- Performance Management KPIs – full set of KPIs was shared, and proposal was for business-related KPIs for escalation to be brought to Committee.
- Sustainability and Climate Adaptability – quarterly update noted. Director-led Sustainability and Climate Adaptability Steering Group had now been established.
- Health & Safety Annual Plan 6 monthly update received and progress noted.
- Estates – Committee approved progressing with the preferred bidders for Otley and Horsforth sites.

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	Limited in terms of 52 week waits but reasonable overall in light of actions being taken.

Committee Escalation and Assurance 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	
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 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	
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	

Author:	Helen Robinson/Lynne Mellor
Role:	Company Secretary/Committee Chair
Date:	17 October 2025

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 6 November 2025
Date of Meeting:	29 October 2025	**Date of next meeting:**	26 November 2025

Introduction

Quorate meeting. The Committee sought assurance with a robust discussion across all key agenda items including Trust priorities, with a deep dive on Waiting Lists where considerable progress to address the waiting lists was noted. The Quarterly Digital and Data Strategy paper was received and progress on Digital Printing was welcomed. Estates Strategy, the NOF and Corporate Benchmarking were also additional reports discussed by the Committee.

Alert	Action
Estates Strategy and update – unclear what risk the Trust is carrying in the absence of a strategy since the ending of the previous strategy in 2024. Unclear from the report what has been delivered from strategy in 2019 and the refresh in 2022.	Return of the strategy paper. Trust to conduct a review of the outsourcing partner whose remit includes the delivery of the strategy.

Advise

- Digital, Data and Technology Strategy Quarter 2 report – Committee noted the pause in relation to the year 2 business case, allowing for a 'stop start continue' exercise review of initiatives including, a reassessment of capacity and capability, alignment with the 10 Year Plan and the outcome of the Leeds Provider Review. An £805 forecast underspend on capital was noted, and an anticipated saving of £942k in 2025/26 as opposed to the planned £1.9m (with the rest to be achieved during 2026/27). Focus was on lessons learnt, and the lack of expertise in the approach to digital procurements was noted. The Committee asked for a clearing mapping of benefits realised and forecast against the 6 major initiative areas. The Committee also wondered if a clearer set of priorities from the review of initiatives could 'start' some work which would enable spending of the capital envelope available whilst helping also bridge the efficiency gap. The Committee also asked for an update on AI at the next session and welcomed the methodology review.
- Digital Letters – assurance now received re: low clinical risk. Now progressing with an SFTP transfer solution, with a forecast plan to be live across all services by the end of November. The Committee requested an update on the lessons learnt with the Options appraisal report in November including a focus on the legal lessons which can feed into any future procurement from the Trust. An options paper will also be provided on the potential closure of the HEARTT wound care pilot project.
- Neighbourhood Model Update – The national model had been launched, and this would be the topic of November's spotlight item. The Committee requested that as part of the report assurances are provided on the Trust objectives, vision, milestones, resources, and risks associated with delivering the LCH elements of the Model, recognising this is part of the wider national improvement programme.
- Estates Strategy – Committee received a brief update on the progress against the 2019-24 strategy and the development of the new 5-year strategic plan. There was concern that there was a gap between strategies, and it was felt that the report did not sufficiently detail what had been achieved or assurance

Committee Escalation and Assurance Report

on plans for the next 5 years. There was a request for staff and wellbeing elements, such as gender-neutral toilets for example, to be included in the new strategy. It was agreed that a revised report would be brought back to the November meeting.

- Enteral feeds business case – committee was supportive but due to the value of the contract the approval would sit with Board rather than Business Committee. To be taken to 6 Nov Board.
- National Oversight Framework – Committee welcomed the update on key actions across the domains and forecasted Q2 position. It requested in the next iteration that in each of the key measures assurance is provided via a targeted plan for continuous sustainable improvement including movement to an improved segment with benefits for patients, service users, and staff.
- Research paper will be brought to the Committee next month.

Assurance

- Q&V – The Committee noted the break-even financial position consistent with planned trajectory, with only 20% non-recurrent. A summary of programme progress was noted, and it was agreed that the report would continue to be brought monthly in the form of an exception report, with a core component for all committees and then committee-specific information, with a deep-dive on alternate months. The scope of the imminent third Internal Audit was noted, and it was anticipated there would be an advisory element regarding embedding the programme beyond year 3. Information was requested on alignment of service redesigns, data requirements and commissioner contracts set against the NOF (see alert above).
- Finance Reports (monthly dashboard and quarterly update) – strong performance noted against financial plan, with a year-to-date surplus of £0.654m and full year forecast of £0.9m, reflecting the Trust's contribution to the WYICS stretch target. Recurrent CIP forecast remains steady at £10.36m although achievement of the full recurrent target remains likely. Updates received on national/system financial positions and the medium-term planning process.
- Corporate benchmarking – discussed and report noted.
- Waiting List Recovery Plan –The Committee passed on its thanks for the considerable progress to reduce the waiting lists for our patients, along with the ambition to not have any waits over 18 weeks. The Committee was assured the risks were being managed and the focus was not just on 52 week waits.
- Throughout the meeting the Committee requested assurances and alignment between waiting lists, commissioning intentions, Quality & Value, and the National Oversight Framework.

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:

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 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	Noted that the enteral feeds business case would be recommended to Board for approval.
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	
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	Reasonable overall but lacking assurance around the gap between the Estates strategic plans and whether it was looking sufficiently far ahead.
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	Reasonable overall but lacking assurance around the gap between the Estates strategic plans and whether it was looking sufficiently far ahead.
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	12 (high)	Reasonable	Limited regarding the contractual position in relation to digital letters but reasonable overall.

Committee Escalation and Assurance Report

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.			

Author:	Helen Robinson/Lynne Mellor
Role:	Company Secretary/Committee Chair
Date:	29 October 2025

Committee Escalation and Assurance Report

Name of Committee:	Audit Committee	**Report to:**	Trust Board 6 November 2025
Date of Meeting:	14 October 2025	**Date of next meeting:**	9 December 2025

Introduction

Quorate meeting with a full agenda and good debate on key topics – good challenging conversations, particularly the update on the progress against the recommendations in the PSIRF Internal Audit Report (limited assurance).

Alert	Action
• Audit Plan – the Chair said he had been alerted to concerns related to the Trust's EQIA processes which would warrant further investigation and lead to an in year adjustment to the Internal Audit Plan.	Committee Chair to discuss with Internal Audit Manager

Advise

- PSIRF Internal Audit Report (limited assurance June 2025) – weaknesses found in the application of PSIRF within Datix. The Executive Director of Nursing and AHPs attended to provide an update on progress against recommendations. 8 out of 12 had been closed, work on remaining 4 was in progress. The Committee noted the update but asked for a further report in December 2025 which provided more assurance on the validation of competed recommendations and governance processes.
- SIRO Report: Committee received the combined report on Cyber security, Information Governance and Data Security issues. Risks around migration to Windows 11 were discussed – 96% completed to date. The Committee asked for more assurance on the availability of essential patches and security features for devices which had not migrated to Windows 11 to be clarified and actions to mitigate the risks.
- The SIRO report was unable to confirm that the same standards applied to the Trust regarding Windows 11 and urgent patches relating to the NHS smart card infrastructure had been implemented by LCH service delivery partners.
- 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. The Action Plan would be discussed in more detail at the meeting in December 2025.

Assurance

- Three benchmarking Audit Reports were received and reviewed by the Committee –Freedom to Speak Up, PSIRF and Data Security Protection Toolkit.
- An update on the number of open recommendations showed a continuing improvement, with additional executive management oversight leading to fewer being overdue.

Committee Escalation and Assurance Report

- The Committee received the Security Management Update for Quarter 1 and 2 2025/26, noting that the security incidents trend had steadily declined since 2023 and reached an all-time low level. The data on reported security incident trends was noted. It was suggested that this report should be shared with the Chair of the People and Culture Committee.
- The Committee received and approved the Trust's approach to achieving the Violence Prevention and Reduction Strategy. It was suggested that this report should be shared with the Chair of the People and Culture Committee.
- External Audit – Committee received a general update. The 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.
- Board Assurance Framework Activity Report – The Committee had determined a reasonable level of assurance in relation to maintaining business continuity at both its April and July meetings. No additional sources of assurance were requested.
- A reduction in the backlog of responding to Freedom of Information requests was noted.
- Counter Fraud – quarterly update report received including information about a series of Cyber Prevention masterclasses held following a phishing exercise.
- The Committee received the quarterly report on financial controls which included information about: Losses and Compensation Payments, Tender and Quotation Waivers, Procurement, Working Capital, including a quarterly update on receivables and payables held by the Trust over 90 days and External Audit Recommendations

Risks Discussed and New Risks Identified

The risks the Trust would be exposed to if devices did not migrate to Window 11 on time and concerns that from the cut-off date essential patches and security features to address vulnerabilities might not be available which would increase the Trust's exposure to risks. An action was taken by the Executive Director of Finance and Resources to clarify the position on the availability of patches and other security features.

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	12 (high)	Reasonable	N/A

Committee Escalation and Assurance Report

significant disruption, then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.			

Author:	Liz Thornton
Role:	Corporate Governance Officer
Date:	15/10/2025

Committee Escalation and Assurance Report

Name of Committee:	Charitable Funds Committee	**Report to:**	Trust Board 6th November 2025
Date of Meeting:	9/9/2025	**Date of next meeting:**	16th December 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 9st September 2025. Quorate meeting with good debate on key topics.

Alert	Action
No alerts	

Advise

- Giving Voice Choir – an options paper to be developed regarding whether the choir should continue to sit within the Speech and Language Therapy Service or with the charity.
- The draft LCH Charitable Funds and Related Charities Annual Report and Accounts 2024/25 were reviewed and approved and will be presented to the Audit Committee on 9 December following independent auditing, prior to Trustee sign off.
- Finance Team to cease using Sage accounting software for the Charitable Funds accounts, and to move to Excel, due to the low number of transactions.
- Charitable Funds Officer work with the Finance Team to review performance against the trajectory set in the Three Year Plan.

Assurance

- The Committee received fundraising updates in relation to events in the next 12 months including the Leeds Half Marathon, London Marathon, the CPR-athon, and agreed the proposal for the Leeds Inflatable 5k Charity Partnership. Ongoing work with Starbucks, Leeds City Council, the White Rose Shopping Centre and the Gym Group was noted.
- Yorkshire 3 Peaks Walk – completed by 7 walkers and £1308 raised to date.
- Finance report covering April –July 2025 received and accepted

Risks Discussed and New Risks Identified

Committee Escalation and Assurance Report

No new risks identified

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

Author:	Helen Robinson
Role:	Company Secretary
Date:	3 October 2025

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (17i)

Title of report:	Performance Report

Meeting:	Trust Board Meeting Held In Public
Date:	6 November 2025

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

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

Previously considered by:	Senior Leadership Team All sections apart from NOF update and Finance report have been considered by Business Committee and Quality Committee

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

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

Leeds Community Healthcare NHS Trust

LCH Performance Brief

August/September 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 the same with the same measures passing and failing their targets. Of importance to highlight is the continued improvement in the time patients are waiting for our non-consultant led services. This will be due to the focus bought to the area by the Access LCH Steering Group. Full information is provided in the Responsiveness section.

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 work is due to conclude at the end of September.

NHS Oversight Framework

We are now able to locally replicate actual metric scores for the four in-year indicators against which LCH is assessed for both LCH and our peers. This provides valuable in-quarter visibility and enables us to anticipate the forthcoming quarterly position.

An improved overall metric score is forecast for Q2, however given the level of improvement this is not expected to alter our segmentation

Q1		Q2	
Metric Score	**Segment**	**Metric Score**	**Segment**
2.8	4	2.69	4

We have noted that the Trust is benchmarked not only against the Non-Acute Peer Group but also against any organisation nationally that delivers the same service, regardless of peer group classification. This does not align with the data presented in the publicly available NOF dashboard.

The Board has completed the capability self -assessment and it is in the final stages of review. These findings will be submitted to NHS England.

Development of the LCH IPR as per the outputs of the Audit Yorkshire review will integrate reporting on the NOF further into this report. Future reports will pivot to the NOF domains and will provide regular updates on the measures included in the framework.

Table 1a – Summary of SPC Indicator Performance and Assurance

	Passing	Inconsistent	Failing	No Target
Improving	DQMI - IAPT 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	Diagnostic 6-week target (DM01) NHS Talking Therapies 18 week treatment target Staff Turnover 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 ND Waiting times (over 5s) NT Contacts NT Productivity NT Staff funding utilised NT Vacancies, Sickness & Maternity WTE Number of complaints
Deteriorating			18-week waiting list target (RTT) 52 week waiting times (RTT) 65 week waiting times (RTT) 78 week waiting times (RTT) DQMI - MHSDS	LMWS Access NHS Talking Therapies Screening within 2 weeks Non-RTT 18 week equity NT Referrals RTT 18 week equity RTT 52 week equity

Table 1b – Non-SPC Indicator Summary

Leeds Community Healthcare NHS Trust

Categorisation of Non-SPC Indicators

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

Table 2 – Indicator movements since previous report

Indicator	Previous Report	This Report	Narrative
NHS Talking Therapies 18-week treatment target	Passing, Improving	Passing, No significant change	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.
Eating Disorders - 1 Week Urgent Target	No Concern	Concern	The service has reported 3 consecutive months of breaches of the 1-week target for urgent referrals.
Overdue PSII Actions	No Concern	Concern	July and August has seen an increase in the number of Overdue PSII Actions, with 22 overdue at the end of August.
NCAPOP Audits	No Concern	Concern	There are concerns relating to the number of audits being completed in timely ways
Total Audits Completes	No Concern	Concern	
Priority 2 Audits	No Concern	Concern	
BME Staff Proportion	Failing, Deteriorating	Failing, No change	Recent declines have stabilised. An action plan for further improvement is described in the report
RTT 52-week equity	No change, No target	Deteriorating, No target	A steep increase is showing in the odds ratio showing the differences in waiting times for patients living in IMD1 vs all other IMDs. There is a widening gap in waiting times, with the most deprived now waiting even longer

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.

There remain several outstanding actions from Patient Safety Incident investigations which are now overdue. These have been escalated to the business units within the Monthly Business Units Reports and at the Quality Assurance and Improvement Group Business Meeting. All actions requiring extension should follow the established overdue Patient Safety Incident Investigation (PSII), Patient Safety Learning Response (PSLR)Action Management process prior to the action becoming overdue.

Following the review and launch of the Patient Safety Incident Response Plan for 2025/26 the PSIRP Priority KPI was proposed to be removed. However, it has been agreed that this measure should stay in place until the Audit Yorkshire Review has concluded with the PSIRP Priority KPI in the meantime reported of no concern and no narrative required.

There was one breach to the statutory duty of candour compliance in July 2025 due to a delay in the letter being completed by the Service following the verbal apology provided.

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- August 2025 however this remains below the 95% target.

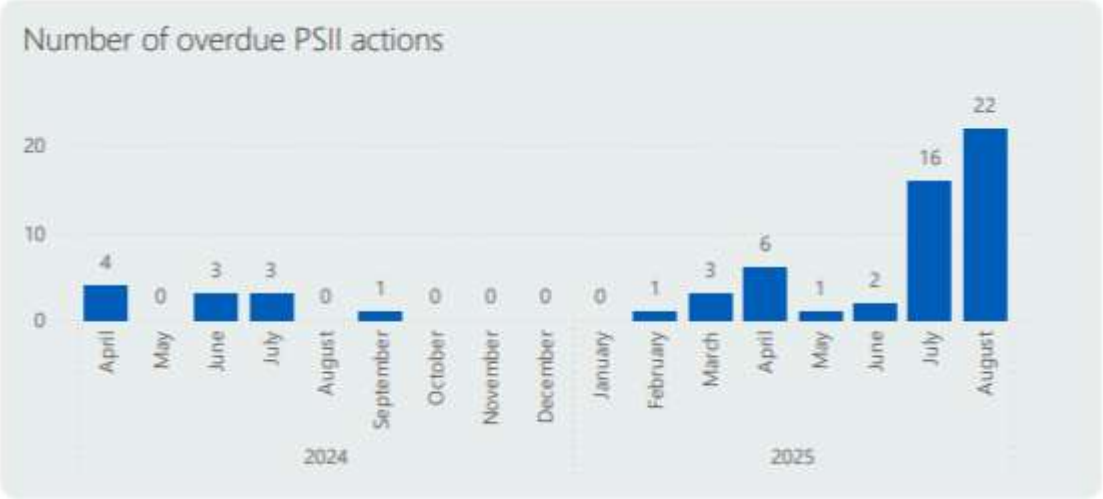
What is being done about it?

A request for this measure to be monitored specifically via local performance panels will be made. This will target services with lower compliance and support them in providing protected time to completion of the training.

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?

The Patient Safety Incident Investigation actions detailed have not been completed within the allocated timescale and have become overdue without prior escalation or request for extensions as per the established overdue Patient Safety Incident Investigation (PSII), Patient Safety Learning Response (PSLR) Action Management process in advance of the due date. There are currently 22 overdue PSII actions (one March, one April, three May, nine June, seven July and one August), Five linked to incidents for the Adult Business Unit and 17 for the Children's Business Unit. Risk 1359 (score 9, possible, moderate harm) is held for any incomplete PSII actions as they remain a risk to patient safety until completion, including when within timescale.

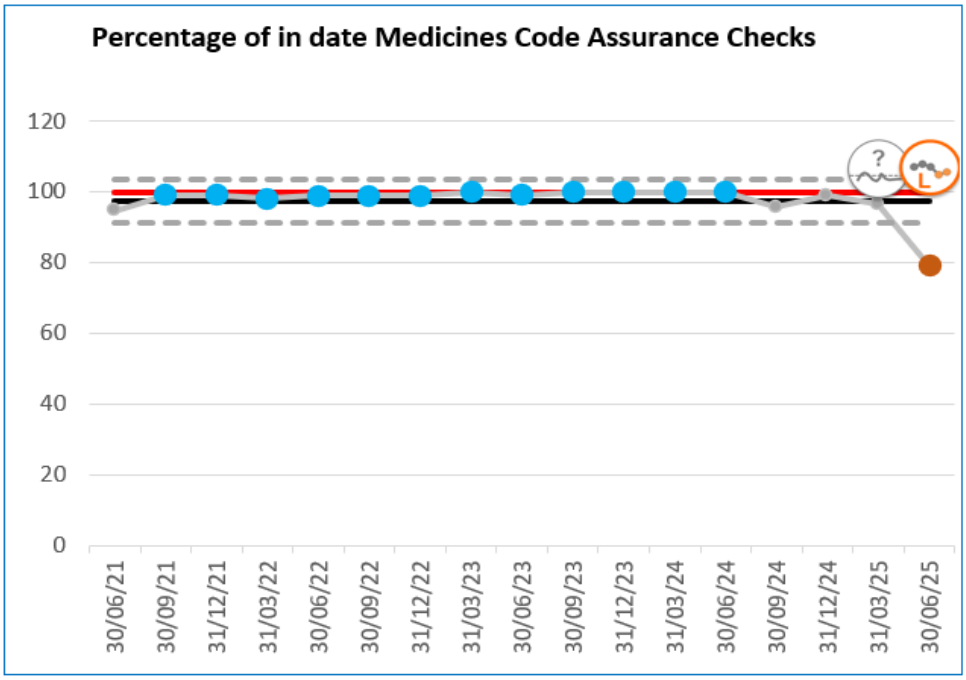
What is being done about it?

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. Overdue actions are also escalated at the monthly Quality Assurance and Improvement Group Business Meeting. The process for agreeing and extension will be reinforced with the Business Units and within Clinical Governance.

When do we expect to see an improvement?

When the action owners have reviewed the actions prior to the due date to complete them in timescale or for any that are at risk of becoming overdue have followed the agreed process for extension.

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):

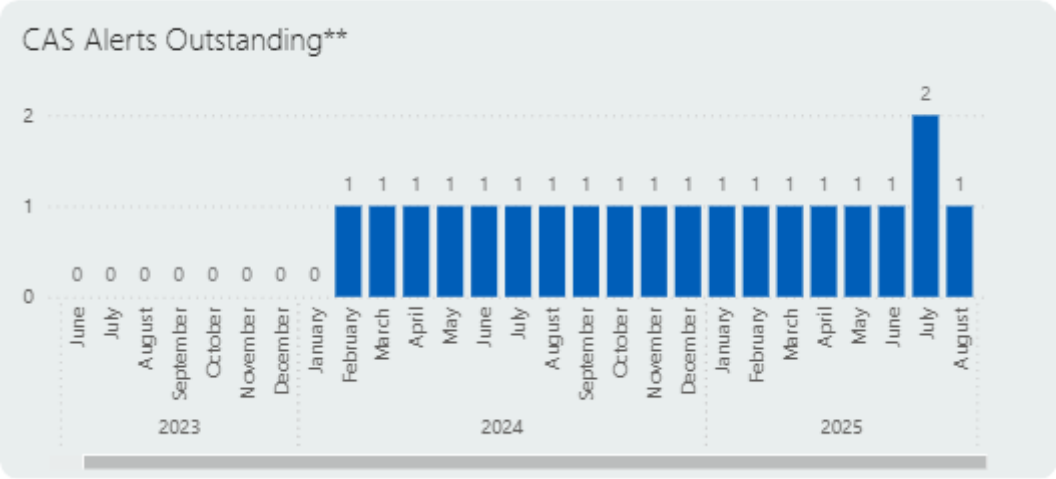
- CUCS – 9 months overdue; changed base in July 2024 (check expected to be completed within three months of change of location); awaiting feedback from service for date to complete check
- Neighbourhood Night Nursing Service – 6 months overdue; changed base in September 2024; awaiting feedback from service 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.

CAS Alerts Outstanding



What is the trend that we see?

There was one overdue CAS alert in July and two in August.

What is being done about it?

There is one continuing alert that is overdue for LCH and across the system with ICB oversight (NatPSA/2023/010/MHRA - Medical beds, trolleys, bed rails bed grab handles and lateral turning devices: risk of death from entrapment or falls). Risk 1168, score 8, unlikely, major harm.

NatPSA/2025/002/UKHSA Potential contamination of non-sterile alcohol-free skin cleansing wipes with Burkholderia app: measures to reduce patient risk. Was due for completion on 29 August 2025, all actions were completed, however the website was not updated until 1 September 2025 due to the Patient Safety Team being in Opel 3 and with additional staff absence.

When do we expect to see an improvement?

Children's Business Unit are compliant with the alert.

Specialist Business Unit are compliant with the elements of the alert that apply to them.

Adult Business Unit teams are reviewing all patients currently provided with equipment, and risk assessments are being documented. Adult patients on active caseloads are undergoing individual reviews. This process is expected to quantify the level of need and propose a trajectory for how the outstanding work will be addressed, including a timeframe based on existing resources. It is also expected to identify what additional support is needed to mitigate the risk to a more acceptable level. System One will support this action by providing accurate patient data. The ABU Bed Rail Risk Assessment for discharged patients has not yet been completed.

Compliance with this alert remains particularly challenging due to the high volume of patients and limited capacity. Alternative internal approaches are currently being explored, while assessments of the active caseload continue. It is held under risk 1168 above and MHRA are aware.

Caring

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

Summary

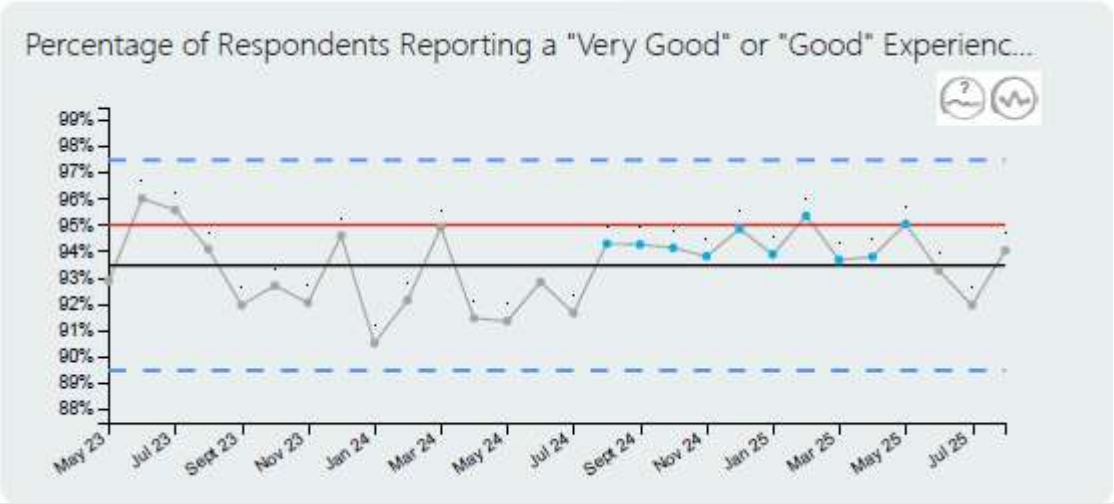
The organisation aims to uphold a strong commitment to caring by ensuring staff engage with individuals compassionately and respectfully. Staff are expected to treat people with kindness, uphold their dignity, and involve them in decisions about their care. While there are examples of positive interactions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

Reporting on the effective domain is provided quarterly. An update will therefore be included in the next Performance Brief.

An interim update on equity is provided below.

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 3 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 28,549 people waiting for care to start at the end of August 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 3,481 at the end of August 2025, from 3,828 at the end of June.

Our Children's Audiology Service were slightly below the target for 99% of patients seen within 6-weeks, achieving 98.6% in August 2025. However, prior to August the target has been met consistently each month this reporting year (from April 2025).

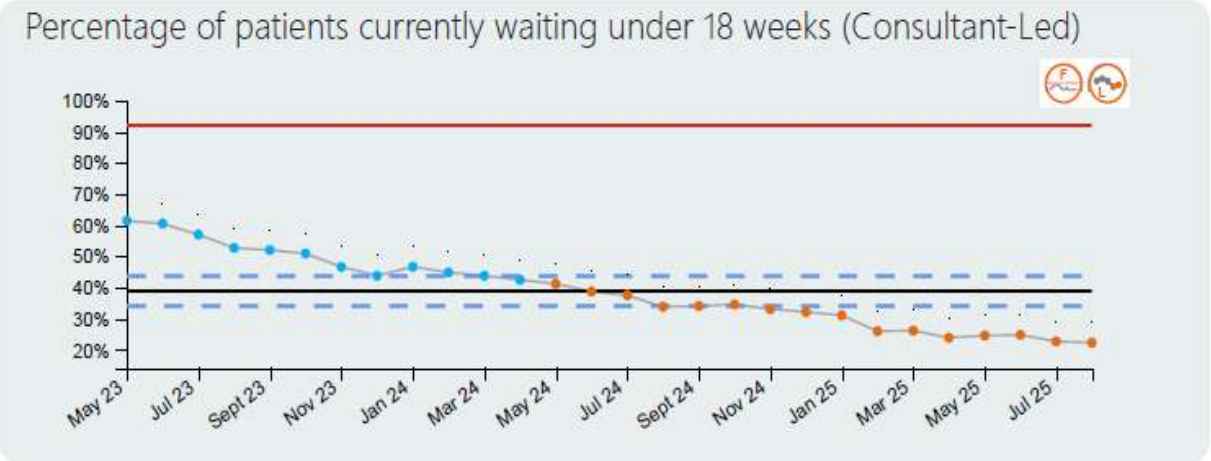
The Trust also continues to meet the target for the Urgent Community Response Standard, although increased scrutiny and focus on this indicator will be applied in the Trust given its inclusion in the NOF framework.

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 table below describes how many patients are waiting for each of the RTT-reportable clinics within ICAN. The primary influence of this trend continues to be for children awaiting Autism Assessment within our Paediatric Neuro Disability Clinics.

Service	Total RTT patients waiting	18-52 weeks	52+ weeks
Paediatric Neuro Disability	2231	517	1374
Community Paediatric Clinics	247	0	0
Other Community Paediatric Clincs	80	1	1

Of the patients waiting more than 52 weeks, 221 have waited between 65-78 weeks and 925 have waited more than 78 weeks.

What is being done about it?

The service presented an action plan and associated business case to Trust Directors in September, which was approved. This action plan contains three distinct strands:

- All patients waiting more than 40 weeks will receive a phone call to ask them to confirm if they still require support. The service has been finding that some patients have been taking up Right to Choose offers but not informing the ICAN team that they have obtained an autism assessment privately. These calls have already started to be made to families.
- The service is implementing new referral criteria for an autism assessment. An EQIA is being written to consider apply these new thresholds to patients already referred.
- The service has begun processes to recruit 4 new locum staff between now and the end of Q3 to solely offer single-assessor autism assessments, prioritising patients with the longest waiting times. It is not expected that these assessments will lead to any follow up appointments within the PND service, removing the risk that speeding up the rate of assessment will increase the number of patients awaiting review appointments

When do we expect to see improvement?

Based on current plans, the service is aiming to have seen or discharged all patients waiting more than 52 weeks for an autism assessment by the end of December. There may however still be a small number of patients waiting more than 52 weeks for a non-autism reason.

% 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 12% 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 289 at the end of July
- There has been a 30% reduction in the waiting list size for Respiratory Services over the last 3 months. At the end of August 88% of waiters were under 6 weeks.
- Community Gynaecology continue to see their waiting list size fall, with a 22% reduction over the last 3 months.
- Our CAMHS Services have achieved overall waiting list reductions of 48% 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

We continue to see overall reductions in the number of people waiting more than 52 weeks (including RTT and non-RTT pathways), falling by 197 since last month, and now standing at 3,481 at the time of writing. The represents a reduction of over 1,100 from the March figure of 4,640. A total of 52% of patients waiting more than 52 weeks are currently awaiting an ND assessment either in CAMHS, CDC or PND.

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

Service	Patients waiting more than 52 weeks
CAMHS	962
Looked After Children*	5
Child Development Centre (CDC)	19
Neo-Natal Abstinence Clinic*	1
PND*	1384
Children's Nutrition and Dietetics*	2
Community Gynaecology	39
CUCS*	16
LeMuRS	1
MSK*	1
Podiatry*	90
Adult SLT*	217
Children's SLT*	0
Cardiac*	0
Community Neuro Rehab*	1
Dental	743
Total	**3481**

**These services are amongst those that will contribute towards the new NHS National Oversight Framework in relation to patients waiting more than 52 weeks.*

What is being done about it?

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

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.

Podiatry

The service will be offering additional clinics on Saturdays, from October to the end of March 2026. It is expected that this initiative is expected to deliver around 480 additional appointments over an 18-week period, which will have a significant impact on the overall waiting list size and specifically the number of people waiting 52+ weeks.

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 2,404 by the end of August 2025, from 2,914 at the end of March 2025. The total number of people waiting more than 52 weeks fell to 743 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 is expecting to recruit locum staff to commence in September, and opt in letters are being sent to people on the waiting list throughout September.

The service currently has 928 people waiting, which has increased from 883 in June 2025. A total of 227 people have waited more than 52 weeks, which has increased from 176 in June 2025.

CUCS

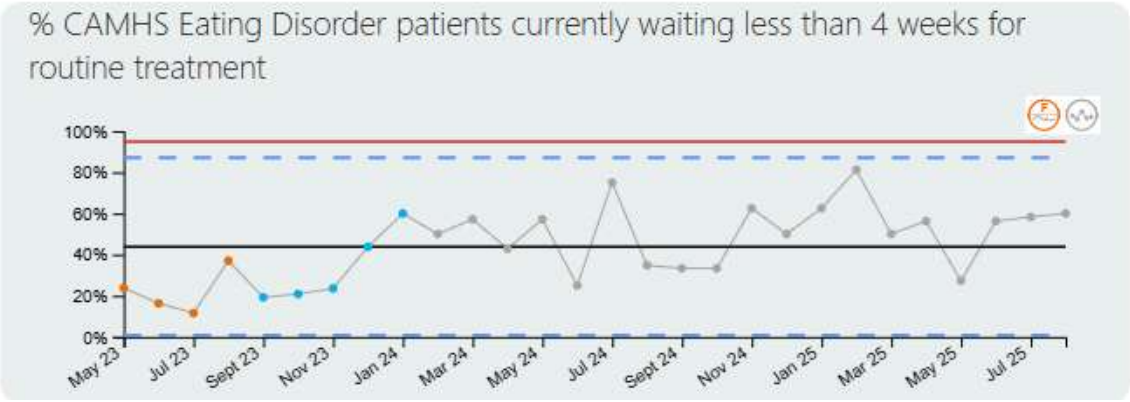
Longer term problems exist for the service with sickness rates and capacity to see bladder and bowel patients. At the time of writing, 12 of the 16 people waiting 52+ weeks have future appointments

booked, however there is a group of 35 patients in the 48–52week range who are at risk of breaching 52+ weeks (23 of these have future appointments booked).

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.

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 several gaps in roles that are sufficiently qualified to offer initial assessment appointments.

What is being done about it?

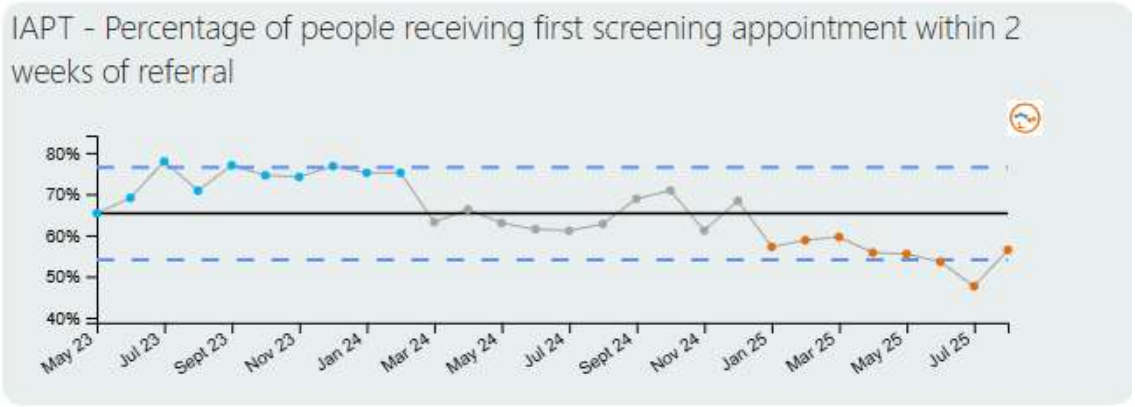
The ICB has recently provided additional funding to increase capacity for assessment appointments. Increasing the availability of the more skilled clinicians in the team will support both the capacity for assessing new patients, and the capability of the service to manage the increased risk and complexity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

A business case against this funding has now been submitted.

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 remains at significantly lower than average levels. The service has reported capacity pressures in consistently achieving this target , with a growing number of staff leaving the service, particularly amongst Helpful Conversation Practitioners.

The service also has concerns relating to the impacts of short notice cancellations from patients, and clinician practices relating to booking of follow ups.

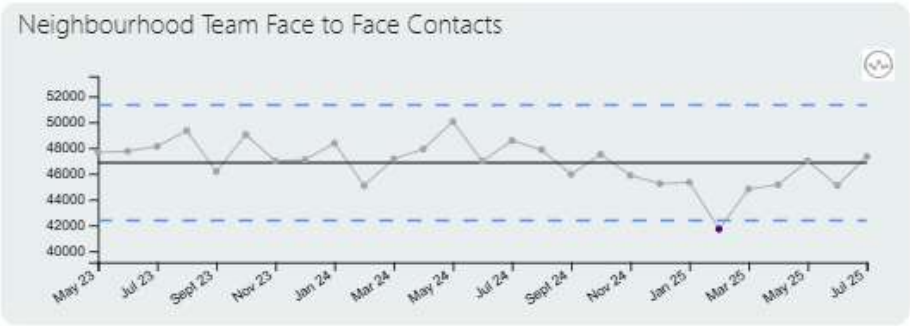
What is being done about it?

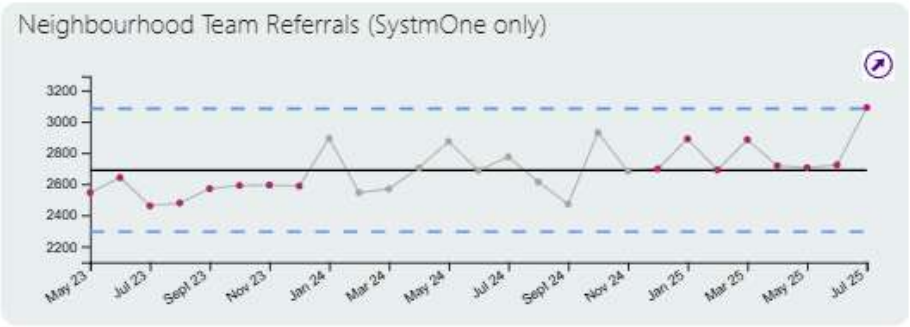
In response, the service is currently not likely to replace many of the staff leaving but is considering policy changes in relation to short notice cancellations. The service is also working with clinicians to reduce the number block-booked follow ups that are created, to free up more capacity to see new patients.

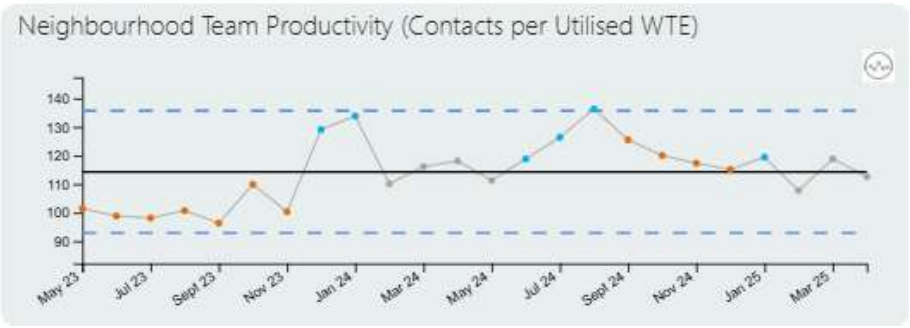
When do we expect to see improvement?

With the service trying to balance out the needs of patients with long waiting times versus the needs of starting care for new patients, it is likely that this indicator will remain at similar levels or potentially deteriorate in future months.

Neighbourhood Teams







What is the trend that we see?

Neighbourhood Teams have received a very high volume of referrals for new patients in July 2025 and they have maintained the average volume of face-to-face contacts (data for August 2025 is delayed).

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?

By the end of September 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 communications to other providers to help reduce unwarranted referrals in Q4 and ensure patients are directed to the right place.

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.

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.

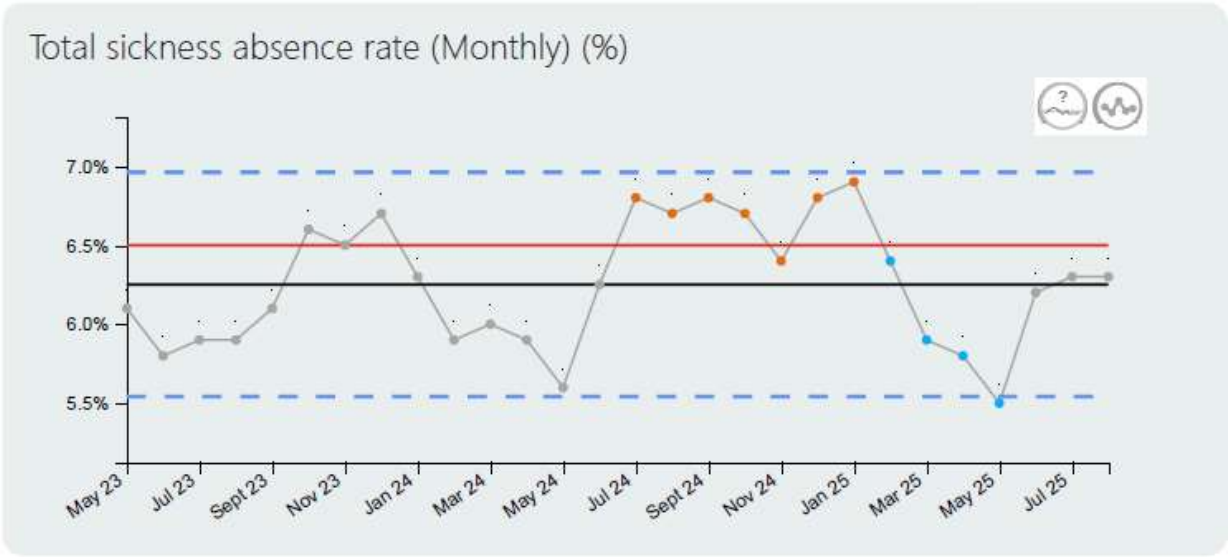
Statutory and Mandatory Training continues to hover just below 90% target.

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 shows that overall sickness absence rates remain within statistical control limits but are consistently close to the organisational target. The latest data points are nearing this threshold, indicating a potential upward trend that requires attention, especially now we are reaching the anticipated seasonal challenges.

The sustained increase in long term sickness absence highlights a concerning nature that could see further failures of the target without being the result of any process change.

What is being done about it?

As part of the National Oversight Framework, The Director of Operations and The People Director are leading sickness panels to work with managers to gain insight to the challenges they are facing with sickness and to provide additional support where required (team level analysis).

A focus group is underway to consider further engagement, Occupational Heath input, root causes and actions, this insight is being shared with the People Directorate to outline specific tasks / requirements to increase staff being well in work.

When do we expect to see improvement?

One of the delivery metrics contained within the National Oversight Framework, is around sickness absence rate. Preventative actions are currently underway; we therefore expect to see a reduction in the coming months given the focus alongside People Partnering / People Directorate input.

AfC Staff appraisal rate

What is the trend that we see?

Following a steady and gradual improvement towards the target since August 2024, we've made even more significant improvements since June 25 resulting in the highest compliance rate since 2021. The last ten months performance has been above the mean.

What is being done about it

The ABU and SBU teams have been set challenges and targets as part of the trust's performance panels, with ongoing monitoring at the BU level. The results of the last few months show this is having a very positive impact on the compliance and efforts to meet the target should be celebrated.

When do we expect to see improvement?

We expect to see continued improvement through 2025/26.

Statutory and mandatory training compliance

What is the trend that we see?

Performance has shown a steady improvement towards the target since June 2024, remaining consistently within 1% of the target 90% compliance rate.

What is being done about it

Performance monitoring is currently conducted at the BU level through performance panels. A statutory and mandatory training dashboard is available to all managers, showing performance broken down to team level.

When do we expect to see improvement?

In the short term, significant improvement is not expected, as reflected in the trends observed over the past eight months. The expectation is that it will remain high and within 1% of the target.

Percentage of staff identifying as BME

What is the trend that we see?

Performance remains marginally below the target. An issue was identified with the configuration of the new recruitment system, meaning that candidates could by-pass identifying their ethnicity.

What is being done about it

The configuration in the system has been corrected, and new recruits who joined during this period are being contacted to update their EDI information within the staff record.

When do we expect to see improvement?

We expect to see improvements October/November

Finance

Executive 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	-	(654)	654	-	(899)	899
3,600	Underlying (Surplus)/ Deficit		1,190	(1,190)		2,388	(2,388)
50,908	Closing Cash Balance	49,656	44,001	**5,655**	43,426	48,387	**(4,961)**
(7,628)	Capital Expenditure (CDEL)	5,712	2,756	**(2,956)**	9,711	9,711	-
	Quality & Value Programme						
9,130	Recurrent Savings	7,002	5,186	**1,816**	14,000	10,368	**3,632**
6,648	Non Recurrent Savings	-	1,816	**(1,816)**	-	3,632	**(3,632)**
15,778	**Total Savings**	**7,002**	**7,002**	-	**14,000**	**14,000**	-
	Temporary Staffing						
2,408	Agency	988	735	**(253)**	2,019	1,762	**(257)**
5,334	Bank	2,677	2,676	**(1)**	5,358	5,190	**(168)**
7,742	**Total Temporary Staffing**	**3,665**	**3,411**	**(254)**	**7,377**	**6,952**	**(425)**
168,716	**Total Gross staff Costs**	**82,867**	**81,584**	(1,283)	**166,091**	**164,660**	**(1,431)**
4.6%	**Temp Staffing Costs as a % of gross staff costs**	**4.4%**	**4.2%**	**(0.2%)**	**4.4%**	**4.2%**	**(0.2%)**

Income & Expenditure

As at the end of September 2025, the Trust reported a year-to-date (YTD) surplus of £0.654m, compared to its break-even plan. The Trust remains on track to achieve its stretch target of £0.9m surplus by year end. Achieving this target is essential for the Trust to deliver its share of the West Yorkshire (WY) system's additional improvement target.

The financial position is underpinned by non-recurrent measures including release of old year accruals no longer required and budget underspends. Taking full year effect on savings already achieved the forecast underlying position at Month 6 is a deficit of £2.38m. Planning assumptions continue to assume recurrent savings will be identified and therefore the Trust will be in a recurrent underlying breakeven position at the start of 26/27.

Cash

The Trust's cash position remains strong, with a year-to-date closing balance of £44.1m, but lower than the planned figure by £5.6m. This variance is mainly due to an increase in receivables. The cash operating days, which is to pay short-term liabilities, is 71 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 September 2025, the Trust has reported a spend of £1.1m on owned assets and £1.68m on ROU assets. The underspend against plan as at Month 6 is related to lower than planned lease remeasurements (£1.0m) 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 £0.65m year-to-date overspend which will be recovered during the year.

Quality & Value Programme

As at the end of September 2025, the Trust's identified CIP remains at £10.368m, broadly in line with August 2025, with a full-year effect of £11.6m. Year to date, the Trust is on track to deliver its £7 million savings plan, comprising £5.186m of recurrent savings, with the remainder achieved through non-recurrent measures. Work continues to secure the outstanding savings required to meet the full annual target.

Temporary Staffing

As at the end of September 2025, year-to-date temporary staffing budgets are underspent by £0.254m and account for 4.2% of gross staff costs, compared to an average of 4.9% in the previous financial year. In the second half of the year, temporary staffing costs are forecast to increase by approximately £0.6m to support winter pressures and waiting list initiatives.

Appendix I – Data pack

NHS
Leeds Community Healthcare
NHS Trust

Performance Brief

Appendix 1 - 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 lownumbers, 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 aone-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 highnumbers, 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 highnumbers, 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 aone-off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

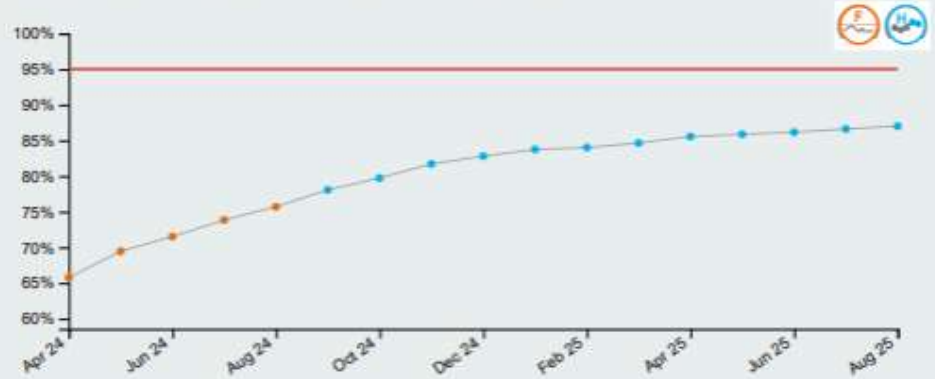
	Assurance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your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

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

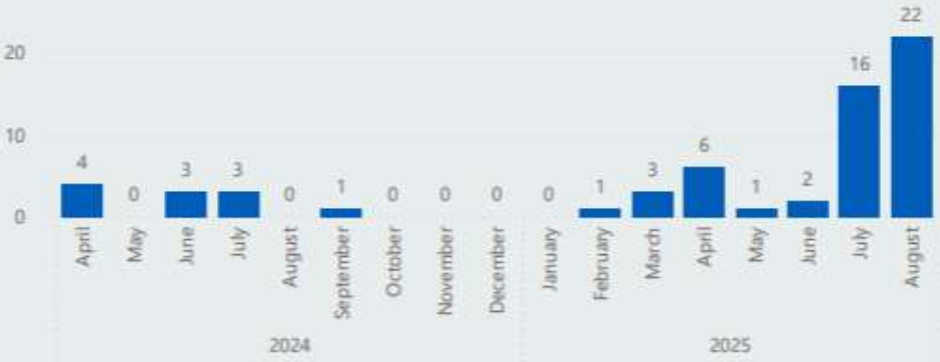
Safe - Patient Safety

NHS
Leeds Community Healthcare

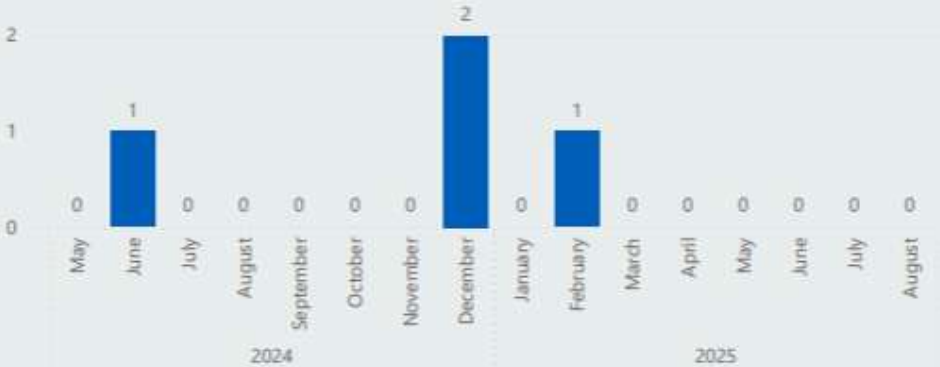
Compliance in Level 1 and 2 Patient Safety Training



Number of overdue PSII actions



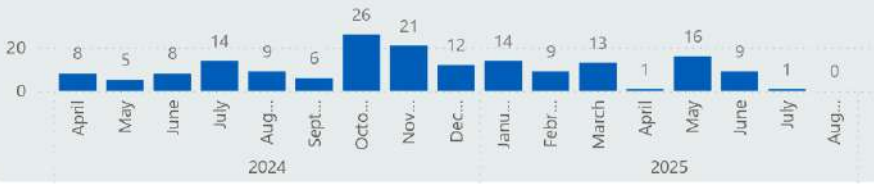
Number of Patient Safety Incident Investigations (PSII)



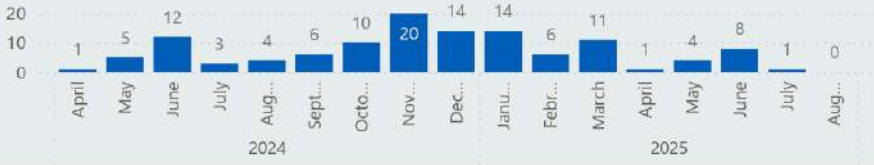
Safe - Patient Safety

NHS
Leeds Community Healthcare
NHS Trust

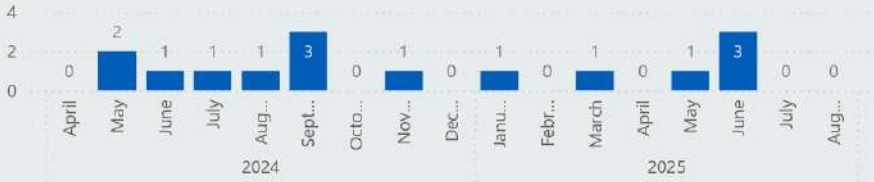
Number of incidents by PSIRP priority - Pressure Ulcers



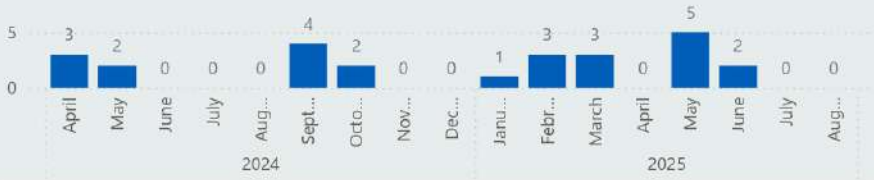
Number of incidents by PSIRP priority - Falls



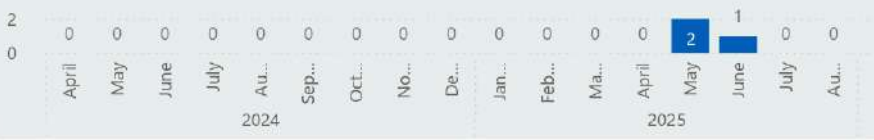
Number of incidents by PSIRP priority - Deteriorating Patient



Number of incidents by PSIRP priority - Meatal Tear



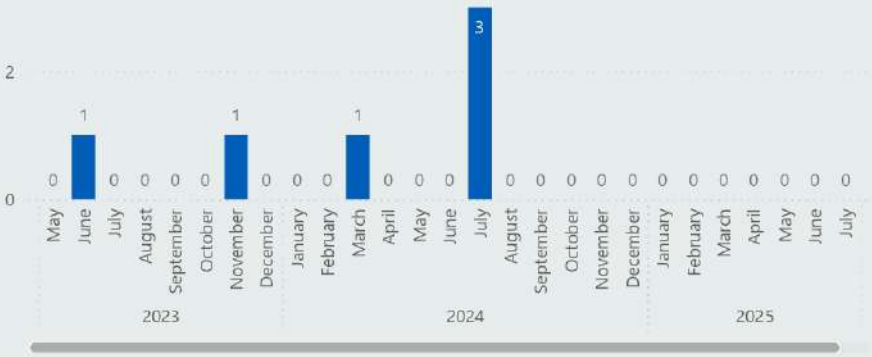
Number of incidents by PSIRP priority - Clinical Triage in Neighbourhood Teams



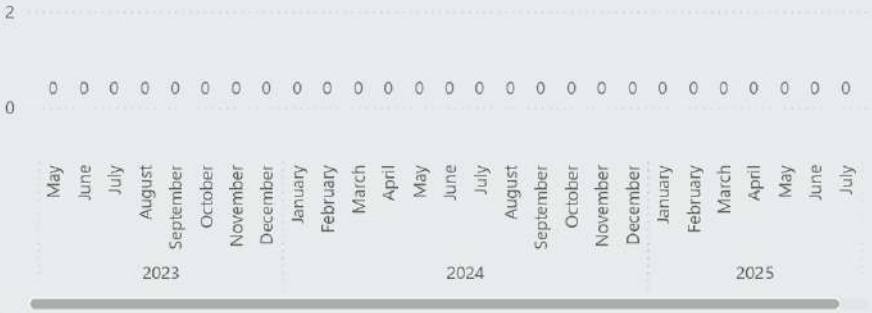
Safe - IPC

NHS
Leeds Community Healthcare
NHS Trust

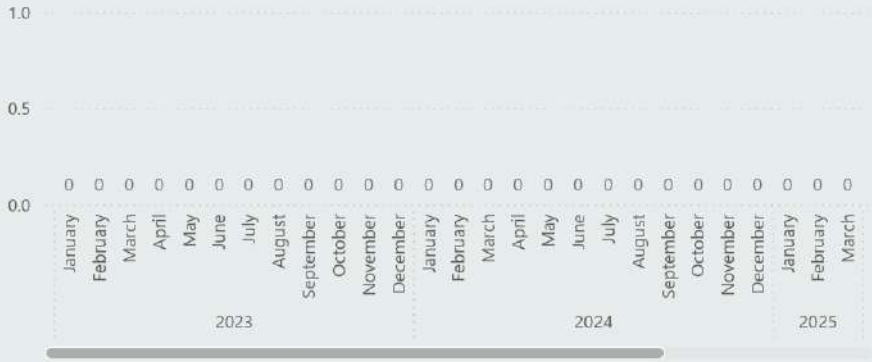
Attributed MRSA Bacteraemia - infection rate**



Clostridium Difficule - infection rate**



Incidents of E.Coli, bacteraemia

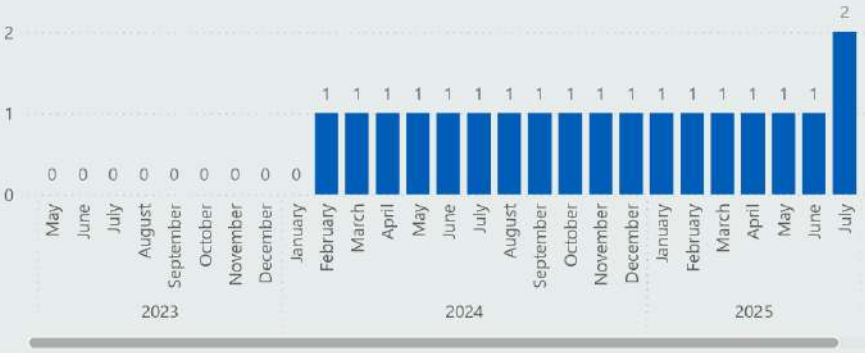


Safe - Other

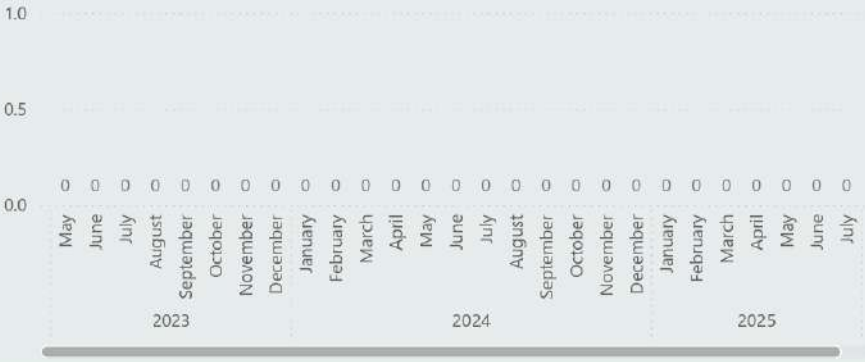
NHS
Leeds Community Healthcare
NHS Trust

Compliance with statutory Duty of Candour

CAS Alerts Outstanding**



Never Event Incidence**



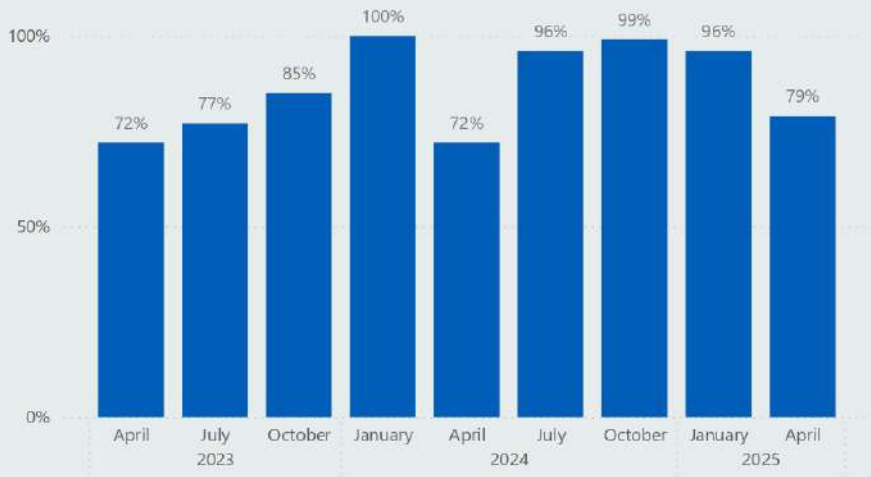
Safe - Safer Staffing

NHS
Leeds Community Healthcare
NHS Trust

Safer Staffing – Inpatient Services

There is not enough data yet to show this chart

Number of teams who have completed Medicines Code Assurance Check...



Safe - DQMI

NHS
Leeds Community Healthcare
NHS Trust

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

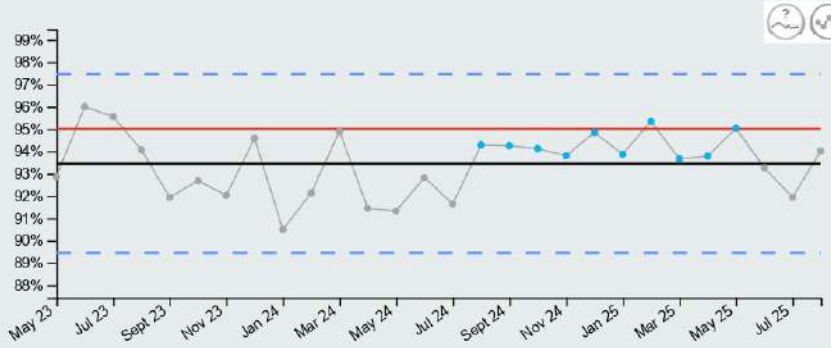
Data Quality Maturity Index (DQMI) - IAPT dataset score**

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

Caring Domain

NHS
Leeds Community Healthcare
NHS Trust

Percentage of Respondents Reporting a "Very Good" or "Good" Experienc...



Total Number of Formal Complaints Received

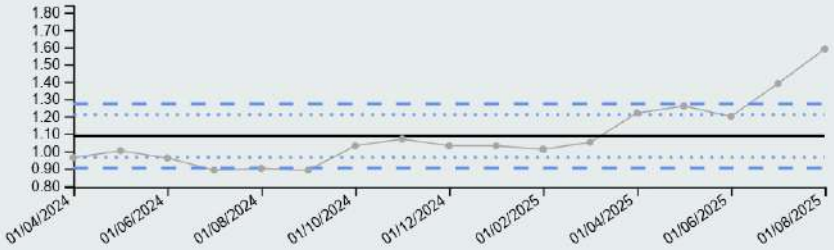
Mixed Sex Accommodation Breaches

No breaches Reported

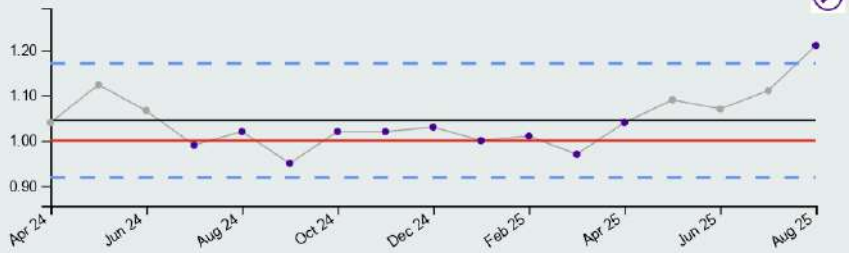
Effective - Equity

NHS
Leeds Community Healthcare
NHS Trust

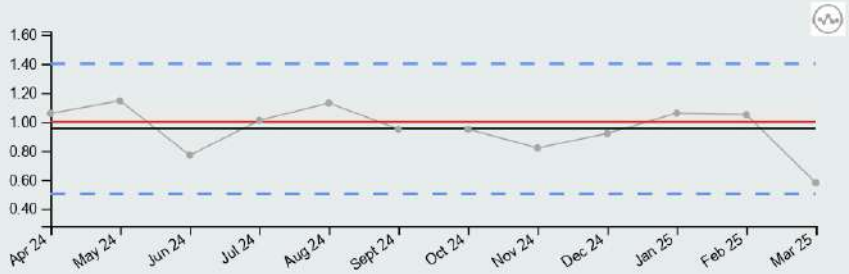
Difference in access to services for patients living in IMD1 vs IMD2-10 - Co...



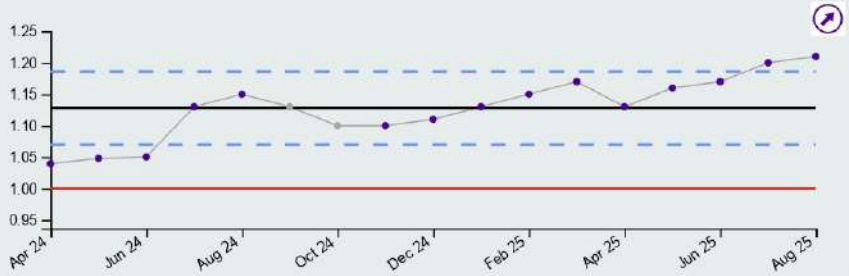
Difference in access to services for patients living in IMD1 vs IMD2-10 - Co...



Difference in access to services for patients living in IMD1 vs IMD2-10 - D...

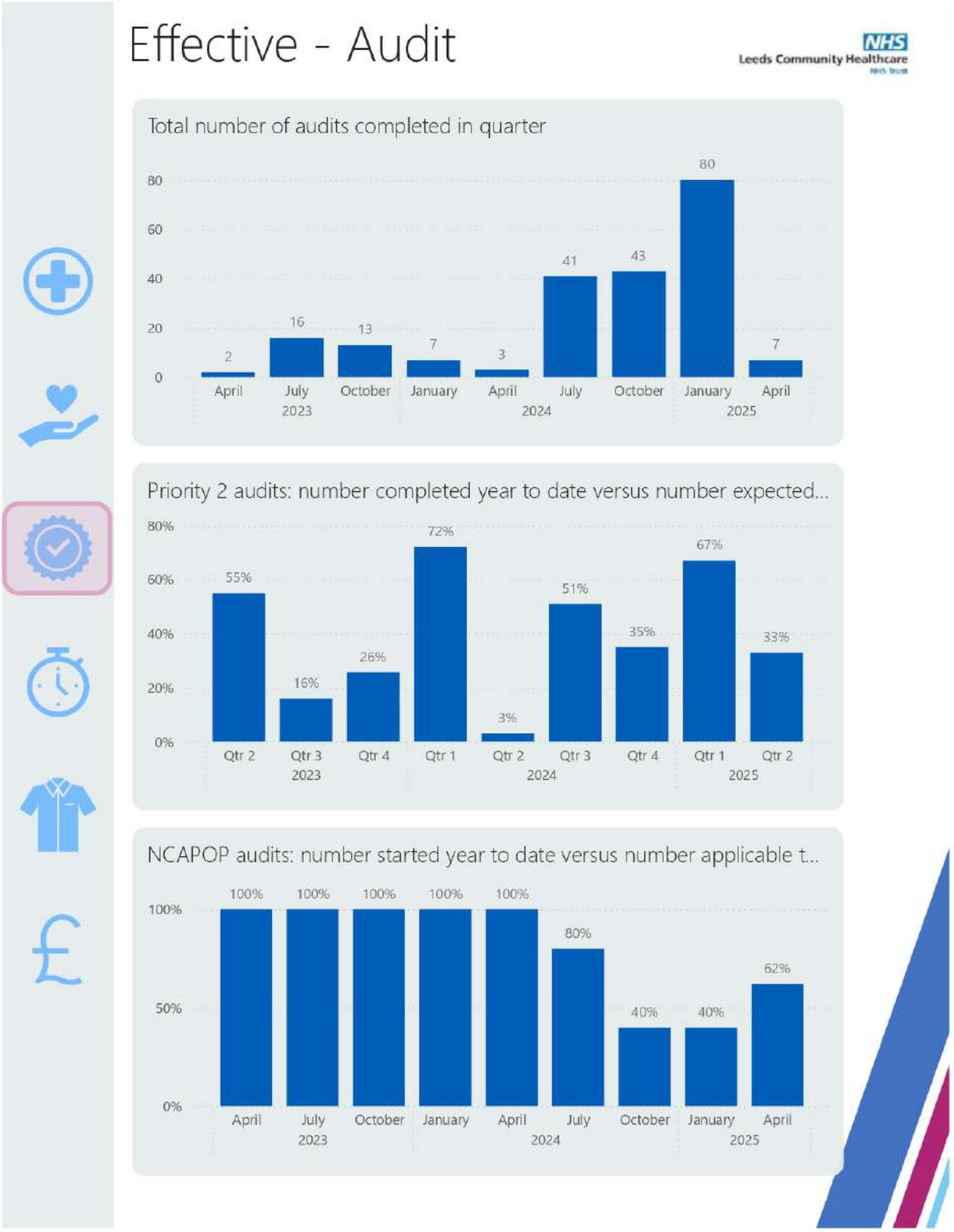


Difference in access to services for patients living in IMD1 vs IMD2-10 - No...



Effective - Audit

NHS
Leeds Community Healthcare
NHS Trust



Effective - NICE Guidance

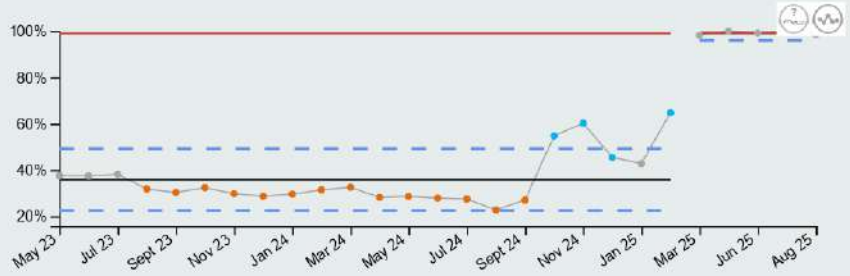
Responsive Domain

NHS
Leeds Community Healthcare
NHS Trust

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

% Patients waiting under 18 weeks (non reportable)

Percentage of patients waiting less than 6 weeks for a diagnostic test (DM...



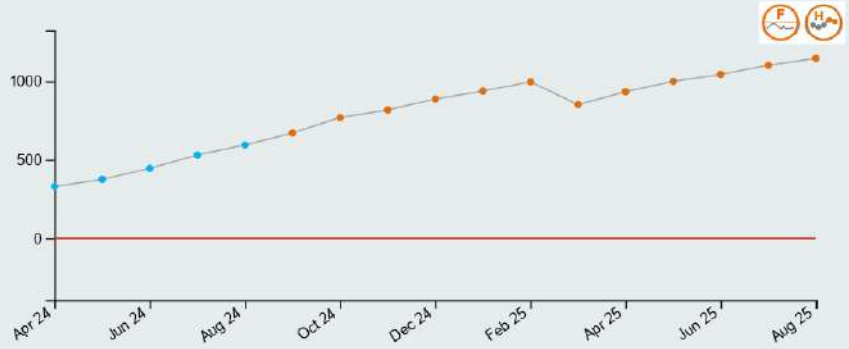
Community health services two-hour urgent response standard

Responsive Domain

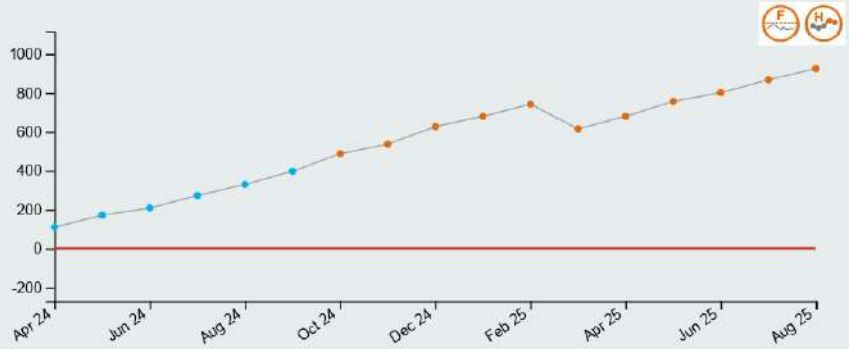
NHS
Leeds Community Healthcare
NHS Trust

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

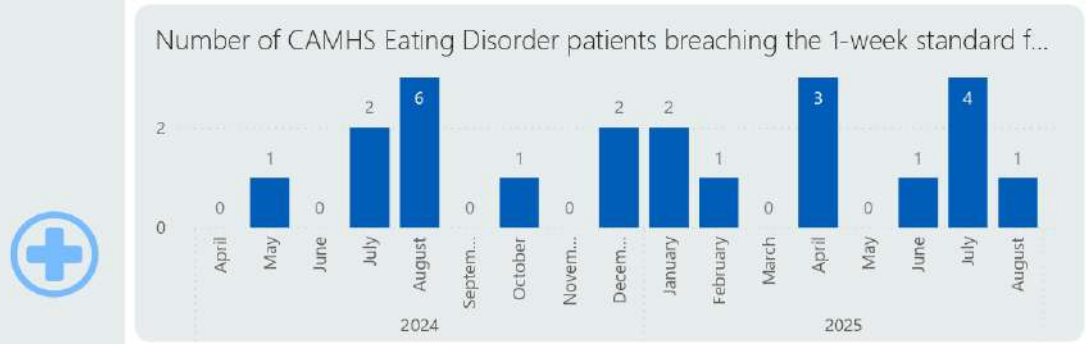
Zero tolerance RTT waits over 65 weeks for incomplete pathways

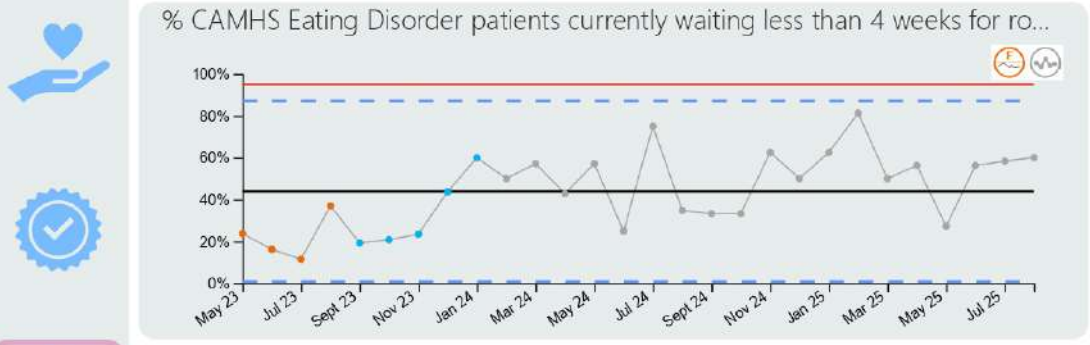


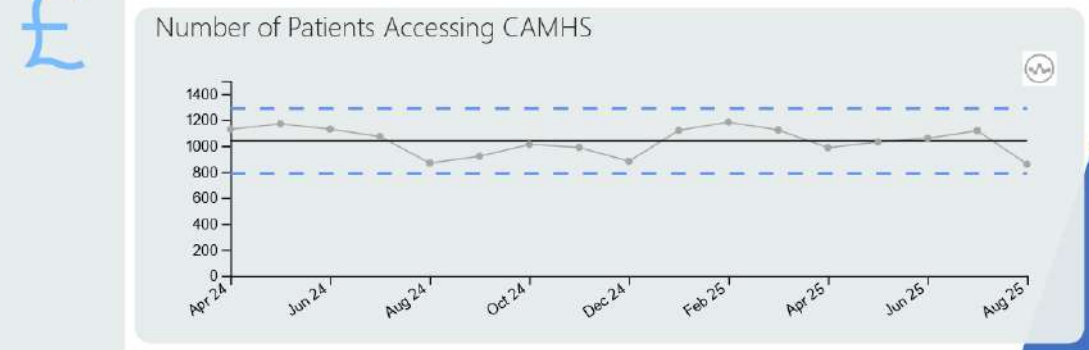
Zero tolerance RTT waits over 78 weeks for incomplete pathways



Responsive - CAMHS



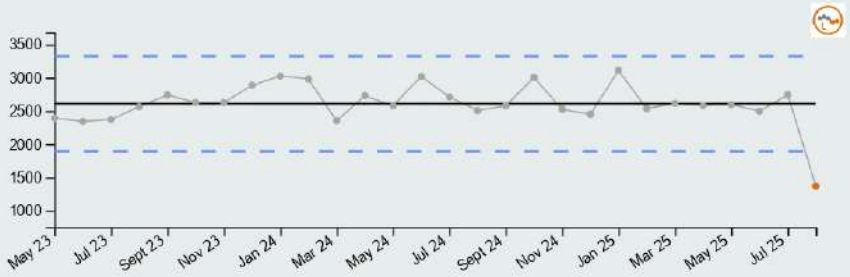




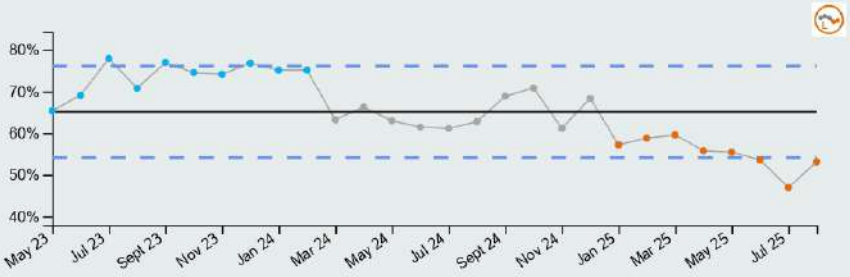
Responsive - LMWS

NHS
Leeds Community Healthcare
NHS Trust

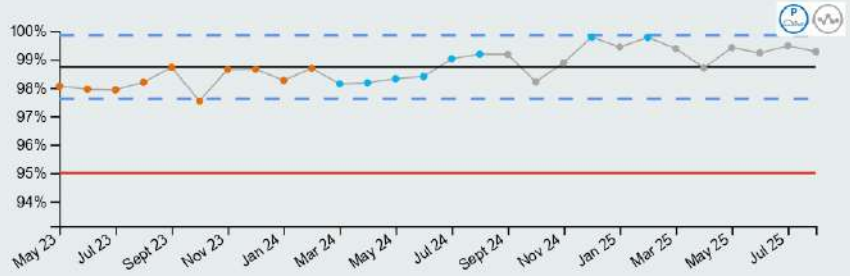
LMWS – Access Target; Local Measure (including PCMH)



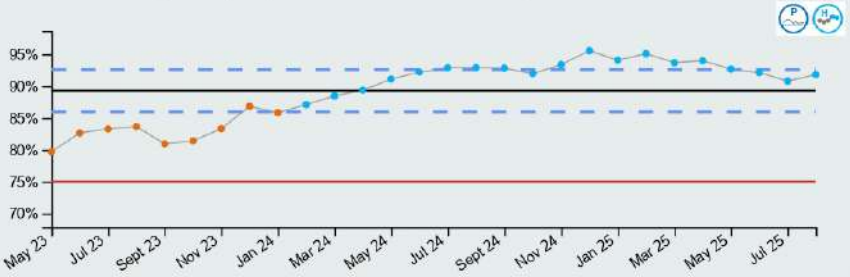
IAPT - Percentage of people receiving first screening appointment within ...



IAPT - Percentage of people referred should begin treatment within 18 we...



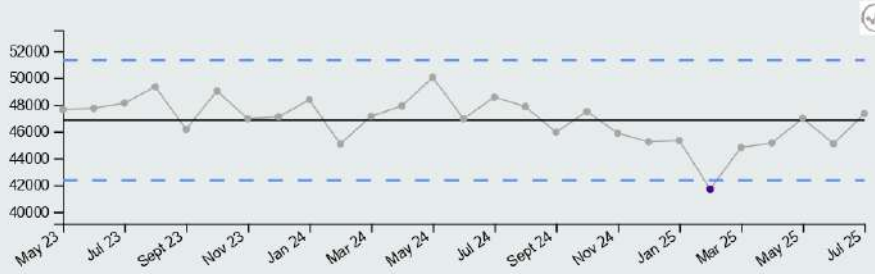
IAPT - Percentage of people referred should begin treatment within 6 wee...



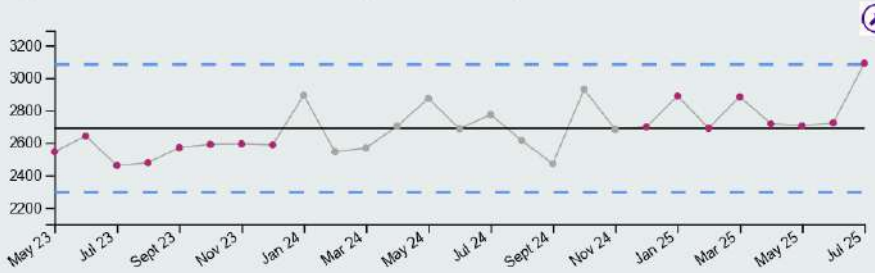
Responsive - NTs

NHS
Leeds Community Healthcare
NHS Trust

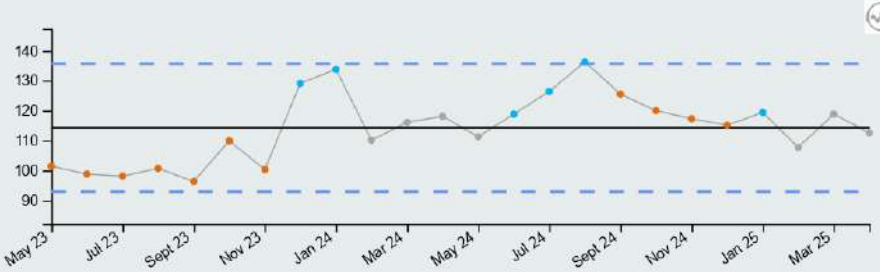
Neighbourhood Team Face to Face Contacts



Neighbourhood Team Referrals (SystmOne only)



Neighbourhood Team Productivity (Contacts per Utilised WTE)



Available virtual ward capacity per 100k head of population

This chart is under development

Responsive - Other

NHS
Leeds Community Healthcare
NHS Trust

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

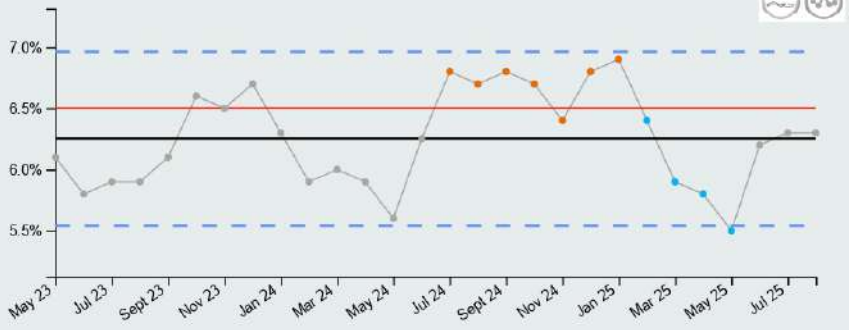
Units of Dental Activity delivered as a proportion of all Units of Dental Acti...

This chart is under development

Well Led - Workforce

NHS Leeds Community Healthcare NHS Trust

Total sickness absence rate (Monthly) (%)



AfC Staff Appraisal Rate

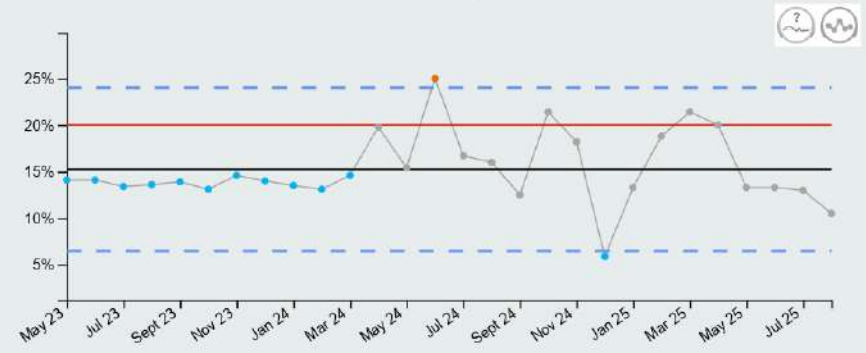
Statutory and Mandatory Training Compliance

Well Led - Workforce

NHS Leeds Community Healthcare NHS Trust

Starters / leavers net movement

Reduce the number of staff leaving the organisation within 12 months



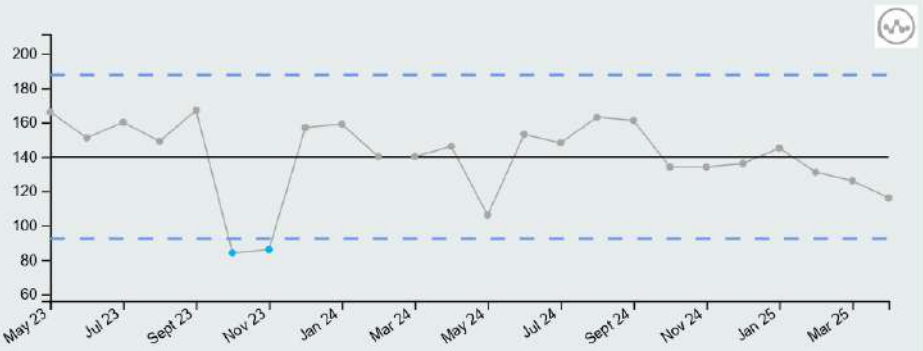
Staff Turnover

Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

Neighbourhood Team Percentage of Funded Posts Utilised

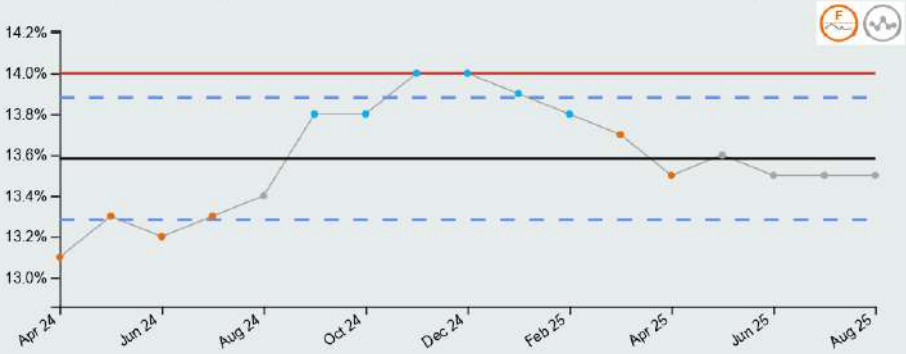
Neighbourhood Team Vacancies, Sickness & Maternity WTE



Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

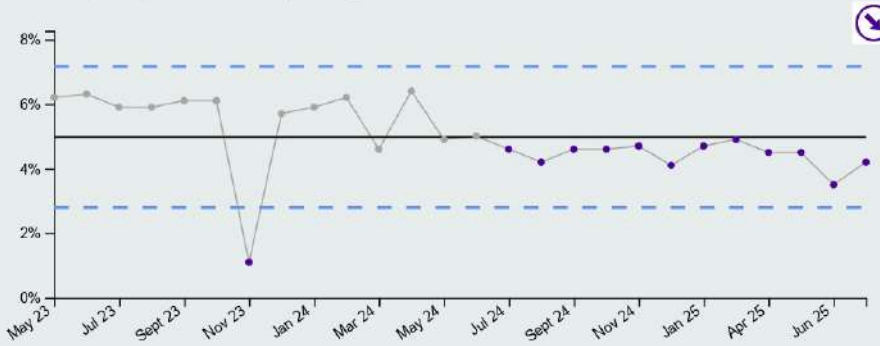
The overall percentage of staff who have identified as BME (including exec. boa...



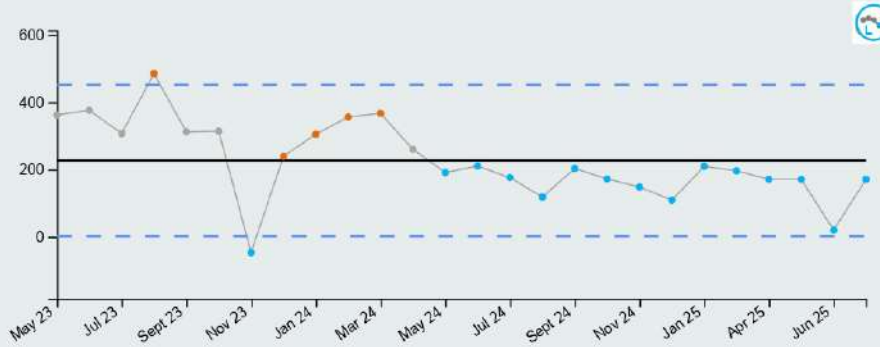
Well Led - Workforce

NHS
Leeds Community Healthcare
NHS Trust

Percentage Spend on Temporary Staff



Total agency cap (£k)



Well Led - Other

NHS Leeds Community Healthcare NHS Trust

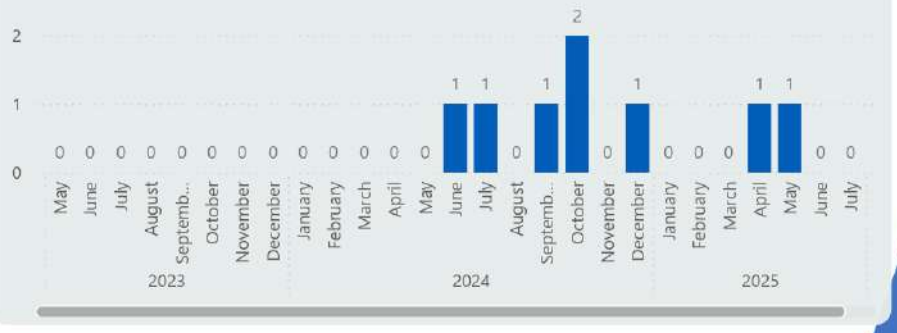
Percentage of Staff that would recommend LCH as a place of work (Staff F...

This chart is under development

Percentage of staff who are satisfied with the support they received from t...

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 Difficile - 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

Medical Device Safety Officer Update on CAS 1643 & Risk register 1168

MHRA Update on Bed rail/sticks/grab handles update for July/August.

Bed rail Risk Assessment for Discharged Patients. ABU continues to progress with active caseloads:

- **Action 1:** Required Policy update. Policy LP270 was completed August 2024.
- **Action 2:** Competency training required: Online training compliance exceeds 76%, target greater than 75%.
- **Actions 3: Action for Leeds Community Equipment Service:** All equipment to be asset tagged with a unique identifier code: LCES reported this is progressing.
- **Action 4: Action for Leeds Community Equipment Service:** This is LCES action to ensure equipment has an in-date service sticker indicating equipment been maintained in accordance to manufacturer's instruction. LCES reported this is progressing.

- **Actions 5:** Children or adults with atypical anatomy (e.g., smaller stature, under 146 cm tall, weighing less than 40 kg, or a BMI under 17). Completed by CBU and SBU. ABU is making progress; however, the lack of adequate resources continues to hinder faster progress. The issue remains on the risk register
- **Action 6:** ABU teams are reviewing all patients currently provided with equipment, and risk assessments are being documented. Adult patients on active caseloads are undergoing individual reviews. Internal work is ongoing to ascertain the number of deceased and deduct from list then, propose a trajectory for how the outstanding work including a timeframe based on existing resources. Adult patients on active caseloads continue to undergo individual review.
- **Action 7:** The ABU Bed Rail Risk Assessment is ongoing to quantify the number of patients on caseload for over 12 months who will require risk assessment. This compliance remains particularly challenging due to the high patient volumes (in the thousands) and limited capacity. Communication is ongoing with the region's ICB on how this can be supported.

MDSO 18/09/2025.

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (18i)

Title of report:	Access to Services: LCH Waiting List Recovery Plan (November)

Meeting:	Trust Board Held In Public
Date:	6 November 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:	This paper provides an update for Business Committee on waiting list improvement plans across key services, building on the September Committee report. It includes trajectories for PND, Adult SLT, CUCS and Podiatry, which have the greatest impact on the Trust's NOF Access to Services score. Narrative is also provided on all other services with 40+ week waits. The paper outlines expected progress in reducing long waits, the anticipated impact on the Trust's NOF position, and provides assurance that robust plans are in place across all services with waits over 40 weeks.

Previously considered by:	Senior Leadership Team 22.10.25 Business Committee 29.10.24

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

	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?	Individual service data includes Health Equity Data and the LCH Responsiveness Dashboard includes IMD wait percentages which are reviewed by the Access LCH Steering Group. Certain services within the plan have highlighted they will be carrying out individual EQIAs in line with their planning.

Recommendation(s)	Acknowledge the plans in place and updated position.

List of Appendices:	NA

Access to Services: LCH Waiting List Recovery Plan

1. Introduction

This paper builds on the previous report for September Business and Quality Committees by presenting trajectories for the four key services that most significantly affect the Trust's National Oversight Framework (NOF) score in the Access to Services Domain. These are Paediatric Neuro Disability (PND), Adult SLT, CUCS and Podiatry. Narrative is provided for all other services with waits over 40 weeks.

The paper sets out the expected progress each service can make in reducing long waits, and the overall impact of these improvements on the Trust's NOF position. It aims to provide assurance to Business Committee that robust and deliverable plans are in place to address these long waits. The paper also includes an update on all other services with waits over 40 weeks to support delivery of the improvement plans.

2. Waiting List Position

The table below summarises the current position for LCH services with patients waiting over 40 weeks. The services below highlighted in green have successfully cleared all 40+ week waits. A more rapid reduction in waits, especially in the 52 week category is expected over the coming months. Trajectories for the six services with more than 50 patients waiting over 40 weeks are outlined in Section 3 to provide assurance on the Trust's overall waiting list reduction plan.

Service	40w July	52w+ July	40w Aug	52w+ Aug	40w Sep	52w+ Sep	40w Oct	52w+ Oct
Community Dental Service	302	829	416	741	431	565		
CAMHS	49	1127	44	997	36	955	25	844
Adult Nutrition & Dietetics	0	0	0	0	1	0	1	0

Children's Nutrition & Dietetics	0	2	0	1	0	1	0	0
Children's Speech & Language Therapy	6	2	5	3	5	0	4	0
Community Neurology	0	1	0	0	1	0	0	0
Community SLT (Speech & Swallowing)	95	176	96	199	118	221	64	140
Continence, Urology & Colorectal (CUCS)	62	16	98	24	132	17	116	23
Diabetes Services	9	0	27	0	44	0	38	4
Looked After Children (CLA)	3	6	8	4	6	6	0	0
MSK	29	32	32	26	24	12	11	9
Other Community Paediatrics (GAN, NAS, ADO)	1	1	1	1	1	1	0	0
Paediatric Neuro Disability Clinics	191	1292	171	1334	177	1385	149	1299
Podiatry	312	62	192	71	181	94	78	60

*October figures accurate as of 21.10.25

3. Individual Service Plans

Individual service plans have been developed for all services with waits over 40 weeks. Below is an update on the 4 services with more than 50 people waiting over 40 weeks for an appointment which contribute to the NOF. The full plans and business cases were included in the September Business Committee papers.

3.1 Paediatric Neuro Disability (PND)

A range of initiatives are underway to reduce waiting times within PND, including contacting all families on the waiting list to confirm ongoing need, a secondary triage by ICAN clinicians against new preschool diagnostic autism assessment criteria, and the engagement of three locums to deliver assessments for those meeting the revised PND assessment criteria. A further review is also being undertaken for 457 patients on the complex medical waiting list, alongside a wider capacity and demand review.

While the additional locum capacity and initiatives presented to the September Committee were expected to clear the 52-week waiting list, early data from the Tier 1 triage shows only a 9% reduction compared to the 20% forecast, and Tier 2 clinical triage has so far reduced eligible cases by around 20% rather than the expected 60%. This is due to higher levels of complexity and more children requiring a consultant led approach than anticipated. These variances have affected progress against the original trajectory, although both initiatives remain in their early stages and outcomes may still align more closely with initial projections as further data emerges.

3.1.1 PND Models

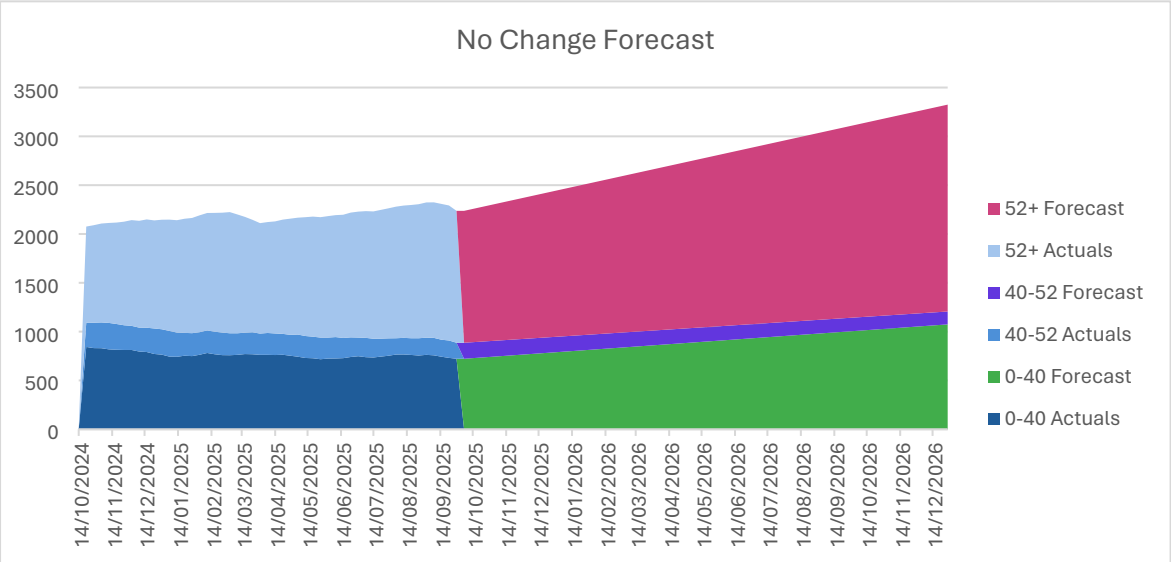


Figure 1 – Table to present 'No Change Forecast' for PND. This demonstrates what would happen if the service took no further action on waiting lists.

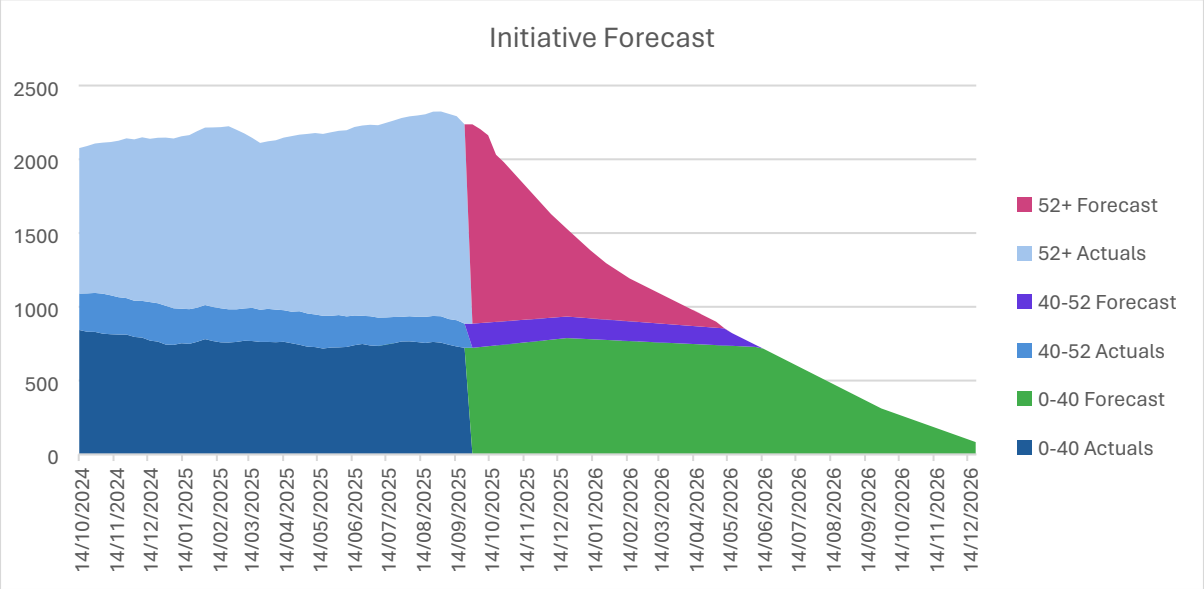


Figure 2 – Table to present the forecast for PND with the initiatives proposed.

3.1.2 Summary and next Steps for PND

Metric	No Change Model	Initiative Modelling
Date when 52+ cleared	Outcome not predicted	May-26
Date when 40+ cleared	Outcome not predicted	June-26
Stable underlying position	Unstable Position Predicted (47.5 growth/wk)	Stable Position Predicted

To achieve the trajectory outlined above, a gap in capacity remains within the service. To address this, the service is exploring the engagement of an additional locum, expected to deliver approximately 150 appointments between November and March. In addition, several substantive Paediatricians have provisionally agreed to undertake weekend clinics, providing a further 54 appointments to support delivery of the plan. These plans are still being finalised and will be included in the November Business Committee report. The modelling suggests that the 52+ week waits will be cleared by May 2026 and the 40 week waits cleared by June 2026.

3.2 Podiatry

Waiting times continue to improve within the service following the transformation work initiated in February 2024, which focused on the moderate diabetes and foot and ankle pathways. The introduction of the opt-in process has also proven highly effective.

Additional capacity for approximately 450 extra appointments is being funded through Access LCH through Saturday clinics running from October to March. These

commenced on Saturday 4 October, with a total October capacity of 100 appointment slots, all of which were filled with full commitment from patients. Saturday clinics are planned to take place every weekend in October and November.

Validation of patients waiting over 40 weeks continues weekly by administrative staff and a dedicated clinician to strengthen discharge processes and reduce repeated cancellations.

3.2.1 Podiatry Models

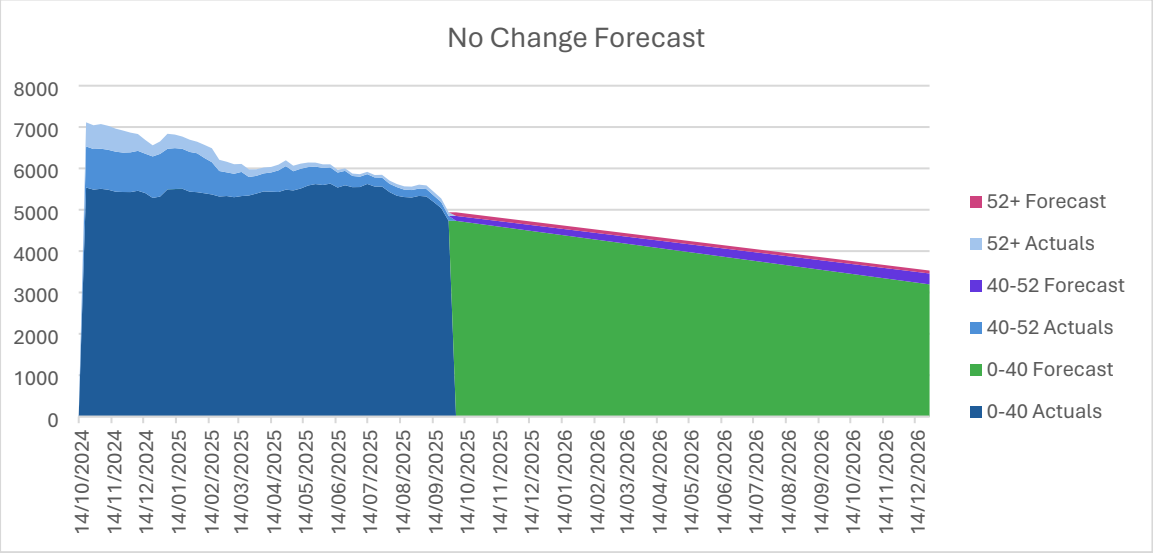


Figure 3 – Table to present 'No Change Forecast' for Podiatry. This demonstrates what would happen if the service took no further action on waiting lists.

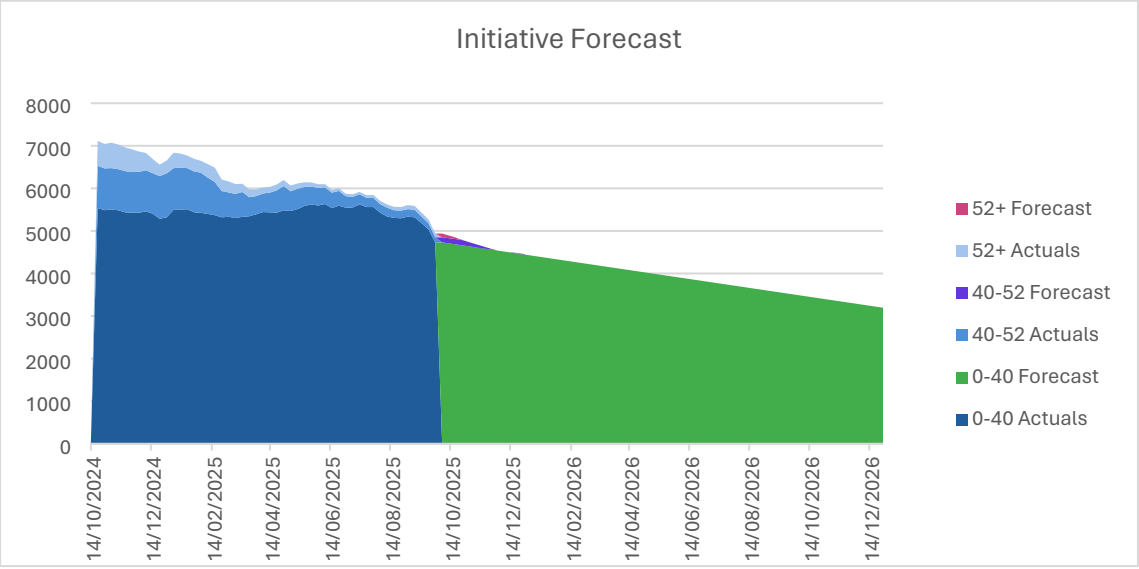


Figure 4 – Table to present the forecast for Podiatry with the initiatives proposed.

3.2.2 Summary and next Steps for Podiatry

Metric	No Change Model	Initiative Modelling
Date when 52+ cleared	Outcome not predicted	Nov-25
Date when 40+ cleared	Outcome not predicted	Dec-25
Stable underlying position	Stable Position Predicted	Stable Position Predicted

The waiting list work will continue as planned in the service with the prediction that 40+ week waits will be eliminated by December 2025.

3.3 Community SLT (Speech and Swallowing)

The service is balancing prioritising urgent waits and patients waiting over 40 and 52 weeks. A staged transformation plan is in place, focusing on 65+ week waiters, refining access criteria, and introducing an opt-in approach. Non-recurrent underspend and Access LCH funds are supporting locum recruitment to address long waits. Further improvements include increased clinic capacity, enhanced productivity, and MDT care-home clinics to streamline delivery.

Data collected so far indicates an opt-out rate of approximately 20%, equating to around 100 patients. The service is monitoring the Index of Multiple Deprivation (IMD) deciles of these patients to ensure the approach does not result in unintended health inequities.

3.3.1 Community SLT Models

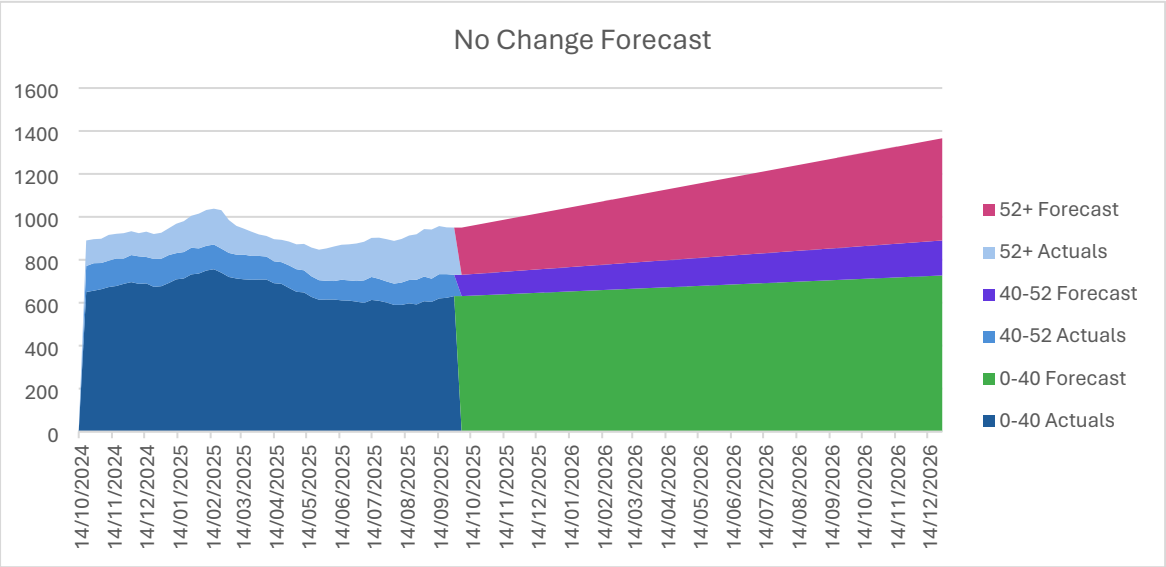


Figure 5 – Table to present 'No Change Forecast' for Community SLT. This demonstrates what would happen if the service took no further action on waiting lists.

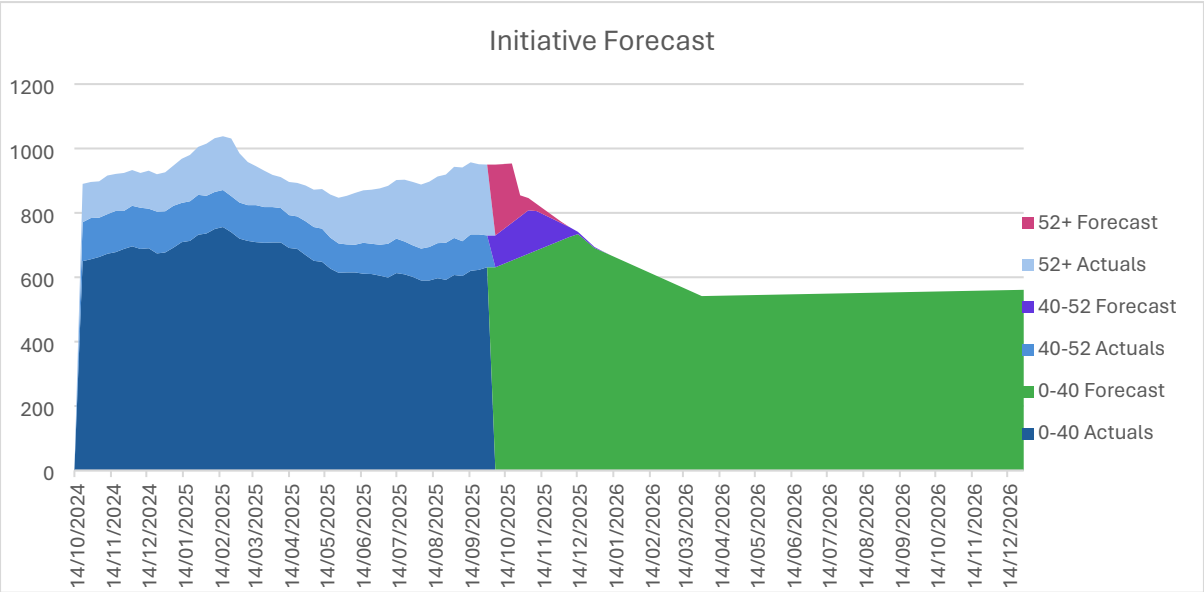


Figure 6 – Table to present the forecast for Community SLT with the initiatives proposed.

3.4.2 Summary and next Steps for Community SLT

Metric	No Change Model	Initiative Modelling
Date when 52+ cleared	Outcome not predicted	Dec-25
Date when 40+ cleared	Outcome not predicted	Jan-26
Stable underlying position	Stable Position Predicted	Stable Position Predicted

Based on current modelling assumptions, the cumulative impact of these initiatives suggests the service will eliminate all 40+ week waits by January 2026. Progress will be monitored closely, with adjustments made as needed to stay aligned with the modelling. For awareness one of the three locums employed has just handed in their notice and the service is looking at alternative provision to stay on plan, but there may be minor slippage from the predicted dates above.

3.4 Continence, Urology & Colorectal (CUCS)

Learning from previous Access LCH initiatives has driven a focus on bladder and bowel pathways, reduced appointment times, and streamlined SystmOne templates. The service has delivered additional appointments and scheduled extra clinics to target the longest waiters. Current work includes reviewing clinic times, caseloads, and benchmarking, piloting Opt-in/Opt-out and PIFU processes. An EQIA-approved bowel pathway change is expected to reduce reviews from six to two, increasing new-patient capacity.

The PIFU (Patient-Initiated Follow-Up) process is currently out for comments following completion of pilot activity. If used effectively, it will remove the need for the final “just

to check" appointment by placing patients on a PIFU list with an open referral to CUCS for a defined period (three months), thereby releasing additional clinical capacity.

The service has trialled and will continue with reduced from 90 to 75-minute new appointment times with admin time at the end of clinic. To support improvement, two additional clinics per week have been allocated for October, providing capacity for approximately 45 new assessments. There was no response or interest from GPwSIs through the GP Confed. However, an ECF for a Band 6 Physiotherapist has been submitted for approval to support with extra capacity to trial a different skill mix.

3.4.1 CUCS Models

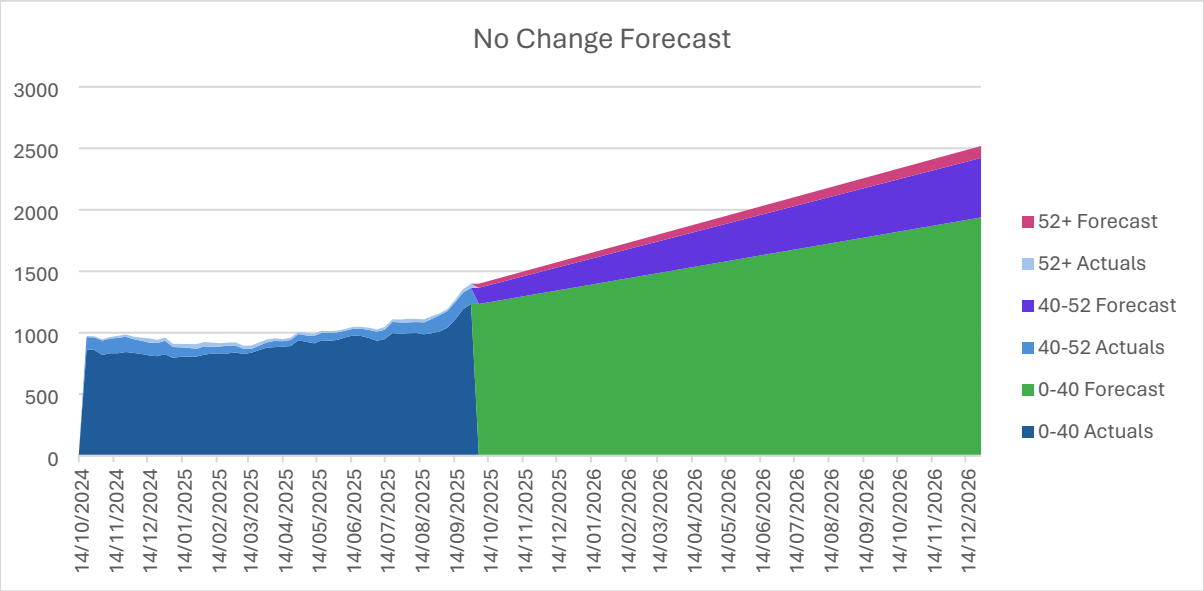


Figure 7 – Table to present 'No Change Forecast' for CUCS. This demonstrates what would happen if the service took no further action on waiting lists.

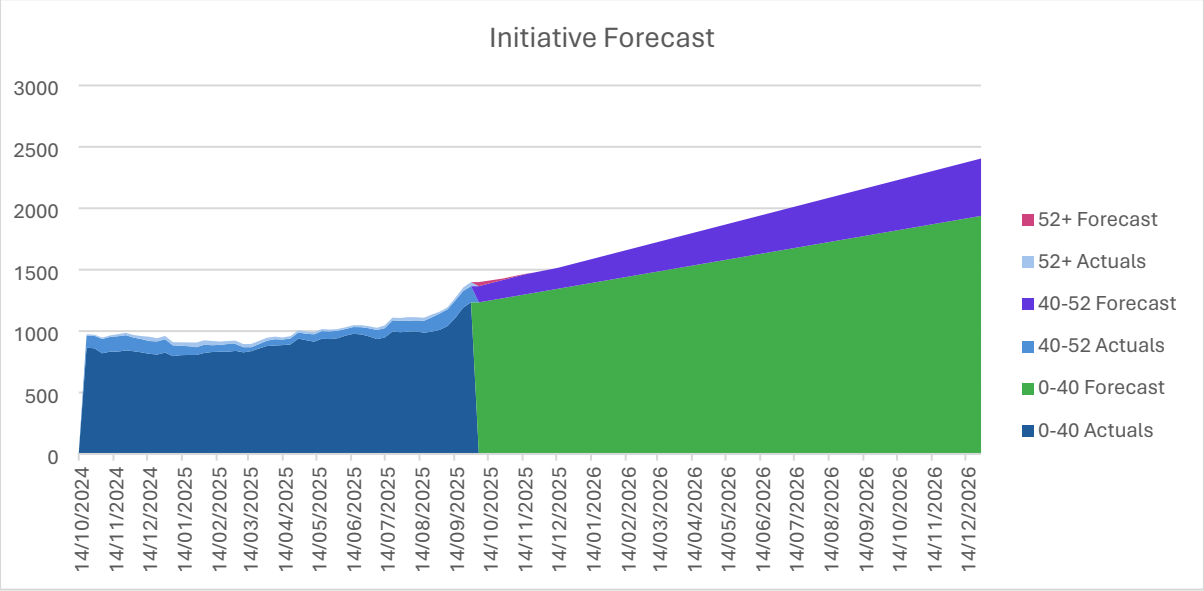


Figure 8 – Table to present the forecast for CUCS with the initiatives proposed.

3.3.2 Summary and next Steps for CUCS

Metric	No Change Model	Initiative Modelling
Date when 52+ cleared	Outcome not predicted	Nov-25
Date when 40+ cleared	Outcome not predicted	Outcome not predicted
Stable underlying position	Unstable Position Predicted (13.5 growth/wk)	Unstable Position Predicted (13.5 growth/wk)

The trajectories suggest that 52+ week waits will be eliminated by the end of February 2025. Further modelling will be carried out as the above initiatives are finalised, to better understand and reduce 40+ week waits. The service is also working with the BI team to better understand and address the projected increase in the overall waiting list, as shown above.

3.5 Community Dental

A Performance Optimisation Plan is already in progress and has delivered a notable reduction in waits. However, Committees were advised that plans required amendment following the last-minute withdrawal of a key recruited staff member. The service is now planning to offer weekend sessions and staff have now been identified to run these clinics (dentists, nurses and a paediatric dental consultant). These changes aim to maintain delivery momentum and mitigate the impact of staffing constraints. The service is currently engaging Clarendon Spa to look at outsourcing part of the waiting list. The service is currently working on trajectories with the BI team.

All three partner organisations within the West Yorkshire CDS Collaborative have agreed waiting list initiative rates, aligned to WYAAT benchmarks. The service is currently engaging the Directors of People and the Nominations and Remuneration Committee to reach agreement on the proposed rates.

3.6 CYMPHS

There has been a steady reduction in patients waiting over 40 weeks, especially within the ADHD Medication Waiting List, yet demand remains high. The two main contributors to current CYPMHS waiting lists are the ADHD Medication Waiting List (365 as of 14*th* October) and the Neurodevelopmental Assessment Pathway (576 as of 14*th* October), which is being addressed at a system level.

It was reported to September Committee that the demand for the ADHD pathway continues to increase, but prescribing capacity remains constrained. Caseload and staffing pressures are compounded by 18% DNA rates, complex ND assessments, and right to choose cases. Work is underway to transfer six-monthly physical health reviews for stable ADHD patients to primary care, reducing demand on assistants, while three-

monthly reviews for children under 10 will continue in line with NICE guidance. Non-recurrent funding is being used for Locums to work with those waiting on the ADHD Meds pathway.

The service has engaged Northpoint to explore outsourcing the triage of outstanding ND waiters. As there is currently no service capacity in place for these patients. Given that this is a regional challenge being addressed at a system level, it is likely that a further outsourcing proposal will need to be considered to address these waits.

3.7 Services with fewer than 50 Patients Waiting Over 40 Weeks

The table below captures all other services with patients waiting over 40 weeks for an appointment.

Service	Position and plan presented to September Committees	Progress since September
Adult Nutrition and Dietetics	The 1 patient waiting over 40 weeks had an appointment booked for September.	The scheduled appointment has been re-booked for October. No further breaches of the 40 week threshold are anticipated.
Children's Nutrition and Dietetics	All patients with waiting times more than 40 weeks have been confirmed as data validation issues.	These validation issues have now been resolved, and the affected patients have been removed from the waiting list. No further breaches of the 40-week threshold are anticipated.
Children's Speech and Language Therapy	The service has already gone a long way in reducing waits and the aim is to reduce waits to 18 weeks for clinic and mainstream pathways, and to under 25 weeks for specialist pathways including DLD, hearing impairment, and communication aids. The service will use a mix of bank and agency staff along with Saturday clinics to reduce waits.	The service has significantly reduced waiting times and now has no patients waiting over 52 weeks, with only four patients remaining over 40 weeks. Of these, three are booked to be seen in October, with just one appointment still to be scheduled. The service is now focusing on achieving 18-week waits across all pathways. To support this, a combination of bank and agency staff will be utilised, and the service is exploring the option of running Saturday clinics between January and March 2026.
Community Neurology	The service is working with the LTHT neuropsychology consultant to review all psychology long waiters. Following this review we will be considering outsourcing the management of these patients.	The service now has no patients waiting over 40 weeks. A previous 40-week breach was due to a duplicate referral error, which has been corrected. A review of psychology waiters by the LTHT neuropsychology consultant will begin w/c 3 November 2026 to prevent future breaches.

Community Paediatrics (GAN, NAS and ADO)	At the time of September committee there were two breaches of 40 weeks in the ICAN Growth and Nutrition Service (GAN) and the ICAN Springfield service (Neonatal abstinence service NAS).	Both patients who were waiting have been seen in early October and the service no longer has any patients waiting over 40 weeks.
Diabetes	At the September Committee, it was reported that the service had prioritised clearing its waiting list and strengthening discharge processes, while a Quality and Value (Q&V) redesign is underway to review exclusion criteria and pathways that may alter the future service offer. Priority is currently being given to patients waiting over 40 weeks within the MDT Diabetes pathway. Funding has been approved to temporarily expand staffing within the service on a fixed-term basis to support delivery of this work.	The service has begun rolling out additional hours to internal staff to support the waiting list plans. Options such as greater involvement from pharmacists and GPs are still being explored to maximise impact.
Looked after Children	A review has taken place for all patients waiting over 40 weeks. This found that these are based out-of-area. Additionally, most have had input from the team, but activities hadn't been recorded correctly, and therefore not genuinely waiting.	The service has reviewed the 'Stop the Clock' process to ensure only genuine waiters remain, with no patients now waiting over 40 weeks
MSK	MSK long waiters over 40 weeks are primarily caused by repeat eRS cancellations, and old eRS UBRNs being used to book appointments, which would require additional admin support. These appointments are initiated by the patient at their chosen entry point following referral.	The service has finalised plans and is beginning to operationalise these, which includes the additional admin support to address the waits and booking appointments. Additional clinics are also being scheduled in.

4. NOF Impact

The table below illustrates the projected impact of the waiting list initiatives and trajectories outlined above. Based on current modelling outlined in Section 3, our position for this metric is projected to improve from the border of Quartiles 3 and 4 to Quartile 2. However, as other Trusts continue to reduce their waiting lists, it is more likely that our final position will sit within Quartile 3. The overall impact remains difficult to predict with certainty, as the comparative scores are based on actual submissions from other Trusts as of August 2025. It should also be noted that as plans above further develop this metric may improve further, or potentially worsen if the remaining waits are not addressed. Any Trust with zero patients waiting automatically receives a score of 1.00. As more Trusts achieve this, the distribution of scores shifts upward, which

inflates the overall metric and makes it harder to predict rankings for those just below the top tier.

Description	Q1 Metric Value	Q2 Metric Value (predicted)	Q3 Metric Value (predicted)	Q4 Metric Value (predicted)	Q1 Metric Score	Q2 Metric Score (predicted)	Q3 Metric Score (predicted)	Q4 Metric Score (predicted)
% of people waiting over 52 weeks for community services	7.41%	7.76%	2.90%	0.89%	3.30	3.26	2.93	2.63

5. Asks for Board and Next Steps

This paper has been developed to provide assurance to the Board and to present trajectories outlining the Trust's plans to reduce long waits, particularly those exceeding 52 weeks, in line with the NOF. All services referenced continue to ensure that patients are waiting safely, with cases regularly reviewed and prioritised based on clinical need rather than purely length of wait. Further work is underway to support CUCS service in understanding their projections. A further report will be provided to the November Business Committee, which will include an update on the financial requirements and wider risks associated with this work.

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (18ii)

Title of report:	Sickness Absence Improvement Project Update

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

Presented by:	Laura Smith / Jenny Allen, Director of People					
Prepared by:	Alan Sewell, Associate Director, People Operations Gary White, Analyst Laura Smith / Jenny Allen, Director of People					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	• This paper provides the Board with assurance regarding the implementation of the Sickness Absence Improvement Project, which has been established to address our current performance position in the NHS Oversight Framework 2025-26. • Leeds Community Healthcare NHS Trust is currently positioned in Segment 4 (low performing) for sickness absence, with a rate of 6.38% (Q4 2024-25), ranking 49th out of 61 comparable non-acute trusts against a sector standard of 5.65%. • The project aims to reduce sickness absence through a systematic improvement programme integrating policy clarification, accountability, capability development, and cultural change. The initiative operates on a quarterly PDCA (Plan-Do-Check-Act) cycle across four integrated workstreams, with clear governance, defined deliverables, and measurable outcomes. • This paper outlines the project scope, governance structures, Q1 deliverables (due November 2025), key risks, and monitoring arrangements to provide confidence that the Trust is taking decisive action to move into Segment 3 in the first instance.

Previously considered by:	N/A (summary of progress considered by Business Committee on 29 October 2025)

Link to strategic goals:	Work with communities to deliver personalised care	
	Use our resources wisely and efficiently	X

(Please tick any applicable)	Enable our workforce to thrive and deliver the best possible care	X
	Collaborating with partners to enable people to live better lives	
	Embed equity in all that we do	

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

Recommendation(s)	It is recommended that the Board: • Notes the progress to date on the Sickness Absence Improvement Project, including the engagement work undertaken, completion of the Project Initiation Document and governance framework. • Notes the proposed approach to target-setting at Business Unit level, which incorporates seasonal variation, geographic variation, and and aims to lift LCH from segment 4 to segment 3 in the first instance. • Notes that detailed improvement targets will be presented once data seasonality analysis is complete (planned for the next reporting cycle).

List of Appendices:	Appendix 1: Detailed Workstream Deliverables Appendix 2: Risks and Mitigations Appendix 3: Sickness Absence data

1. Introduction

Sickness absence is a significant performance metric within the NHS Oversight Framework 2025-26 and contributes directly to segmentation scoring for all NHS Trusts. The framework places particular emphasis on workforce wellbeing and operational resilience, with sickness absence rate identified as a scored metric within the People and Workforce domain.

Leeds Community Healthcare NHS Trust currently sits in Sector 4 (low performing) due to a sickness absence rate of 6.38% (Q4 2024-25), ranking 49th out of 61 comparable non-acute trusts. The national sector average is 5.65%, indicating LCH is performing 0.73 percentage points over. This position presents both a significant operational challenge and a clear opportunity for improvement.

The Board approved the Sickness Absence Improvement Project in recognition that systematic, evidence-based intervention is required to improve performance and move the Trust into Segment 3. This project represents a foundational shift from reactive management to proactive, capability-driven improvement embedded across the organisation.

2. Project Aim and Scope

The Sickness Absence improvement Project aims to reduce sickness absence by implementing a systematic improvement programme that integrates policy clarification, clear accountability, capability development, and cultural change to achieve measurable and sustainable improvements in organisational health and absence rates.

Key Characteristics:

- Quarterly delivery model with iterative review and refinement
- Internal resource allocation with specialist external analytical support
- Integrated approach targeting both reactive and proactive interventions
- Applies to all staff groups across the organisation, with targeted support for high-absence areas
- Explicitly designed to move the LCH from Sector 4 to Sector 3 positioning

3. Project Workstreams and initial engagement exercise:

The project is structured around four integrated workstreams, each with defined outcomes, deliverables, and accountability. Workstream leads are supported by the Project Steering Group and report monthly to the Senior People Leadership Team.

Committee oversight is provided via the People & Culture Committee, which will continue to receive project updates at each Committee meeting.

Following a series of focused engagement sessions with managers, People Partners in the initial weeks of the project, several areas for improvement have been identified.

These include inconsistency in how absence policy is interpreted and applied across services; varying levels of clarity on escalation pathways and formal processes; and opportunities to better utilise occupational health and employee support services.

Managers have indicated that clearer guidance, improved training, and standardised processes would support more consistent and confident application of policy. Additionally, there is scope to strengthen the visibility and promotion of available support services, particularly the Employee Assistance Programme.

Workstreams:

The four workstreams are designed to address these identified areas through a combination of process clarity, capability development, and improved service integration:

- **Workstream 1: Guidance, Training, Process and Systems**
  Objective: Establish clear, consistent, and standardised processes for managing sickness absence across the organisation. Ensure managers, employees, and People Partnering teams have accessible, practical guidance on what to do, when to do it, and how to do it.

- **Workstream 2: Occupational Health Service Review**
  Objective: Ensure the Trust occupational health provider delivers value and contributes effectively to reducing and preventing sickness absence.

- **Workstream 3: Employee Assistance Programme Review**
  Objective: Increase awareness and uptake of employee support services, with particular focus on high-absence areas and teams experiencing elevated stress-related absence.

- **Workstream 4: Organisational Health Analysis**
  Objective: Identify how organisational factors (culture, leadership, team dynamics, working conditions) influence individual and team health, and develop evidence-based interventions to address these systemic drivers.

Detailed deliverables have been developed for each of the workstreams and are set out at ***Appendix 1***. Risks and associated mitigations are described at ***Appendix 2***.

4. Performance Targets and Data

Target-setting is underway and will incorporate the following principles:

- ***Seasonal variation:*** Targets will account for predictable seasonal fluctuations in absence (e.g., winter peaks) to ensure realism and relevance.
- ***Geographic variation:*** Targets will consider differences in geographic region.
- ***Sector benchmarking:*** Baseline target to move from Segment 4 into Segment 3, accounting for the dynamic nature of segment positioning.
- ***Intervention-linked targets:*** Expected improvements will be linked directly to the activities and interventions being delivered.
- ***Business unit disaggregation:*** Targets will be set at business unit level to enable clear accountability and tailored support.
- ***Dashboard integration:*** Targets will be built into a performance dashboard with monthly data updates and quarterly reporting.

Appendix 3 shows examples of the range of data currently under analysis by the Sickness Absence Improvement Project to determine appropriate targets.

5. Conclusion

The LCH Sickness Absence Improvement Project is has been running for over 8 weeks and has undertaken a range of engagement work to identify impactful areas of improvement; as well as establishing its project governance and workstreams.

The project's overarching baseline target is to move LCH from Segment 4 to Segment 3, Setting and refining detailed targets to provide a clear quarterly trajectory, considering a range of variables, is a current priority for the Project.

6. Recommendations:

It is recommended that the Board:

- Notes the progress to date on the Sickness Absence Improvement Project, including the engagement work undertaken, completion of the Project Initiation Document and governance framework.

- Notes the proposed approach to target-setting at Business Unit level, which incorporates seasonal variation, geographic variation, and and aims to lift LCH from segment 4 to segment 3 in the first instance.

- Notes that detailed improvement targets will be presented once data seasonality analysis is complete (planned for the next reporting cycle).

Appendix 1: Detailed Workstream Deliverables

Workstream 1: Guidance, Training, Process and Systems

Objective: Establish clear, consistent, and standardised processes for managing sickness absence across the organisation. Ensure managers, employees, and People Partnering teams have accessible, practical guidance on what to do, when to do it, and how to do it.

Q1 Deliverables (Due November 2025):

- Comprehensive training package covering policy, manager responsibilities, employee support, reporting, return-to-work processes, short and long-term absence management, occupational health, EAP, and reasonable adjustments. Delivery formats include in-person and virtual options.
- Refreshed guidance and templates converted from existing Wellbeing at Work policy into one-minute guides for rapid reference, including absence reporting forms, return-to-work checklists, and case review documentation.
- Redesigned intranet absence pages with improved navigation, uploaded resources, FAQs, and integrated wellbeing support links.
- Documented roles and responsibilities framework for managers, employees, and People Partners, including governance review mechanisms and escalation criteria.

Workstream 2: Occupational Health Service Review

Objective: Ensure the Trust occupational health provider delivers value and contributes effectively to reducing and preventing sickness absence.

Q1 Deliverables (Due November 2025):

- Contract performance review with service provider, including feedback from Trust services and recommendations for renewal or service reset.
- Clear service standards including referral processes, response times, and reporting expectations.
- Quality assurance mechanism to monitor service delivery and gather user feedback.
- Mid-contract review process to ensure ongoing accountability and performance tracking.
- Integration protocols ensuring occupational health guidance aligns with policy, toolkit, and organisational analysis findings.

Workstream 3: Employee Assistance Programme Review

Objective: Increase awareness and uptake of employee support services, with particular focus on high-absence areas and teams experiencing elevated stress.

Q1 Deliverables (Due November 2025):

- Promotional materials to raise awareness and encourage proactive use of EAP services, with targeted messaging for high-absence teams.

- Alignment of EAP support offerings with identified root causes of sickness (stress, wellbeing, psychological support).
- Integration of EAP guidance into manager and employee-facing training materials and communications.
- Identification of targeted intervention opportunities in high-absence areas using EAP resources.

Workstream 4: Organisational Health Analysis
Objective: Identify how organisational factors (culture, leadership, team dynamics, working conditions) influence individual and team health, and develop evidence-based interventions to address these systemic drivers.

Q1 Deliverables (Due November 2025):

- Healthy organisations/teams assessment framework using established diagnostic tools.
- Targeted diagnostics in one or two high-absence areas to establish baseline understanding of organisational factors contributing to absence.
- Findings translated into practical actions, including manager support, team interventions, and policy adjustments.
- Grant bid preparation (NHS Charities) to establish longer-term, funded approach to addressing causes of sickness, particularly stress, trauma, and anxiety.

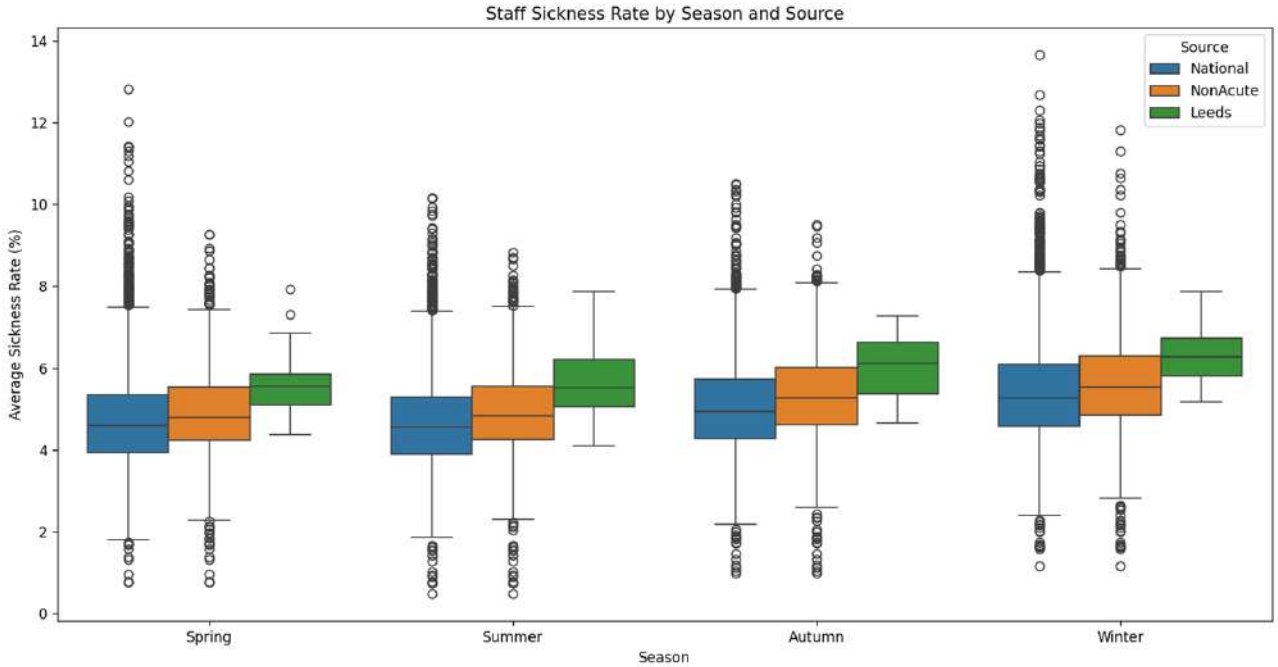
Appendix 2: Risks and Mitigations

Risk	Impact	Mitigation
Unpredictability of sickness absence	Sickness cannot be controlled; external factors (e.g., seasonal illness, personal circumstances) are beyond organisational influence. Targets may be challenging to achieve despite sustained effort.	Considered targets with applied with seasonal adjustment. Quarterly review will allow recalibration. Focus will be on process adherence and manager capability rather than absence rate alone.
Competitive sector benchmarking	Even with excellent improvements, the Trust may remain in Sector 4 if other trusts improve faster. This could undermine staff engagement and momentum.	Success will be communicated as process achievement and cultural change, not just numerical targets.
Cultural change requirement	The project requires behavior and mindset change across managers and staff. Resistance, inconsistent application, or lack of engagement could limit impact.	Robust change management including clear communication, training, and incentive alignment. Senior leadership modelling commitment. Recognition and celebration of early wins.
Concurrent internal audit	The Trust is undergoing internal audit of long-term sickness absence management. Audit findings could require project scope adjustment or reveal process gaps.	Project governance will incorporate audit findings when known. Regular liaison between project team and audit to ensure alignment and avoid duplication.

Appendix 3: Sickness Absence Data

OVERALL SEASONALITY THEMES

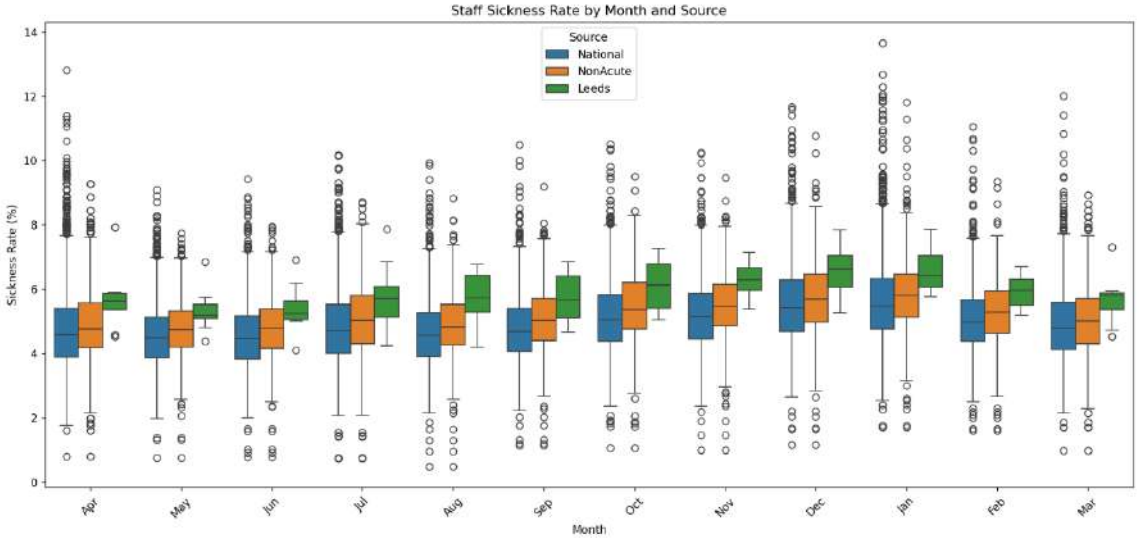
- April 2017 – May 2025 data):



Season	National	Non Acute	LCH
Spring (Mar-May)	4.73%	4.90%	5.56%
Summer (Jun-Aug)	4.66%	4.92%	5.63%
Autumn (Sep-Nov)	5.03%	5.32%	6.05%
Winter (Dec-Feb)	5.40%	5.61%	6.38%

- The same trend can be seen with monthly breakdowns (see diagram on following page, showing April 2017-May 2025)
- We have chosen 'Prophet'[1] as our Python model to predict 'Do Nothing' future values.

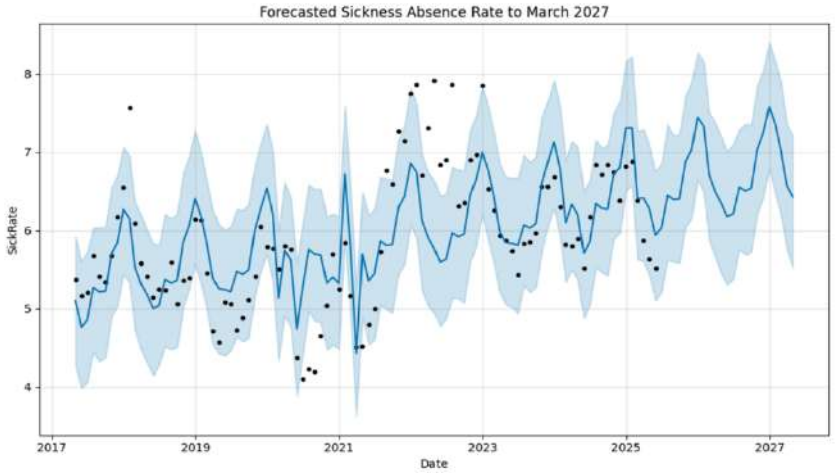
[1] Prophet is an open-source forecasting tool developed by Meta that enables users to model and predict time series data with strong seasonal patterns and historical trends.



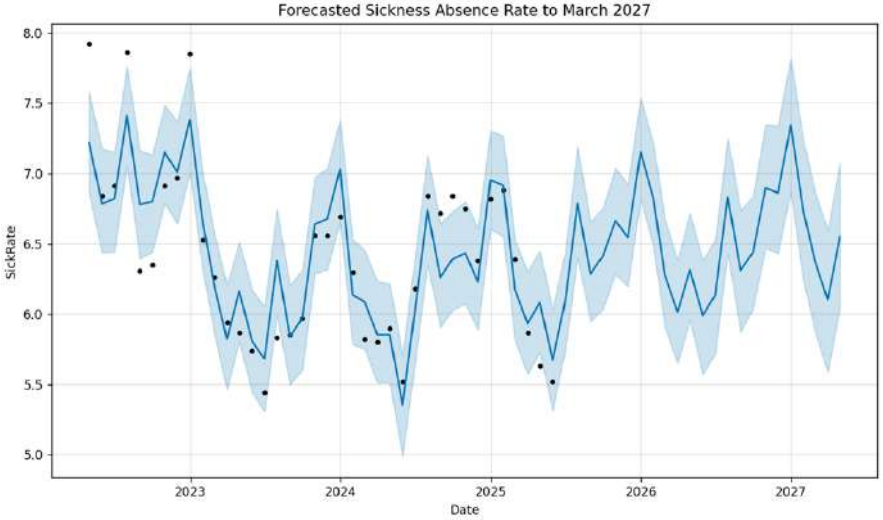
FORECASTING

We have looked at the data from April 2017 and various scenarios post covid. Each scenario has its pros and cons. On balance the April 2017 position seems the most robust. Post Covid, the time series is small and can be sporadic (High Summer 2022 sickness absence).

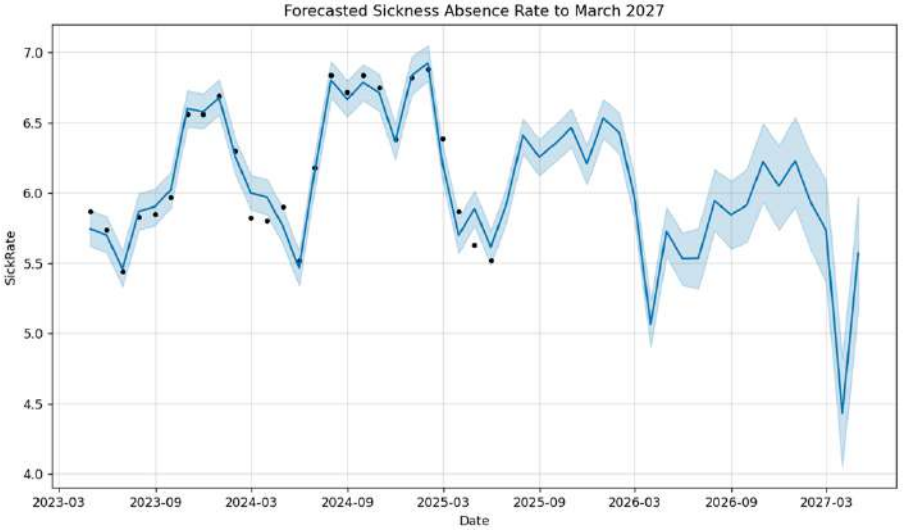
APRIL 2017 - LCH



APRIL 2022 - LCH

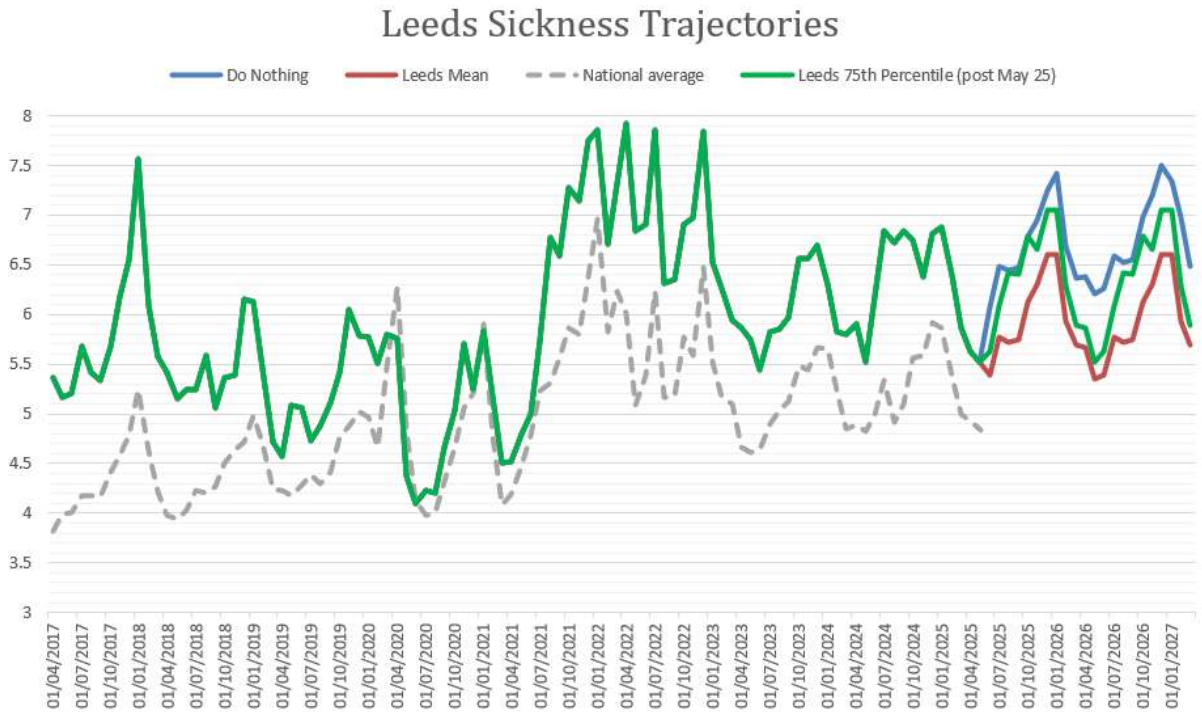


APRIL 2023 – LCH



TRAJECTORIES

If using the Leeds Mean position (by month) for seasonality over the time period April 2017 – May 2025. All scenarios can be seen below.



NOF IMPACT

The table below is taken from the full list of hospital Trusts (from which our metric score is calculated). A forecasted metric quartile is estimated for the remainder of this financial year.

TIMEFRAME	NATIONAL AVG (TAKEN FROM LAST SEASONAL QTR)	LCH	FORECASTED QUARTILE
Oct – Dec 2025	*5.68%*	*6.34%*	*3 (mid)*
Jul – Sep 2025	*5.11%*	*5.74%*	*3 (mid)*
Apr-Jun 2025	*4.9%*	*5.5%*	*3 (lower)*
Jan- Mar 2025 (actual)	5.62%	6.38%	4

Committee Escalation and Assurance Report

Name of Committee:	People & Culture Committee	**Report to:**	Trust Board 6th November 2025
Date of Meeting:	23rd September 2025	**Date of next meeting:**	11th December 2025

Introduction

Second quarterly meeting with a full agenda and detailed discussions. Overriding theme of discussions was on staff wellbeing and engagement in the current climate of divisive political opinions. The two areas in the people arena which are driving the Trust's current NOF score were also widely discussed. There was a continued focus on evolution of the Committee's business and attendance to ensure it is serving the Trust, people and the workforce strategy in the most effective way. The lack of operations representation was noted, query whether the Business Unit GMs should be invited to attend a future meeting.

Alert	Action
• The current NOF score and the work that needs to be done to drive improvements in staff engagement and sickness absence figures, together with other aspects of the discussions, led the Committee to find limited assurance in relation to risk 6. This was on the basis that LCH is benchmarking near the bottom of the league tables for community trusts and whilst action plans had been developed and presented during the meeting, they were lacking in targets/milestones or a definition of the ambition and the Committee needed to see evidence of progress. The deterioration in the scores for recommending LCH as a place to work was particularly concerning, as being a strong indicator of culture in an organisation. Long term sickness absence was a particular concern and the Committee noted that there had been a steer from the Business Committee some time ago for targeted action to be taken to reduce long term sickness absence, it appeared that little progress had been made in this area so the P&C Committee wished to see what was being done differently to manage long term cases. It was noted that there were concerns about the performance of the occupational health provider. Overall it was requested that the risks around the NOF should be added to the corporate risk register.	• Continued focus on development of action plans with more clearly defined targets and milestones; also a strong signal from the Committee to ensure local management had ownership and accountability for engagement scores and sickness absence in their area.
• There was a discussion about staff wellbeing in the context of current political climate and growing tensions around topics such as immigration. It was noted that incidence of race related abuse were increasing. The Committee was pleased to learn of the planned listening events, to be hosted by Karen Lai and John Walsh. However, the Committee was concerned about the potential for an undertone of racism in working environments, which might fall short of a "reportable incident" and how the Trust was recognising this through its communications and support tools available to staff.	• The Committee has requested a further paper from the People Directorate setting out what is being done differently, following lessons learned after last year's race riots and the plan to tackle growing incidences of racist attitudes or baheviour. Committee also requested that race related incidents be made clearly visible in the data presented at Board and through Committees so that trends and risks could be identified.

Committee Escalation and Assurance Report

Advise

- The Committee discussed a number of options for roll out of a Consultant job planning tool which is now mandated and agreed to recommend the option to purchase an off the shelf product to allow for rapid roll out. The cost was already allocated via the digital agenda and would go forward to be discussed by the Digital Committee.
- The employee relations data was reviewed and it was noted that racially motivated incidents were on the increase – see comments above in the Alert section. More generally, employee relations cases were also on the increase and there is a higher volume of issues currently being dealt with.

Assurance

- Committee received a number of useful data sets including the Q&V human factors data, indicating that there were no patterns of deterioration in people metrics as a result of Q&V activity; Committee was also presented with draft KPIs and a new system of metrics in the People Directorate which would give much greater granularity of data across services and would provide extremely valuable insights. The Committee thought that this was an excellent piece of work and highly valuable in managing risk, we were also assured that team managers would be trained in how to use this data in their own areas.
- Committee reviewed the annual People Inclusion Report for 24/25 and was assured that statutory obligations around equality, diversity and inclusion were being complied with; although there was more to be done to understand the data on health inequalities within the workforce. The risks to delivering the plan were discussed and it was acknowledged that project management resource was a potential risk.
- The internal audit from June 2025 in relation to appraisal processes was before the Committee and concerns were raised that the audit was “low assurance”. Whilst most of the target dates from management actions had passed and the Committee was informed that appraisal rates had improved, there was no breakdown to show progress against actions, therefore the Committee felt that this factored into the “limited assurance” for strategic risk 6.

Risks Discussed and New Risks Identified

- The people related risks were presented and discussed. An issue with Datix capability for reporting of H&S incidents was discussed and concern was raised that the issue is unlikely to be fixed before September 2026. There are complexities in configuring Datix to be able to manage incidents effectively, therefore they are currently being captured and tracked outside the system. The Committee expressed some concerns about this and noted that reconfiguration of Datix was being delayed because of resource constraints. The Committee requested further assurance that incidents were being robustly captured, logged and tracked whilst this issue was ongoing.
- The Committee requested that the risk around the NOF be added to the corporate risk register.

Committee Escalation and Assurance Report

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 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.	15 (extreme)	Reasonable	Committee saw the EDI report and people KPIs and was assured that statutory obligations were being complied with.
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.	12 (high)	Limited	See Alert comments above. The current NOF position and other issues before the Committee including the audit report on appraisals meant that the Committee concluded there were some gaps in assurance. The expectations were discussed during the meeting.

Committee Escalation and Assurance Report

Author:	Rachel Booth
Role:	Committee Chair
Date:	26/09/25

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (20i)

Title of report:	Annual People Inclusion Report 2024/25					
Meeting:	Trust Board Meeting Held In Public					
Date:	6 November 2025					
`	Director of People					
Prepared by:	People Solutions Team					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval ✓	
Executive Summary:	This paper provides the Trust Board with a strategic update on our current position and the actions we will take to further advance equity, diversity, and inclusion (EDI) across the Trust. It evidences our continued commitment to meeting statutory responsibilities under the Equality Act 2010 Public Sector Equality Duty (PSED) and the NHS Standard Contract, while also driving meaningful cultural change that supports our people and the communities we serve. Specifically, the paper includes: • The current position of our progress against the NHS EDI Improvement plan Hight Impact Actions. • Proposed actions and priorities for the LCHT People Inclusion improvement plan 2025/26 to strengthen and sustain our inclusion and belonging ambitions.					
Previously considered by:	People & Culture Committee Trust Leadership Team					
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	✓				

<table>
<tr><td rowspan="2"></td><td colspan="4">Collaborating with partners to enable people to live better lives</td><td></td></tr>
<tr><td colspan="4">Embed equity in all that we do</td><td>✓</td></tr>
<tr><td rowspan="2">Is Health Equity Data included in the report (for patient care and/or workforce)?</td><td>Yes</td><td>x</td><td>What does it tell us?</td><td colspan="2">HIA 4</td></tr>
<tr><td>No</td><td></td><td>Why not/what future plans are there to include this information?</td><td colspan="2"></td></tr>
<tr><td>Recommendation(s)</td><td colspan="5">The Trust Board is recommended to:

• Note our current position in delivering against the NHS EDI Improvement Plan High Impact Actions.

• Ratify the Trust People Inclusion Improvement Plan 2025/26, confirming that its continued delivery provides assurance the Trust meets workforce obligations under the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract.</td></tr>
<tr><td>List of Appendices:</td><td colspan="5">Appendix A – Trust People Inclusion Improvement Plan 2025/26.

Appendix B – Risk Register, detailing key strategic and operational risks associated with the Trust People Inclusion Improvement Plan 2025/26.</td></tr>
</table>

Annual People Inclusion report 2024-25

1. Introduction

1.1 This Equality, Diversity, and Inclusion (EDI) Annual Report, covering the period from 1 November 2024 to 31 August 2025, summarises the actions taken and highlights the progress made throughout 2024-25 in line with the NHS EDI Improvement Plan. This plan ensures compliance with the Public Sector Equality Duty (PSED), as required by the Equality Act 2010.

1.2 The section below, reminds us of the range of statutory, NHS or Organisational requirements within which the Equality, Diversity, and Inclusion work, operates within.

2. Background

2.1 The Public Sector Equality Duty (PSED) requires public bodies to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations between people with and without protected characteristics.

2.2 The NHS Long Term Workforce Plan defines the staffing needs, size, shape, and mix, required to deliver high-quality patient care now and in the future.

2.3 The NHS EDI Improvement Plan aims to improve workplace culture and staff experience, supporting retention and attracting diverse talent. *(See Appendix A)*

2.4 The Equality Delivery System (EDS) supports NHS organisations in improving services and creating inclusive workplaces. The Trust is rated as ‘Achieving’ across all three domains.

2.5 Ongoing social unrest has highlighted persistent inequalities. As a Leeds Anchor institution, the Trust plays a key role in tackling discrimination locally and across the Leeds workforce.

2.6 Staff networks have been updated on developments related to the Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) and have played an active role in shaping the draft Trust People Inclusion Improvement Plan.

3. Trust People Inclusion Improvement plan - high impact actions.

3.1 **High Impact Action 1.** *Measurable objectives on EDI for Chairs, Chief and Board members.*

Current Position

The information gathered indicates that, at present, all Trust directors and two non-executives have confirmed ED&I objectives. Work is underway with support from the Company Secretary and the Chair to ensure a full suite of ED&I objectives are implemented and sustained across the full Trust Board membership.

We are achieving the desired outcome through the regular reports provided to the Trust Board, NHS Staff Survey reports, Workforce Strategy updates and annual Trust Board EDI development workshops.

3.2 **High Impact Action 2.** *Overhaul recruitment processes and embed talent management processes.*

Current position

Diverse recruitment panels - In March 2024, the BME Fair Recruitment processes was introduced for a BME member of staff to be involved with the full recruitment and selection of posts at Band 7+. Sixteen members of staff have signed up to support the process.

Talent Management – People Solution are providing post-programme support for I Thrive/We Thrive development programme ensuring lasting impact by keeping participants engaged, tracking their progress, and offering tailored development opportunities.

Together with other One Leeds Workforce partners we continue to, as one of our positive actions, actively targeted areas of Leeds with higher representation of BAME populations in hyper-local recruitment campaigns. Currently, as part of Leeds One Workforce Programme, LCHT, together with other health and social care partners are delivering a varied programme of work, in particular Project 5.2 Schools and Young People – Health & Care Careers. Further details can be found by clicking here.

The Trusts Finance Department is committed to the One NHS Finance – Creating a Diverse Workforce, Maintaining an Inclusive Culture, Demonstrating Inclusive Leadership: Practical Steps to Embed Equality, Diversity, and Inclusion within Your Teams. This commitment reflects the department's ongoing dedication to fostering a diverse workforce, cultivating an inclusive environment, and modelling equitable leadership. It aligns with the Trust's strategic priorities around transparency, belonging, and systemic change across all levels of financial practice.

3.3 **High Impact Action 3.** *Eliminate total pay gaps with respect to race, disability, and gender.*

Current position

The 2025 Disability Pay Gap analysis shows a mean pay gap of 2.39%, indicating earnings differences at higher levels, while a near-zero median gap suggests balance at the midpoint. Employees with declared disabilities are present across all quartiles but concentrated in middle wage ranges.

The Ethnicity Pay Gap at LCHT reveals disparities, with a mean gap of 6.4% and a median gap of 7.4%. BME employees remain clustered in lower pay quartiles, while White employees dominate higher bands. Interestingly, BME employees received higher bonuses under the old NCEA scheme, highlighting bonus distribution inconsistencies.

The Gender Pay Gap analysis shows men earning 3.1% more on average, but a median gap of 3.8% favouring women suggests pay equity at mid-salary levels. Women make up 85% of LCHT's workforce, surpassing the broader NHS average of 77%.

The Trust Equality, Diversity, and Inclusion Action Plan 2025-2026 (*Appendices A) contains* actions designed to address the Disability, Ethnicity and Gender pay gaps.

3.4 **High Impact Action 4.** *Health Inequalities within their workforce*

The Trust focus remains on staff's physical, mental, and financial wellbeing and provides a wide range of support identified on the MyLCH Health and Wellbeing Pages

The LCH Staff Health and Wellbeing Facebook group - caring for each other, continues to flourish by providing support and information to over 900 members of staff.

An overarching Health and Wellbeing Action Plan, alongside a tailored support offer for staff engaged in the Quality and Value Programme, has been developed and continues to evolve in response to staff needs. This flexible approach ensures wellbeing remains a core priority throughout organisational change.

In addition, Trust staff have access to The Thrive at Work Hub, which is designed to support and empower health and care employees & managers in Leeds to thrive in their roles while managing their own health.

The Trust has a Board level Wellbeing Guardian, who continues to meet with the Director of People, to ensure health and wellbeing remains in line of sight to the Trust Board.

3.5 **High Impact Action 5.** *Comprehensive Induction and onboarding programme for International recruited staff*

NHS England has recognised the Trusts commitment to internationally educated nurses through the Pastoral Care Quality Award, highlighting best practice support for international recruits. A dedicated Pastoral Lead (Registered Nurse) continues to support current and incoming staff. The Trusts accommodation offer has been published as a best practice example in the International Retention Toolkit. Survey feedback shows high satisfaction and strong retention intent among internationally educated nurses.

3.6 **High Impact Action 6.** *Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.*

On 4 September 2023, NHS England launched its first-ever Sexual Safety Charter in collaboration with key partners across the healthcare system. The Trust is proud to be a signatory to this charter, affirming its commitment to a zero-tolerance approach toward any unwanted, inappropriate, or harmful sexual behaviours in the workplace. By signing up, the Trust endorses the charter's ten core principles and actions designed to foster a culture of safety, respect, and accountability across all levels of the organisation.

As part of our commitment to creating a safer and more supportive working environment for Trust staff, we will be implementing the NHS England Violence Prevention and Reduction Standard. This will ensure alignment between the national Violence Prevention and Reduction Strategy and High Impact Action 6 (HIA6).

The Violence Prevention and Reduction (VPR) Standard enables LCHT to take proactive steps to reduce violence and abuse toward staff. Facilities and Safety will complete an initial assessment against NHS VPR indicators, using both quantitative and qualitative data. Each indicator will be RAG-rated, with supporting evidence gathered to identify improvement areas. Findings will inform a targeted action plan, backed by senior leadership and monitored through clear governance routes.

The Trust now includes subject matter experts with lived experience on Panel hearings to identify discrimination, including microaggressions. This model is expanding to reflect all protected characteristics. Investigations are conducted by individuals with relevant lived experience, ensuring informed and appropriate handling of concerns, aligned with Too Hot to Handle recommendations.

The Trust People Inclusion Improvement Plan 2025/26 (Appendix A) outlines actions to eliminate conditions that enable bullying, harassment, and aggression, and to reduce incidents and disparities in experience across protected groups.

4. Next steps for 2025/26

4.1 The Trust People Inclusion Improvement Plan 2025–26 (Appendix A) outlines targeted actions across equality data, recruitment, development, health and wellbeing, and tackling harassment and bullying. It supports delivery of Workforce Strategy objectives, ensuring greater representation and reducing disparities in employee experience, with any remaining gaps actively addressed.

4.2 In 2025/26, we will continue improving equality data quality on ESR, a key enabler of inclusive practice and enhanced staff experience. The plan reinforces our commitment to addressing workplace harassment and promoting a culture of psychological safety and wellbeing.

4.3 In 2025/26, we will continue strengthening the quality of equality data held on ESR, a critical enabler of inclusive practices and enhanced employee experience. Through the Trust People Inclusion Improvement Plan, we remain committed to tackling harassment, bullying, and abuse in the workplace, supporting a culture where staff well-being is actively protected and promoted.

4.4 The risk matrix (Appendix B) outlines the key risks associated with the Inclusion Improvement Plan. These risks are currently being managed within the Trust's defined tolerance levels. Oversight mechanisms, established controls, and regular review processes are already in place, ensuring that each risk is actively held, monitored, and addressed as part of our commitment to inclusive, accountable practice.

Recommendations

The Trust Board is recommended to:

- Note the Trusts current position in delivering against the NHS EDI Improvement Plan High Impact Actions.
- Ratify the Trust People Inclusion Improvement Plan 2025/26, confirming that its continued delivery provides assurance the Trust meets workforce obligations under the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract.

APPENDICES A

Leeds Community Healthcare NHS Trust

Trust People Inclusion Improvement Plan 2025 - 2026.

	Measure *NHSE require improvement no specific targets have been allocted*	Action	Lead (s)	Review Date	Delivery Date	
	Organisational priority -Staff Equality Data					
1	Reduce the percentage of unknown and prefer not to say categories held on ESR for the following protected characteristics, currently - Ethnicity - 16.3% (613) Disability – 19.9% (737) Religion or Belief – 29.3% (1103) Sexual Orientation – 21.5% (821)	Continue to provide clear and accessible information ensuring that staff have easy access to information about the importance of equality declaration and how it contributes to creating an inclusive workplace.	Rich Cooper	31.12.25	31.3.26	WDES WRES EPGR DPGR
2		Regularly track and analyse equality declaration rates to identify any trends or patterns that may indicate areas for improvement. Use this data to inform targeted interventions and strategies to increase staff declaration.	Tom Breckin			
3		Promote ESR Equality Data update self-service function to all staff through MyLCH, Corporate Induction (Staff handbook and marketplace) and People Partners	Tom Breckin, Bukola Aigbogun, Rich Cooper			WDES WRES EPGR DPGR
4		Continue to provide the Workforce Equality Data dashboard and continued access for all LCH staff.	Tom Breckin			

	Measure *NHSE require improvement no specific targets have been allocted*	Action	Lead (s)	Review Date	Delivery Date	
		High impact action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.				
5	Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process.	The Trust Chair will continue record mutually agreed EDI objectives in executive directors' appraisals	Helen Robinson	_	31.3.26	WDES WRES EPGR DPGR LGBTQIA+
6	Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025).	The Trust board will receive patient & staff stories at Trust Board meetings, increase the number of Non-Exec visits to services & teams and continue to provide active Executive sponsorship to staff networks.	Helen Robinson	_	31.3.26	
7	NHS boards must review relevant data to establish EDI areas of concern and prioritise actions.	Progress will continue be tracked and monitored via the Board Assurance Framework	Helen Robinson	-	31.3.26	
		High impact action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.				
8	A reduction of the disparity between protected characteristics in the recruitment & selection process	All recruiting managers to attend the Trust Recruitment and Selection Managers course & refresher courses	Tom Breckin	31.12.25	31.3.26	WDES WRES DPGR EPGR GPGR LGBTQIA+
9		Review our fair and inclusive recruitment processes that target under-representation and lack of diversity and make recommendations and implement improvements	Rich Cooper	31.12.25	31.3.26	
10		As part of the fair and inclusive recruitment processes review the LCHT learning offer around Recruitment	Rich Cooper	31.12.25	31.3.26	
11		We will be actively supporting and promoting Inclusion and Belonging through the lens of the Disability, Neurodiverse & Long-Term Conditions, LGBTQI+ and Race Equality networks supporting the network chair /vice chair and sponsor.	Rich Cooper	31.12.25	27.2.26	

	Measure *NHSE require improvement no specific targets have been allocted*	Action	Lead (s)	Review Date	Delivery Date	
12	A reduction of the disparity between protected characteristics in the recruitment & selection process	Provide options for widening participation in the BME Fair Recruitment process to include staff who have declared a disability and/or identify as LGBTQIA+, ensuring intersectional representation and equity.	Rich Cooper	31.12.24	31.3.25	WDES WRES DPGR EPGR GPGR LGBTQIA+
13		Provide post-programme support for I Thrive/We Thrive ensuring lasting impact by keeping participants engaged, tracking their progress, and offering tailored development opportunities.	Rich Cooper	31.12.24	31.3.25	WRES EPGR
	High impact action 3: Develop and implement an improvement plan to eliminate pay gaps.					
14	Increase the number of women in the Gender Pay Gap Reporting Quartile 4 (Highest)	Promote local, regional, and national development and networking opportunities for women – in 2024-24, 5 members of LCH took part in the Leeds Heath & Care Academy Springboard women's development programme, compared to 14 in 2023-24.	Rich Cooper	31.12.25	31.3.26	GPGR
15	Increase the use of skill-based assessment tasks in recruitment *(DWP best practice*)	Through quarterly communication with Recruitment Managers.	Tom Breckin	31.12.25	31.3.26	GPGR
16	Ensure all of LCH promotion, pay and reward processes are transparent for all	Continue adhering to the Agenda for Change Job Evaluation Process and Job Evaluation Panel, and clear and transparent processes for non-Agenda for Change staff	Tom Breckin	31.12.25	31.3.26	GPGR
17	Increase the number of men who are working flexibly in accordance with the Flexible Working Policy	Promote the Trusts flexible working policy for men and women through quarterly promotion pieces & personal stories in MyLCH and through People Partner networks	Bukola Aigbogun	31.12.25	31.3.26	GPGR
18		This data is not currently collated and reported on ESR. People Partners and People Process to explore how this data can be collated and reported on via ESR.	Bukola Aigbogun & Tom Breckin	31.12.25	31.3.26	GPGR

	Measure *NHSE require improvement no specific targets have been allocted*	Action	Lead (s)	Review Date	Delivery Date	
19	Increase the number of men who are taking Shared Parental Leave – currently 1.	Encourage the uptake of Shared Parental Leave - to share childcare more equally. We will continue to collaborate with the Men's Health Forum to raise awareness and increase uptake and quarterly promotion pieces and personal stories in MyLCH.	Steve Keyes	31.12.25	31.3.26	GPGR
20	Reduce the Ethnicity Pay Gap	To conduct a deeper analysis of LCHT's Ethnicity Pay Gap data in alignment with the NHS Workforce Race Equality Standard (WRES) and our EDI Improvement Plan, with the aim of identifying structural drivers of disparity, informing evidence-based interventions, and considering the adoption of best practice models. Both from within the NHS and across other sectors, to advance race equity in pay, progression, and workplace experience.	Rich Cooper	31.12.25	31.3.26	WRES EPGR
21	Reduces the Disability Pay Gap	To undertake a detailed analysis of LCHT's Disability Pay Gap data in alignment with the NHS Workforce Disability Equality Standard (WDES) and our EDI Improvement Plan, applying the social model of disability to identify systemic barriers to equity. This analysis will inform targeted actions to address disparities, including the role of accessible recruitment, progression pathways, and the consistent application of reasonable adjustments. We will also explore and consider adopting best practice approaches—both within and beyond the NHS—to strengthen disability inclusion and ensure fair pay and career development opportunities for disabled colleagues.	Rich Cooper	31.12.24	28.2.25	Disability Confident EPGR WDES
	High impact action 4: Develop and implement an improvement plan to address health inequalities within the workforce.					
22	Line managers should continue to have regular wellbeing conversations with their teams supported by national resources, including the health and wellbeing framework	This has been included in the Trusts Compassionate and Courageous Leadership management training and Wellbeing at Work Policy. This continues to be included in the appraisal process, there is a a specific H&WB section, this ensures as a minimum H&WB is checked annually	Steve Keyes	31.12.25	31.3.26	WDES WRES DPGR EPGR GPGR LGBTQIA+
23	NHS organisations are encouraged to adapt NHS England's policy on menopause awareness as applicable to their local workforce. They should also adopt and implement the Supporting our NHS people through menopause: guidance for line managers and colleagues.	Continued promotion as a Menopause friendly Employer – highlighting the of support available, managers awareness sessions and 1-1 support provided through OH provider.	Steve Keyes	31.12.25	31.3.26	

	Measure *NHSE require improvement no specific targets have been allocted*	Action	Lead (s)	Review Date	Delivery Date	
24	Achieve reaccreditation of the Disability Confident Leaders Accreditation	Review the delivery of the current Disability Confident Leaders delivery plan.	Rich Cooper	31.12.25	31.3.26	Disability Confident WDES
		Conduct a peer assessment of performance and intentions with the Disability, Neurodiverse & Long-Term Conditions Staff Network.	Rich Cooper	10.10.25	31.10.26	
		Submit evidence for Disability Confident Leaders reaccreditation	Rich Cooper	-	1.12.27	
	High impact action 5: Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff.					
25	Deliver the LCHT comprehensive induction, onboarding, and development programme for internationally recruited staff, as required.	Continue to provide support to internationally recruited nurses	Jude McKaig	31.12.25	31.3.26	WRES EPGR
	High impact action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.					
26	Year on year improvement scores and reduction of disparity of experience between different protected characteristics.	Continue to ensure that Panel hearings now include a subject matter expert with lived experience and the capability to identify discrimination, including microaggressions. This model is being broadened to reflect the full spectrum of protected characteristics. Investigations are carried out by individuals with relevant lived experience and expertise in identifying discrimination aligned to the nature of each concern. This ensures appropriate and informed handling of issues raised. (Too Hot to Handle report)	Claire Staveley	31.12.25	31.3.26	WRES WDES
27	Create a safe, secure, and supportive working environment for all LCHT staff by preventing and reducing incidents of violence, aggression, and abuse in the workplace NHS Staff Survey 2024 Benchmark Report	Complete an initial assessment against the key indicators of the NHS Violence Prevention and Reduction (VPR) Standard, using both quantitative and qualitative data to inform a robust evaluation. This will include applying a Red, Amber, Green (RAG) rating to each indicator, gathering supporting evidence and examples, and identifying areas for improvement. Based on the findings, we will develop a targeted improvement action plan, secure senior leadership sponsorship, develop a VPR Policy, develop a VPR Strategy, agree KPI's and establish clear governance routes to monitor progress, escalate risks, and celebrate achievements.	Cara McQuire	31.12.25	31.3.26	WDES WRES LGBTQIA+

	Measure *NHSE require improvement no specific targets have been allocted*	Action	Lead (s)	Review Date	Delivery Date	
28	Create a safe, secure, and supportive working environment for all LCHT staff by preventing and reducing incidents of violence, aggression, and abuse in the workplace	Deliver 10 Compassionate & Courageous leadership sessions for managers as part of the Managers Development Programme	Rich Cooper	31.12.25	31.3.26	WDES WRES DPGR EPGR GPGR LGBTQIA+
29		Deliver 10 The Art of the Difficult Conversations sessions for managers as part of the Managers Development Programme	Rich Cooper	31.12.25	31.3.26	
30		Continue to deliver a 'Conflict & Aggression telephone course'	Cara McQuire	31.12.25	31.3.26	
31	Every service in LCH takes part in two Cultural Conversations in 2025/26 (*Health equity strategy action and TLT decision*)	Offer support, including the Leading Cultural Conversations development sessions to service and team managers in LCHT.	Em Campbell Rich Cooper	31.12.25	31.3.256	

Appendix B

Risks and Mitigations for ESR Data Challenge and High Impact Actions

Action	Strategic Risks	Reputational Risks	Operational Risks	Mitigation Strategies
ESR Data Challenge				
Reducing 'unknown' and 'prefer not to say' responses across protected characteristics	Incomplete data creates blind spots in equity planning and limits our ability to meet NHS EDI standards.	Staff and partners may perceive a lack of transparency, reducing trust in our dashboards and decision-making.	Disparities remain hidden, and reporting becomes unreliable, weakening board assurance.	Co-design trust-building campaigns with staff networks. Embed ESR data quality into board objectives. Integrate data prompts and checks into onboarding.
HIA 1: Leadership Accountability				
Ensuring execs, chairs, and board members have measurable EDI objectives	Cultural transformation may stall without visible leadership commitment. We risk misalignment with national mandates and ICS expectations.	Staff confidence in leadership may decline. External scrutiny could increase.	EDI delivery becomes fragmented, weakening traction on other HIA actions.	Embed EDI objectives into appraisal systems. Publish progress in board papers to demonstrate transparency.
HIA 2: Inclusive Recruitment & Talent				
Targeting under-representation and improving diversity in leadership	Lack of diversity in leadership signals structural barriers and risks non-compliance with WRES/WDES.	Perceived inaction may damage our employer brand and staff morale.	Bias in recruitment and progression limits access to development and weakens talent pipelines.	Audit and redesign recruitment processes. Ensure diverse panel membership. Train managers in inclusive recruitment and progression practices.

Action	Strategic Risks	Reputational Risks	Operational Risks	Mitigation Strategies
HIA 3: Pay Gap Improvement				
Developing and delivering a plan to eliminate pay gaps	Structural inequities persist, undermining our People Promise and risking challenge from unions and regulators.	Staff may disengage if pay disparities are left unaddressed, affecting morale and retention.	Legal risks increase and succession planning becomes inequitable.	Conduct intersectional pay audits. Develop targeted action plans. Link pay equity to leadership development and succession planning.
HIA 4: Workforce Health Inequalities				
Addressing disparities in access, outcomes, and wellbeing	Failure to meet Core20PLUS5 goals weakens our strategic credibility and alignment with wellbeing strategy.	Marginalised staff may feel neglected or unheard, reducing trust in wellbeing offers.	Disparities drive increased sickness absence and disengagement.	Use ESR and OH data to identify gaps. Co-design wellbeing plans with staff networks. Embed equity into all wellbeing offers and communications.
HIA 5: International Staff Support				
Delivering tailored induction, onboarding, and development	Poor integration affects retention and weakens our global recruitment reputation.	Staff may feel unsupported or excluded, risking negative feedback or attrition.	Inconsistent onboarding leads to missed development opportunities.	Continue delivering tailored induction and support systems. Monitor experience and progression. Link support to retention and career development strategies.
HIA 6: Safe Working Environment				
Eliminating bullying, discrimination, harassment, and violence	An unsafe culture undermines inclusion, belonging and NHS values.	Reputation suffers if staff confidence erodes, with potential for whistleblowing or media exposure.	Increased turnover, sickness, and fractured team cohesion reduce productivity.	Strengthen reporting and response systems. Embed the Violence Reduction strategy. Monitor trends and act swiftly on emerging hotspots.

Leeds Community Healthcare NHS Trust

Agenda item:	2024-25 (21i)

Title of report:	Significant Risks and Risk Assurance Report

Meeting:	Trust Board Held In Public
Date:	6 November 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. The report provides the Trust Board with an overview of the Trust's clinical or operational risks currently scoring 15 or above, and an overview of the risks scoring 12. This is based on information extracted from the Datix risk module on 8 October 2025. There are two risks on the Trust risk register that have a score of 15 or more (extreme). There are a total of 20 risks scoring 12 (very high).

Previously considered by:	Trust Leadership Team by email 14 October 2025 Risk Management Group 16 October 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	Yes		What does it tell us?	
	No	✓	Why not/what future plans are there to	N/A

and/or workforce)?			include this information?	

Recommendation(s)	• Note the changes to the significant risks since the last risk report was presented to the Board; and • Consider whether the Board is assured that planned mitigating actions will reduce the risks.

List of Appendices:	No appendices

Significant Risks and Risk Assurance Report

1. Introduction

1.1 The risk register report provides the Board with an overview of the Trust's material risks currently scoring 15 and above (extreme risks). It summarises all risk movement, the risk profile, themes and risk activity since the last risk register report was received by the Board (September 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.

2. Risk register movement

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

	Current	Previous (September)
Total Open Risks	106	91
Risks Scoring 15 or above	2	2
New Risks	19	17
Closed Risks	4	8
Risk Score Increasing	4	1
Risk Score Decreasing	13	7

2.2 The following updates have been provided for risks scoring 15 (extreme) or above since the last risk register report.

Risk	Risk Type	Current Score	Months at current score	Risk Appetite
1048: Mind Mate SPA increasing backlog of referrals (system-wide risk).	**Operational**	**15**	**Closed**	**Cautious (4 – 6)**
Previously Risk 1048 covered both neurodevelopmental and emotional wellbeing triage waiting lists and was scored at 15. Following progress that has been made in reducing the risk associated with the mental health triage waiting list, Risk 1048 has been closed and replaced with two risks to reflect the position with the separate pathway waiting lists. • Risk 1383, neurodevelopment triage waiting list (scored at 15) – see below • Risk 1384, mental health triage waiting list (scored at 12)				

Risk	Risk Type	Current Score	Months at current score	Risk Appetite
1383: Mind Mate Neurodevelopmental (ND) Assessment Triage Waiting List	**Operational**	**15**	**New (replaced 1048)**	**Cautious (4 – 6)**
The current score is 15 but will start to decrease because of the 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. This risk has an interim target score of 12 to be reached by 31/3/26. The target will then be aligned to the risk appetite in 2026/27.				
1179: Impact/Management of Neurodevelopmental Assessment Waiting List.	**Operational**	**15**	**12**	**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 1/10/25). Executive Director of Nursing following up.				

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	14
954	Diabetes Service waiting times	12	12	5
957	Increase in demand for the adult speech and language therapy service.	12	12	6
1042	Provision of equipment from Leeds Community Equipment Services (LCES)	12	12	14

ID	Description	Rating (current)	Rating (previous)	Months at current score
1125	National supply issues with enteral feeding supplies by Nutricia	12	12	5
1168	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment	12	8	Increased
1198	Impact of ADHD medication waiting list	12	12	17
1221	Likelihood of a cyber attack	12	12	9
1231	Failure to identify a child or young person experiencing clinical deterioration	12	8	Increased
1295	Primary Care Industrial Action	12	12	8
1303	Out of compliance mobile phones (Operating system not compliant with CE+)	12	12	6
1312	The Trust Risk and Incident reporting system (Datix) is preventing accurate reporting / assurance both internally and externally.	12	12	4
1313	Climate Adaptability Resilience Planning	12	12	5
1319	The number and long waits of high priority patients on the ABU Therapy waiting lists	12	12	3
1327	Finance Team Capacity & Capabilities	12	9	Increased
1329	Failure to deliver financial plan	12	12	4
1356	Patient Safety Incident Investigations	12		New
1366	Manual STI test requests risk patient safety and increase operational burden	12		New
1379	Political Climate / protests, staff safety	12		New
1384	Mind Mate Mental Health Assessment Triage Waiting List	12		New

13 of the 20 risks scoring 12 have not changed since the last report (static). Three of the 13 risks have been static for over 12 months: Risks 877, 1042 and 1198.

When risk scores have been static for over 12 months, the detail is escalated to TLT and the Quality and Business Committees. Static risks are also included in the scope of the Risk Management Group (RMG). A deep dive into static risks is scheduled at the next meeting of the RMG on 22 January 2026.

4. Risk profile – all risks

4.1 The total number of risks on the risk register is currently 106. Of these there are 38 clinical risks and 68 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	3	1	0	0	4
4 - Major	0	6	9	0	0	15
3 - Moderate	2	17	29	11	1	60
2 - Minor	1	9	9	4	1	24
1 - Negligible	0	2	1	0	0	3
Total	3	37	49	15	2	106

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 the risk to patient safety for example, as a result of capacity exceeding demand, primary care industrial action, and process transformation. Specifically, thirty-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]. This includes health and safety, compliance with information	The BAF strategic risks directly linked to compliance with standards / legislation are:

[1] Risks: 877, 1109, 1125, 1139, 1168, 1169, 1187, 1196, 1231, 1284, 1285, 1295, 1301, 1307, 1308, 1309, 1319, 1324, 1335, 1341, 1342, 1353,1354, 1356, 1359, 1361, 1363, 1364, 1365, 1366, 1369

[2] Risks: 902, 1089, 1178, 1204, 1206, 1221, 1242, 1296, 1303, 1304, 1305, 1312, 1313, 1379

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

6. Impact

6.1 Risk and assurance

This report is part of the governance processes supporting risk management in that it provides information about the effectiveness of the risk management processes and the controls that are in place to manage the Trust's most significant risks.

7. Next steps

Risks will continue to be managed in accordance with the risk management policy and procedure, and the Board will receive an update report at the meeting to be held on 5th February 2026.

[3] Risks: 772, 954, 957, 994, 1015, 1042, 1098, 1179, 1198, 1311, 1383, 1384

[4] Risks: 1227, 1228, 1318

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

8. Recommendations

The Board is recommended to:

- Note the changes to the significant risks since the last risk report was presented to the Board; and
- Consider whether the Board is assured that planned mitigating actions will reduce the risks.

Author: Anne Ellis, Risk Manager
Date written: 20 October 2025

Leeds Community Healthcare NHS Trust

Agenda item:	2025-2026 (21ii)

Title of report:	Risk Management Policy and Procedure (review)

Meeting:	Trust Board Held In Public
Date:	6 November 2025

Presented by:	Lynsey Ure, Executive Director of Nursing and AHPs					
Prepared by:	Anne Ellis/Helen Robinson					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	✓

Executive Summary:	The Risk Management Policy and Procedure is reviewed on a 3-yearly basis. The Policy has been reviewed by the Risk Manager, consulting with managers within the Trust, and then presented to the Clinical and Corporate Policies Group for further review and comment. The revised policy is now presented to the Board for approval.

Previously considered by:	Clinical and Corporate Policy Group 23 Oct 2025

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

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 - Equality Analysis has been undertaken on this policy and any outcomes have been considered in the development of this policy

Recommendation(s)	The Board is asked to: • Approve the revised Risk Management Policy and Procedure

Leeds Community Healthcare NHS Trust

Risk Management Policy and Procedure	
Author (s)	Anne Ellis, Risk Manager
Corporate Lead	**Leeds Community Healthcare NHS Trust** Executive Director of Nursing and Allied Health Professionals
Document Version	7
Document Status	DRAFT
Date reviewed and agreed by Clinical and Corporate Policies Group (CCP)	23rd October 2025
Date approved by Trust Board	
Date issued	
Review date	3 years from ratification date
Policy Number	PL354

Changes made to this version:

Section	Detail of each change made
Policy	
	• This is a new policy document and replaces PL354 v5 – Risk Management Policy and Procedure
Procedure	
	• This is a new procedure document and replaces PL354 v5 – Risk Management Policy and Procedure

Executive summary

This policy and appended procedure define the risk management framework and sets out the approach the Trust will take to the management of risk within the organisation, ensuring that sound risk management principles are an integral part of its governance structure and processes.

It details the respective responsibilities for corporate and operational risk management throughout the Trust.

The appended risk management procedure provides guidance for assessing, scoring and recording risks and assists with the development of mitigating action plans.

The appended risk appetite statement provides clarification for identifying target scores, ensuring that risks are adequately controlled.

The appended Board Assurance Framework procedure informs the Board, committees, trust leadership team and company secretary of their roles in ensuring the strategic risks to the Trust's objectives are being managed effectively.

This policy applies to all employees, locum and agency staff and non-executive directors and, where appropriate, independent contractors.

Equality Analysis

Leeds Community Healthcare NHS Trust's vision is to provide the best possible care to every community. In support of the vision, with due regard to the Equality Act 2010 General Duty aims, Equality Analysis has been undertaken on this policy and any outcomes have been considered in the development of this policy.

Contents

1. Introduction

Leeds Community Healthcare NHS Trust's Board is committed to leading the organisation to provide the best possible care in every community, thereby ensuring that the organisation makes the very best possible use of public funds.

Risk management is the recognition and effective management of all threats and opportunities that may have an impact on the Trust's reputation, its ability to deliver its statutory responsibilities and the achievement of its strategic goals.

The purpose of this policy and procedure is to establish risk management as an integral part of Leeds Community Healthcare NHS Trust's culture where there is effective management of risk and appropriate escalation through the Trust's governance structure.

This policy defines the risk management framework and sets out the approach the Trust will take to the management of risk within the organisation ensuring that sound risk management principles are an integral part of its governance structure and processes.

The appended risk management procedure supports staff to identify, assess, manage, and monitor the risks that threaten the organisation's ability to achieve its objectives.

The appended risk appetite statement documents the amount of risk the Trust is willing to accept in the pursuit of its strategic goals.

2. Aims and Objectives

Effective risk management means having a planned and systematic approach to the identification, assessment and management of the risks facing the Trust and is the means of preventing harm to service users and staff, providing a safe environment and improved quality of care.

To achieve this, we have set the following objectives

In order for the Trust to be successful it is important that risk has a suitably high profile and everyone recognises the part they play in helping to manage risk. Risk should not be seen as an ‘add on’ to your role or something that someone else does. Risk is all around us and part of our day-to-day life and therefore it is important that every one of us can recognise a risk and has the ability to raise concerns appropriately.

The purpose of this document is to set out the Trust’s approach to risk management. It supports the wider Risk Management framework and more detailed direction is held in the appended risk management procedures, associated guidance and relevant training.

2.1 Scope

This policy and any associated procedures, guidance, templates, training and instruction, apply to all executives, non-executives, clinical and non-clinical staff employed by the Trust, and people representing the Trust such as contractors and volunteers.

All foreseeable strategic, clinical, and operational risks will be identified, evaluated, documented, monitored, and treated in keeping with this policy and overarching strategy.

The risk register includes all types of risks to the Trust’s strategy and objectives. The risk register records risk as either Clinical or Operational. This policy does not support person-specific or asset-specific risk assessments and is instead designed to support safe and effective operational service delivery from the Board to teams, and all those departments in between within the Trust.

3. Definitions

Hazard	Anything/situations with the potential to cause harm, damage or loss.
Risk	The chance that something will happen that will have an impact on the achievement of the Trust’s objectives. A risk can be a threat or an opportunity. A risk is measured in terms of likelihood (frequency or probability of the risk occurring) and consequence (impact or magnitude of the effect of the risk occurring).
Strategic Risk	Risks that have the potential to impact on the achievement of the Trust’s strategic objectives.

Clinical Risk	Defined as 'risks which have a cause or effect which is primarily clinical or medical'. Examples include clinical care activities, waiting times, consent issues and medicines management.
Operational Risk	Risks that primarily relate to the way in which the Trust is organised, managed and governed. Examples of operational risks include: • Financial • Fraud • Reputational • Staff safety and wellbeing • Security • Working environment • Information governance • Business continuity • Emergency planning (EPRR) • Cyber security
Consequence	The result (the impact) of a particular threat or opportunity should it actually occur.
Likelihood	The measure of the probability that the threat or opportunity will happen, including a consideration of the frequency with which this may arise.
Controls	The existing systems and processes, which help minimise the risk.
Risk Score	A means of prioritising risks by measuring each risk in terms of consequence x likelihood.
Assurance	Confidence, based on sufficient evidence, that internal controls are in place and are operating effectively, and that objectives are being achieved.
Residual Risk Rating	The amount of risk that remains following implementation of all actions designed to reduce the risk.

Risk Appetite	The amount and type of risk that an organisation is willing to pursue or retain. The Trust's risk appetite statement is appended to this policy.
Risk Assessment	The process used to evaluate a risk and to determine whether controls are adequate or more should be done to mitigate the risk.
Risk Management	The systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk. Within the Trust, risk management encompasses all clinical and non-clinical risks.
Risk Tolerance	The Trust's readiness to bear the risk after mitigation in order to achieve its objectives. Tolerance relates to specific or individual risks, rather than the more general approach represented by risk appetite.
Risk Register	A record of the risks faced by the Trust that could affect the delivery of objectives.
Board Assurance Framework (BAF)	The BAF provides the Board with a register of strategic risks and gives assurances that the risks are being managed effectively.
Risk Owner	The person allocated the responsibility of ensuring that actions to control the risk are implemented.
Accepted Risk	A risk that is above appetite but accepted that it is managed to its lowest level – must be approved by the TLT and reviewed at least annually.

4. Responsibilities

All staff employed by Leeds Community Healthcare NHS Trust must work in concordance with the Leeds Safeguarding Multi-agency Policies and Procedures and local guidelines in relation to any safeguarding concerns they have for service users and the public with whom they are in contact.

The Trust has a system and processes (governance framework) within which risk is addressed and managed. Responsibilities for risk management are set out below:

4.1 Chief Executive

The Chief Executive has overall accountability and responsibility for risk management within the Trust and for compliance with the relevant regulations and is responsible for making the Trust's Annual Governance Statement. Delegated responsibility for the implementation of this policy is as shown below.

4.2 Executive Director of Nursing and Allied Health Professionals

The Executive Director of Nursing and Allied Health Professionals is the Board member with operational responsibility for risk management and ensuring that business units and corporate teams are supported to fulfil their responsibilities in line with this policy. This is facilitated by the Risk Management Group, chaired by the Executive Director of Nursing and Allied Health Professionals.

4.3 Company Secretary

The Company Secretary, on behalf of the Chief Executive, is responsible for the Board Assurance Framework and ensuring that mechanisms are in place so that the Risk Register is available for Board of Directors and Board Committee oversight as appropriate.

4.4 Executive Directors

The Executive Directors are responsible for those risks which are relevant to their areas of responsibility. In particular, the Executive Medical Director and Executive Director of Nursing and Allied Health Professionals, are responsible for risk that has a direct impact upon patient care, safety and quality of care, and the Executive Director of Finance and Resources for financial risk. The allocation of risks to individual Directors is shown in both the Board Assurance Framework and the Risk Register.

4.5 Trust Leadership Team (TLT)

The Trust Leadership Team (TLT) has delegated responsibility to oversee and review the contents of the Trust risk register on a monthly basis by receiving an update and details of any risk escalations. The TLT will also receive the committee escalation and assurance report from the Risk Management Group.

4.6 Risk Management Group

The Risk Management Group (RMG) meets quarterly and is an operational group reporting to TLT. It is made up of Senior Management to ensure that assurance on risks can be received by providing challenge on overdue risk reviews and actions, identification of emerging risks and common risk themes across the Trust and escalation of risks with scores that have been static for more than 12 months.

The RMG receives assurance from senior managers on all low, moderate and high risks in their business units/corporate areas, that they are being actively managed and reviewed.

The RMG also considers all risks due for review since the previous meeting and ensures that they are reviewed, and the risk information has been appropriately updated in the Trust's integrated risk management system.

The RMG will consider if the risk scores are still correct for any risk they review and if it needs adjusting, they will agree who will adjust as appropriate, which may escalate or de-escalate a risk.

4.7 Trust Board

The Board of Directors is responsible for ensuring that robust systems of internal control and management are in place, and for reviewing the effectiveness of internal controls through its assurance framework. This responsibility is supported through the governance committees of the Board of Directors (see 4.8).

To inform the Annual Governance Statement made by the Chief Executive in the annual accounts, the Board of Directors must be able to demonstrate that it has been informed, through the Board Assurance Framework, about all significant risks and that it has arrived at its conclusions on the totality of risk, based on the evidence presented to it.

The Trust Board is responsible for approving the risk appetite statement and the risk management policy.

4.8 Board Committees

The Audit, Business, Quality and People and Culture Committees are established as governance committees of the Trust Board. The committees' primary role in respect of risk management is to seek assurance on behalf of the Board that internal control and risk management systems are sufficiently robust to ensure delivery of organisational objectives and strategies. Where there are significant concerns or gaps in assurance or control, the committees escalate these to the Trust Board.

The Quality Committee has delegated responsibility for assurance of clinical risk.

The Business Committee has delegated responsibility for assurance of non-clinical risks, largely related to corporate services including workforce, information and financial functions.

The People and Culture Committee has delegated responsibility for receipt and review of relevant risks (including those referred from other committees or sub-committees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework.

Each committee will:

- Scrutinise risks that have a current risk score of eight or more as reported by the Risk Manager to the Committee every other meeting and where relevant, propose further risk reduction treatment: and
- Provide the Board with assurance against the strategic risks assigned to the Committee

In addition, the Quality Committee will:

- Oversee the detailed analysis and performance management and correlation of clinical risks, clinical impact of non-clinical risks, complaints, incidents and clinical audit to provide evidence of effective clinical risk management to the Board.

The Audit Committee has oversight of strategic risks relating to its terms of reference, for example cyber security and information governance.

The Audit Committee has ultimate oversight of the Board Committees' role in risk management.

The Audit Committee will:

- Ensure that a robust risk management process is in place and test this through internal audit reports.
- Receive and recommend the annual governance statement, which includes assurances about the Trust's risk and control framework, to the Board for approval.
- Monitor the effectiveness of the Board Assurance Framework process.

4.9 Committee Subgroups

The Committee Subgroups have delegated responsibility for identifying, reviewing and escalating risk to the relevant sub-committee.

4.10 Non-Executive Directors

Non-Executive Directors provide independent scrutiny and judgement in relation to the working of the Trust's risk management processes.

4.11 Risk Manager

The Risk Manager's role is to ensure the maintenance of a comprehensive risk register system, and that the inclusion of prioritised risk issues are reported to the RMG.

The role also ensures that standards and procedures relating to risk are embedded throughout the organisation; and supporting services through the provision of expert advice and guidance in implementing the risk management procedure.

4.12 Senior Managers / Service Leads

Senior Managers and Service Leads within the Trust are responsible and accountable for:

- The day-to-day effective management of risks of all types within their areas of responsibility.
- The ongoing maintenance and review of the service's risks and should ensure that they and their staff are working in accordance with the risk management procedure detailed in Appendix 1.

Senior Managers must ensure that:

- Risks are identified, proactively and reactively
- Risk assessments are undertaken
- Appropriate documentation of the risk assessment is produced in accordance with the risk management procedure
- Risk assessments and action plans are agreed and verified
- Risks are entered onto the risk register at the appropriate level and a target risk score is set, in line with the Trust's risk appetite statement
- New risks and updated information about risks are introduced and discussed at relevant forums and performance meetings
- The risk register and associated action plans are actively reviewed to ensure maintenance of an up-to-date risk register
- All reasonably practicable measures have been taken to reduce the risk, recognising resource and financial restrictions, in line with the Trust's risk appetite
- If it is considered that the risks are 'extreme' (have a current risk score of 15 or above), the risk assessments must be discussed with the relevant director
- There are mechanisms in place to keep local staff and managers informed of risks in their area and this will usually be through their team briefings, email, meetings
- Providing appropriate reporting and assurance for their risks to the RMG, raising any concerns and issues regarding service risks.

4.13 Risk Owner

The risk owner (as identified on the risk register entry) is the manager who can affect the risk outcome i.e. take or delegate decisions, and must ensure that:

- Their allocated risks on the risk register (regardless of score) and associated action plans are actively reviewed at the appropriate review frequency to ensure maintenance of an up-to-date risk register

- All reasonably practicable measures have been taken to reduce the risk, recognising resource and financial restrictions, in line with the Trust's risk appetite
- There is appropriate liaison with risk specialists (e.g. Risk Manager, Fire Safety Adviser, Health and Safety Officer, Local Counter Fraud Specialist, Infection Prevention and Control lead, Safeguarding Lead, Quality Lead etc.) for the management of the risks in services

The risk owner will retain the management of individual risks, irrespective of the risk score. Within each risk, actions can be assigned to other staff. Directors may assign themselves the ownership of extreme/high risks if they feel this is appropriate and then delegate actions to appropriate staff.

4.14 All Staff

Management of risk is a fundamental duty of all employees whatever their role. Employees are required to follow Trust policies and procedures, which explain how this duty is to be undertaken.

All employees must ensure that identified risks and incidents are reported and dealt with swiftly and effectively, reported in line with relevant Trust policies and procedures to their immediate line manager. If appropriate, report to their Health and Safety representative, in order that further action may be taken where necessary. Health and Safety is a core element of each employee's responsibility.

5. Risk Statement

Risk Management is an integral part of the Trusts' quality, governance and performance management processes and seeks to increase the probability of success and reduce the likelihood of failure.

All staff have a role in considering risk and helping to ensure it does not prevent the delivery of high-quality care.

The Board seeks to encourage a culture in which risk assessment and management of risks are an integral part of decision-making, and where necessary, resources are proportionately directed to manage risks to the safety of people, quality of care and assets of the Trust.

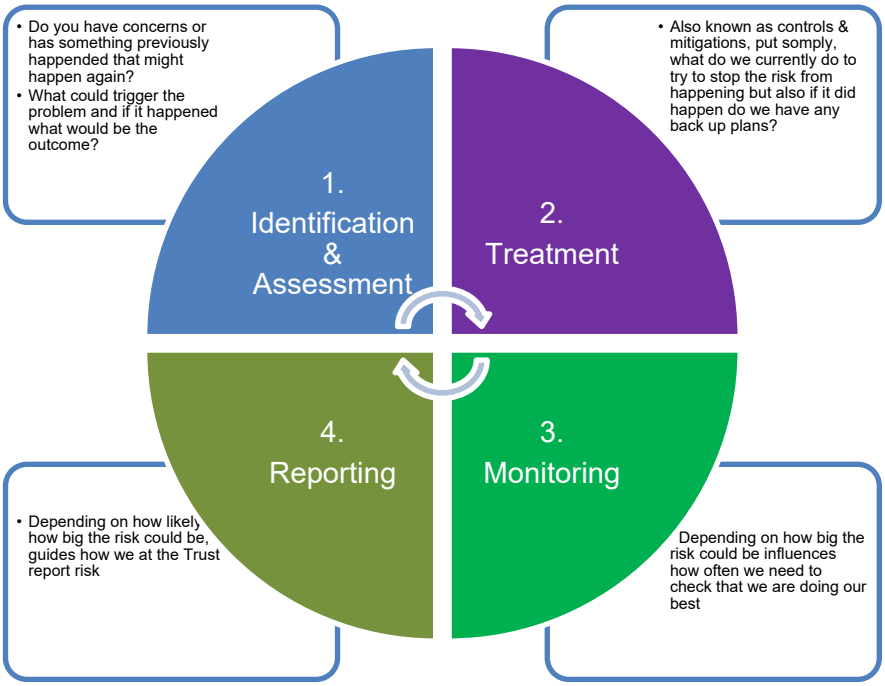
Sound risk management will be employed to maintain regulatory and legislative compliance, assist in the continuous improvement of service delivery and quality and improve the Trust's processes and procedures

To do this the Trust has set out the following policy so that all staff are able to:

1. Identify and assess risk

2. Identify and implement suitable risk treatment (controls) to help reduce the likelihood of risks happening or the impact they cause
3. Monitor how well the risk is being managed and any improvements needed
4. Report risk using the relevant reporting system and escalation process.

The diagram below outlines what the risk management approach looks like in practice; further detail of the four stages is provided in the risk management principles section of the policy (Section 9).



6. Risk Appetite

Risk appetite refers to the level of risk the Trust is willing to tolerate or expose itself to when controlling risks as they arise or when embarking on new projects. An organisation may accept different levels of risk appetite for different types of risk, or in relation to different projects.

Each year the Trust Board determines its risk appetite statement. The current Trust Risk Appetite Statement can be found on the Risk Management page of the Trust intranet.

Risk appetite informs the risk target levels, which are considered for individual risks. Based on the risk appetite a target risk score is set for individual risks; this is the level to which the risk is to be managed to. The benefits of this approach include:

- Management focus on risks that can be managed / reduced
- Identification of targeted actions to reduce risks to target

- Timely reduction of risks
- Identification / escalation of static risk / ineffective actions
- Management focus on risks that are not reducing

7. Board Assurance Framework and Risk Registers

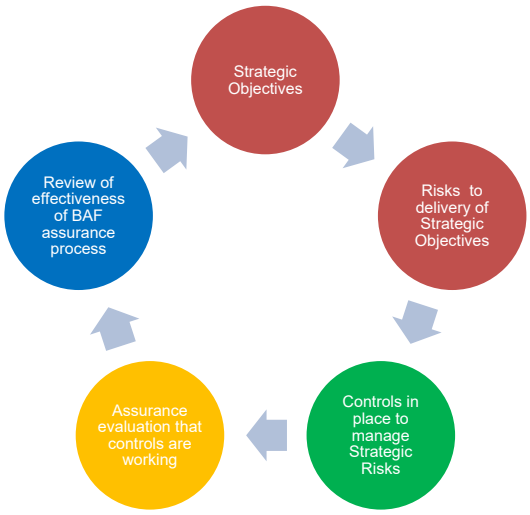
7.1 Board Assurance Framework

The Board Assurance Framework (BAF) is a tool to enable the Board to assure itself that the strategic risks to the achievement of its strategic objectives are being appropriately managed. It is interlinked with the Risk Register and is structured around the Board's strategic objectives. The Chief Executive is required to sign an Annual Governance Statement each year, and the Board Assurance Framework informs the declarations to be made in this statement.

"Strategic risks" are the risks that are most consequential to the organisation's ability to execute its strategies and achieve its objectives. Strategic risk can disrupt a business's ability to accomplish its objectives.

The BAF is a live document that should capture the Board's thinking around the management of strategic risks. The BAF documents risks to the Trust's strategic goals and corporate objectives, controls and sources of assurance.

The Board, TLT and the governance committees each have a unique function when reviewing the BAF. The following diagram summarises the BAF process which allocates a unique role to each group – the Board, TLT, the Board Committees and the Audit Committee. The BAF process is detailed in Appendix 2.



Board	The role of the Board is to agree the strategic objectives and identify the risks to delivering on these.
TLT	The role of the TLT is to determine how great the risk is and to control the risks.
Board Committees	The role of the committees who are assigned BAF risks is to check that the controls are working by agreeing the sources of assurance needed, reviewing

	the evidence (within the sources of assurance) and inform the Board whether those risks are being effectively controlled.
Audit Committee	The role of the Audit Committee is to determine whether the assurance process is effective.

7.2 Risk Register

The Trust uses an online integrated risk management system (Datix to record clinical and operational risk assessments and risk registers at all levels. Person-specific or asset-specific risk assessments are outside the scope of this policy and are not recorded on the Datix risk register.

The system enables risk register reports to be produced for review and audit purposes, and enables risks to be escalated as appropriate, therefore supporting a culture of proactive risk management.

For quality assurance purposes, all risk registers and supporting documentation are subject to inspection and review, without notice, by the Risk Manager or internal audit. All changes to risks must be recorded onto the Datix system. Datix has an integral audit trail function therefore any changes made to the risk register are recorded.

8. Training

The Trust employs an experienced Risk Manager who delivers risk management training and provides support and direction in all risk management related matters.

Mandatory health and safety training for managers incorporates risk assessment training. In addition to the mandatory training, bespoke training is provided to support teams and services with managing risk. Training can be requested and tailored to the needs of all staff, including the Trust Board**.**

In addition, the Risk Manager will identify training needs and target training through the application of the Risk Register Quality Procedure (Appendix 3).

There is a page dedicated to risk management on the Trust's intranet, this provides access to and signposts to advice and guidance, and the policy and procedure.

9. Risk Management Principles

9.1 Identification and Assessment

How we identify a risk

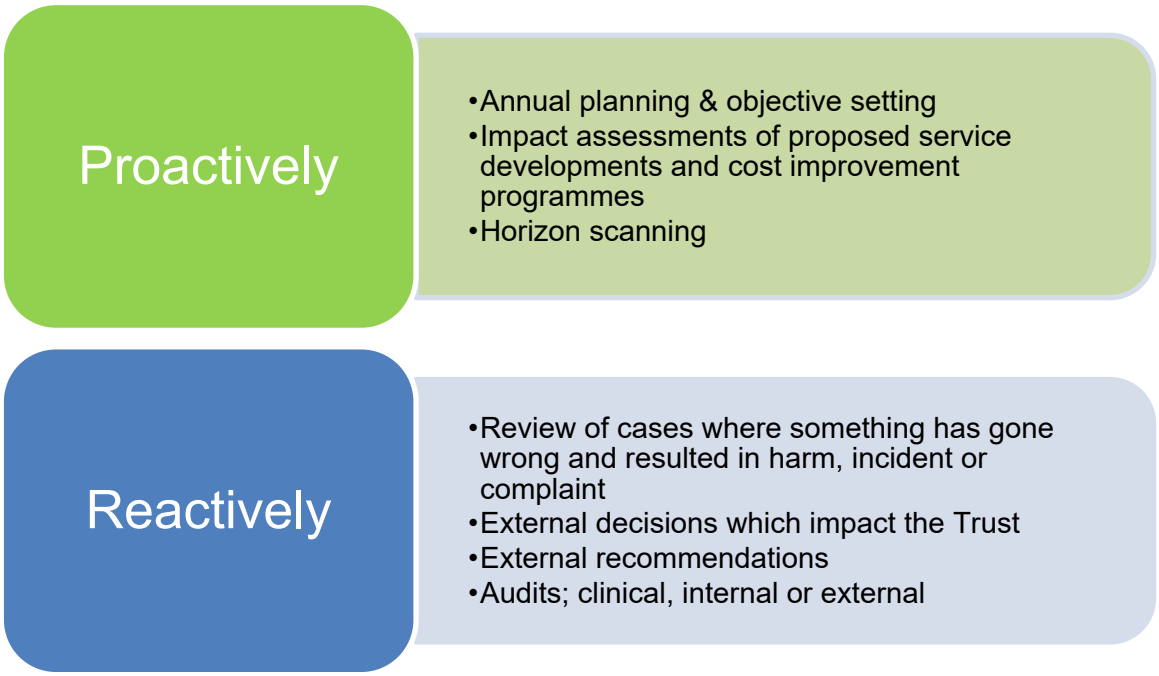
When identifying risk it is important to note that risks and issues often get confused with each other:

- Risks are things that **might happen** and if they did, would affect the organisation's ability to achieve its objectives and / or the success of the organisation.

- Issues are things that **have happened,** were not planned and require management action.

There are two ways in which we can identify risk. Either by looking ahead and thinking what might happen (proactively), or by learning from experience of others (reactively).

The diagram below gives some examples of how we might identify a risk, for example proactively would be before the risk has happened, reactively would be post event or after we have recovered from the impact;



Risk Assessment

Once we have identified a risk we must assess how significant it is and how likely we think it is to happen. To do this we must consider what would cause the risk to happen as this is what influences the likelihood. Then we must consider the effect the risk would have which will tell us how big the potential impact could be.

Risk assessment generally begins with understanding the objective (what the Trust is trying to maintain or achieve) and then an identification of threats that may prohibit or delay achieving that objective. The cause and impact of these threats coming into effect are what is being assessed.

How risk is recorded

Once we have identified a risk, owners must record it so that the Trust can continue to monitor and ensure we are managing the risk. A risk owner is the accountable person best placed to manage the risk.

The risk register is a record of all the risks that may affect the Trust's ability to achieve its strategic, clinical or operational objectives. The electronic risk management system used by this Trust to record and monitor risks is 'Datix'. Risks referred to at section 7.2 of this policy must be recorded on Datix.

Datix allows the Trust to create 'Risk Registers' which are the central point for recording and monitoring the lifecycle of risk assessments. It is here that the owner of each risk must maintain risk records and manage improvement actions.

Effectively describing risks

The risk description must clearly and concisely articulate the cause, the risk and the effect the risk would have, should it happen.

When describing a risk, there are three parts:

Part 1	**As a result of …**	Describe the cause – something that is known
Part 2	**There is a risk that …**	Describe the uncertain event that might happen if it's not managed
Part 3	**Which would lead to …**	Describe the effect / impact

An example is:

The above example would be written as 'As a result of an ineffective recruitment strategy there is a risk that the Trust fails to recruit suitably qualified staff which would lead to inappropriate staffing levels.'

How risk is evaluated

The Trust uses a 5x5 risk grading matrix which helps assess, using scores of 1-5, likelihood and consequence of each risk (see below):

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

There are three scores to consider when evaluating a risk:

Initial (unmitigated) risk score	• The risk rating score without any controls in place. This score should remain the same throughout the lifetime of the risk and is used as a benchmark to measure the effectiveness of controls.
Current (residual) risk score	• The risk rating score with existing controls in place. As part of the ongoing review process, the score may change until it reaches an acceptable level. • The current risk score identifies the level at which the risk will be managed and scrutinised.
Target risk score	• The expected risk rating score after all action and mitigation is complete. • When setting the target score, risk owners should refer to the Trust's risk appetite statement (see Section 6) to determine an acceptable risk level. Having said that, all risks must ideally be mitigated to their lowest possible level, which could be below the risk appetite level. • Risk owners can set an interim target score that is above the risk appetite where it is understood that it will take longer than 12 months to reduce to an acceptable level.

To maintain an objective and consistent approach across the organisation, the Trust's risk assessment matrix above must be used to 'score' each risk. The risk assessment matrix has a series of definitions that set out what each consequence and likelihood category mean. The impact risk score (1-5) is taken from the relevant consequence description category, and the likelihood score (1-5) is determined similarly but based on how likely we believe the risk is to occur. A more detailed scoring matrix can be found in Appendix 1, Risk Management Procedure which provides examples of how we might differentiate between a consequence or likelihood score.

9.2 Risk treatment

Once a risk has been identified and assessed, the next step is to decide how to treat the risk. Options for treating the risk are sometimes referred to as the '5 Ts' and are listed below:

- **Mitigate (treat)** the risk by taking action to reduce its likelihood and / or impact;
- **Accept (tolerate)** the risk by informed decision;
- **Avoid (terminate)** the risk, e.g. by discontinuing a specific activity;
- **Transfer** the risk, e.g. to a service provider;
- **Take or increase** the risk to pursue an opportunity.

The risk score and appetite combine to determine the appropriate treatment of a risk. The majority of risks recorded on the risk register will require mitigating actions to reduce the overall level of risk to within appetite.

For each risk an action plan is required to be added to Datix. Multiple actions can be added to a risk on Datix. Action plans should identify the action required, the person who will be responsible for ensuring the action is implemented, and the timescales involved.

9.3 Risk Review

An integral part of effective risk management is ensuring that risks are reviewed on a regular basis. The following Risk Review flow sets out how risks are monitored in the Trust:

Each role in the diagram above has specific responsibility relating to risk review as follows:

Risk Owner Review of individual risks
Progress against implementation of the action plan, assurances on the operation of the controls and the current level of the risk score are considered during routine risk

reviews. Where risks are not reducing as expected or are increasing, risks are escalated to business unit senior leadership and considered as part of the business unit risk review for decision on further action / decision on how the risk should be managed.

Senior Manager / Service Lead Review
Business unit / directorate senior management are responsible for review of:

- New / emerging risks
- Increasing risks
- Static risks (risks that are not reducing following implementation of mitigating actions)
- Reducing / closed risks
- Moderation of risks; risk grading, risk ownership and effective management of risks

Business unit and directorate representatives are required to highlight the following information to the RMG on a quarterly basis:

- New / emerging risks / themes
- Escalated risks – increasing and static
- De-escalated risks – reduced and closed

Risk Management Group (RMG)
The purpose of the RMG is to regularly review the contents of the Trust's risk register and provide the required level of assurance to the TLT that risks are appropriately identified, assessed and managed.

The Terms of Reference for the RMG can be found on the Risk Management page of the Trust Intranet.

Trust Leadership Team (TLT)
The TLT responsibility for risk review involves oversight and review of risks scoring over 12 on a monthly basis by receiving an update and details of any risk escalations. The TLT will also receive the committee escalation and assurance report from the RMG.

9.4 Risk Reporting

An integral part of effective risk management is ensuring that risks are reported and escalated within the Trust to ensure that appropriate action and prioritisation of resources can take place.

The table below describes the management and reporting arrangements.

Risk Score	Management Arrangements	Reporting Arrangements
1-3 Low 4-6 Medium	Any risks currently scoring 1-6 will be reviewed by the risk owner as appropriate but at least twice per year. Review and updates are recorded on Datix. An appropriate risk owner for low/medium risks is a service manager. Monitored at monthly performance meetings at business unit level.	Whilst low and medium scoring risks are not reported through the governance structure, they are: • Included in reports of overdue risk reviews and risks that have been static for over 12 months to the RMG • Included in the risk profile reported to the Board Committees and Trust Board.
8-12 High	Risks currently scoring 8-12 will be reviewed by the risk owner as appropriate but at least quarterly. Review and updates are recorded on Datix. An appropriate risk owner for high level risks is a senior manager e.g. general managers, clinical leads, heads of service etc. Monitored at monthly performance meetings at business unit level.	High risks are reported to the TLT every month and to the RMG. Reported to the Quality Committee (clinical and operational risks), Business Committee (operational risks) for consideration and People and Culture Committee (workforce and organisational development risks).
15-25 Extreme	Risks scoring 15-25 will be reviewed by the risk owner at least monthly. Review and updates are recorded on Datix. An appropriate risk owner for extreme risks is a director or a senior manager reporting directly to the responsible director. Monitored at monthly performance meetings at business unit level.	Extreme risks are reported to the TLT every month and to the RMG. Reported to the Quality Committee (clinical and operational risks), Business Committee (operational risks), People and Culture Committee (workforce and organisational development risks) and the Trust Board.

10. Monitoring Compliance and Effectiveness

Minimum requirement to be monitored / audited	Process for monitoring / audit	Lead for the monitoring / audit process	Frequency of monitoring / auditing	Lead for reviewing results	Lead for developing / reviewing action plan	Lead for monitoring action plan
Key Performance Indicators	Annual report provided to the Audit Committee.	Risk Manager	12 Monthly	Audit Committee Chair	Risk Manager	Risk Manager
Risk Management system	Audit Committee to review audit findings on risk management system and BAF	Audit Committee Chair	As per audit plan	Audit Committee Chair	Risk Manager	Risk Manager
Board Assurance Framework (BAF)	Audit Committee to review internal audit findings on BAF	Audit Committee Chair	As per internal audit plan	Audit Committee Chair	Company Secretary	Company Secretary
Risk Management Training	Annual report provided to the Audit Committee	Risk Manager	12 Monthly	Audit Committee Chair	Risk Manager	Risk Manager

11. Risk assessments

Risks identified with the implementation of this policy and procedure have been assessed and mitigated as far as possible, in line with the Trust's risk appetite. Should any further risks be identified following implementation, these will be assessed, and consideration will be given to a review or revision of the policy and procedure.

12. Approval and ratification

The policy has been approved by the clinical and corporate policies group and ratified by Senior Leadership Team on behalf of the Trust's Board.

13. Dissemination and implementation

The Clinical Audit & Effectiveness Team will support the dissemination of this policy by ensuring it is sent to the Quality Leads via email, uploaded to the LCH Intranet and shared via the Trust's weekly newsletter or the Trust's approved briefing.

Implementation will require directors, general managers and heads of service to ensure that staff have access to this policy and procedure and understand their responsibilities.

14. Training Needs

This topic does not feature in statutory and mandatory training requirements. Up to date information is available on the Intranet for training provision.

15. Review arrangements

This policy will be reviewed in three years following ratification by the author or sooner if there is a local or national requirement.

16. Associated documents

- PL276 Counter Fraud and Anti-Bribery Policy
- PL268 Incident Management Policy (including Serious Incidents)
- PL395 Equity and Quality Impact Assessment Policy
- PL282 Health and Safety Policy
- PL301 Information Governance Policy and Framework
- PL371 Managing Conflicts of Interest Policy and Procedure (Including Standards of Business Conduct)

17. References

- Local Government Association (2025) Must know guide: Risk management
- National Quality Board (2024) NHS England » Principles for assessing and managing risks across integrated care systems

- National Quality Board (2022) NHS England » National Guidance on Quality Risk Response and Escalation in Integrated Care Systems
- The Institute of Risk Management (2011) Risk Appetite & Tolerance
- The Institute of Risk Management (2018) Standard Deviations: A Risk Practitioner Guide to ISO 31000
- The Professional Association for Healthcare Finance (2024) NHS audit committee handbook | HFMA
- Financial Reporting Council (2024) Corporate Governance Code Guidance
- Government Finance Function and HM Treasury (2025) Orange Book
- Counter Fraud Authority (2025) Guidance for NHS Organisations: Incorporating the Failure to Prevent Fraud Offence into Fraud Risk Assessments (FRAs)

Leeds Community Healthcare NHS Trust

Appendix 1 – Risk Management Procedure

RISK MANAGEMENT PROCEDURE

1. Risk Identification and Assessment process

1. Risk to delivery of objectives identified (e.g. Trust, Business Unit, department, team). Using the risk assessment template at section 1.1.

Describe the risk as follows:

"As a result of (issue)…there is a risk that…which could lead to (consequence)…"

2. Assess the **Initial (unmitigated) risk score**

This is the level of risk if no mitigations were in place, the worst-case scenario if we did nothing.

a) Identify the risk consequence from the risk description and assess the consequence score using the consequence table at section 1.4. There may be more than one consequence, and each consequence should be scored individually on a separate line.

b) Establish the likelihood of the risk occurring using the Likelihood table at section 1.3.

c) Multiply the likelihood by the consequence to find the initial risk score.

3. Assess the **Current Risk Score**

a) List the existing controls in place – these are measures already in place to mitigate the risk.

b) Recalculate the risk score (step 2) to establish the current risk score.

4. Assess the **Target Risk Score**

a) Taking into consideration the risk appetite for the risk (Risk Appetite Statement at Appendix 2), determine an acceptable level of risk for the risk.

b) Calculate the Target score at which the risk will be managed to. Interim target scores can be utilised for risks which require mitigation over an extended period.

5. Identify **actions** to reduce the current risk score to target.

a) If the current score is higher than the target score identify actions to reduce the current score to the target score.

b) Include target dates and owners for individual actions.

6. **Approval** to add to the Risk Register (Datix)

a) The service manager should review the risk assessment and send to the corporate senior manager or business unit leadership team for consideration for the risk register, agreement of the risk score* and identification of risk owner.
*where there is more than one consequence / risk score, it is usually the highest score that is added to Datix.

b) It is not only risks that are above target and require reduction that should be added to the risk register. Risks that are being managed at or below the target should be added and monitored for changes to the risk.

1.1 Risk Assessment Template

Risk Assessment Title		Team		Date Completed	Review Date
Venue (if applicable)	**Directorate / Portfolio**	**Issue**			
Risk Assessment completed by (name and job title)	**Manager of Service**	**Approved to add to Datix***	**Y/N**		
		Approved by			

Risk Description: As a result of… There is a risk that… Which could lead to…	Initial (unmitigated) Risk Score Likelihood X Consequence = risk score with NO controls	Existing Controls Measures already in place to mitigate / reduce the risk	Current Risk Score Likelihood X Consequence = risk score WITH existing controls	Target Risk Score Likelihood X Consequence = acceptable level of risk	Actions What needs doing to reduce to target, what extra controls need to be put into place?	Action by Who is responsible for the actions?	Due Date When should the actions be completed by?

This risk assessment should be sent to the corporate senior manager or Business Unit leadership team for consideration for the risk register.

1.2 Trust Risk Assessment Matrix

Risks are first assessed on likelihood (probability of the risk happening) and secondly on consequence (what would happen should the risk occur).

The assessment is completed by scoring the likelihood and the consequence. Tables 1 and 2 set out the scoring, which is based on a scale of 1-5. Table 3 is the matrix to which these scores are then applied. This gives the scoring a Red/Amber/Yellow/Green status which indicates the size of the risk.

1.3 Table 1: Likelihood score – time-framed and probability descriptors

When deciding the likelihood score, always remember to consider the risk controls that are already in place.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Broad Descriptor	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	This will probably happen/recur, but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	Less than 0.1 per cent	0.1 – 1 percent	1 -10 percent	10 – 50 percent	Graeter than 50 percent

1.4 Table 2: Consequence Score

Choose the most appropriate descriptor for the identified risk from the left-hand side of the table then work along the columns in the same row to determine the consequence score (1-5), which is the number given at the top of the column.

When deciding the consequence score, always remember to consider the risk controls that are already in place. Where more than one descriptor is applicable, the highest score should be used. Please note – this is for guidance only and a holistic picture is required

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Injuries / harm - Patient **(Physical / Psychological)**	• **Impact prevented –** any patient safety incident that had the potential to cause harm, but it was prevented. • **Impact not prevented** – any patient safety incident that ran to completion, but no harm occurred • Incorrect medication dispensed but not taken • Incident resulting in a bruise / graze	• Minor Injury or illness – first aid treatment needed • Health associated infection which may result in permanent harm • Any patient safety incident that required extra observation or minor treatment and caused minimal harm to one or more persons • Wrong drug or dosage administered, with no adverse effects • Self-harm resulting in minor injuries • Category 2 pressure ulcer	• RIDDOR /Agency reportable incident • Moderate injury or illness requiring professional intervention • Adverse event which impacts on a small number of patients • Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but no permanent harm to one or more persons • Wrong drug or dosage administered with potential adverse effects • Self-harm requiring medical attention • Category 3 pressure ulcer	• Major Injury/ long term • incapacity / disability (e.g. loss of limb) • Incident leading to death • Any patient safety incident that appears to have resulted in permanent harm to one or more persons • Wrong drug or dosage administered with clinically significant adverse effects because of this. • Category 4 pressure ulcer • Retained instruments/ material after surgery requiring further intervention • Slip, trip or fall resulting in injury such as dislocation / fracture such as neck of femur,	• Multiple permanent injuries or irreversible health effects • Any patient safety incident that directly resulted in death of one of more persons • Unexpected death • Suicide of a patient known to the service in the last 12 months • Homicide committed by a mental health patient

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
			• Incorrect or inadequate information / communication on transfer care	multiple fractures/ blows to head • Failure to follow up and administer vaccine to baby born to a mother with hepatitis	
Injury - Staff / Agency / Student (carrying out nursing duties) **(Physical / Psychological)**	• Adverse event requiring no / minimal intervention or treatment. • Incident resulting in a bruise / graze • **Impact prevented –** any safety incident that had the potential to cause harm, but it was prevented. • **Impact not prevented** – any safety incident that ran to completion, but no harm occurred	• Minor Injury or illness – first aid treatment needed • Health associated infection which may result in permanent harm e.g. needle stick injury	• RIIDDOR /Agency reportable incident • Requiring time off work for over seven days • Healthcare associated infection e.g. Clostridium difficile (C Dif), Methicillin-resistant Staphylococcus aureus (MRSA)	• Major Injury/ long term incapacity / disability (e.g. loss of limb) • Over 14 days off work • Slip, trip or fall resulting in injury such as dislocation / fracture/ blow to head • Physical attack resulting in serious injury • Long term healthcare associated infection >6 months • Post-traumatic stress disorder as diagnosed by a healthcare professional	• Multiple permanent injuries or irreversible health effects • Incident leading to paralysis • Incident leading to long term mental health problems as diagnosed by a healthcare professional • Any staff safety incident that directly resulted in death of one of more persons
Personal Security	• Verbal abuse	• Physical attack such as pushing, shoving or pinching causing minor injury such as laceration, sprain, or anxiety resulting in occupational health counselling (no time spent off work required)	• Physical attack causing moderate injury • Threats to use a weapon to attack any person (not limited to staff) where no such weapon is confirmed to exist • Discovery of weapons such as a knife or gun	• Use or threat of use of a weapon on staff or any person for who the Trust has a duty of care, where the presence of a weapon is known or reasonably suspected • Staff reported missing during working hours • Staff attacked	• Rape / serious sexual assault • Use of weapon leading life changing injury, death or long-term injury.

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
			in a patient home, grounds or premise		
General Security	• Security incident with no adverse outcome • actual attempted arson attack prevented • Prevention of a suspected or likely arson attack where no actual attempt has yet been made	• Security incident managed locally (e.g. rang police) • A person behaving suspiciously or apparently attempting to conceal their activities in any part of the premises or surrounding grounds. • Controlled drug discrepancy – accounted for	• Security incident leading to compromised staff / patient safety • Breach of security – unauthorised person enters premise/restricted area • Loss of belongings through theft at building	• Breach of security leading to a serious compromise of staff / patient safety • Suspicious package left / received • Bomb discovery	• Any suspicious package or potential Improvised explosive device opened, moved or interfered with by an unqualified person (Ammunition Technical Officer/ Explosive Ordinance Disposal technician) • Bomb detonated • Chemical weapons released
Fire Safety	• Minor short term (less than 1 day) shortfall in fire safety system	• Temporary (less than 1 month) shortfall in fire safety system / single detector etc. (non-patient area)	• Fire code non-compliance / lack of single detector - patient area etc.	• Significant failure of critical component of fire safety system (patient area)	• Failure of multiple critical components of fire safety system (high risk patient area)
Patient Experience	• Reduced level of patient experience which is not due to delivery of clinical care	• Unsatisfactory patient experience directly due to clinical care – readily resolvable	• Unsatisfactory management of patient care – local resolution (with potential to go to independent review)	• Unsatisfactory management of patient care with long term effects • Significant result of misdiagnoses	• Incident leading to death

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Staffing & Competence	• Short Term low staffing level (less than 1 day) • temporary disruption to patient care • minor competency related failure reduced service quality, 1 day • low staff morale affecting one person	• On going low staff level – minor reduction in quality of patient care • 75%-95% staff attendance at mandatory / key training • Unresolved trend relating to competence reducing service quality • low staff morale (1%-25% staff)	• Unsafe staffing level • Late delivery of key objectives / service due to lack of staff • 50% - 75% staff attendance at mandatory / key training • Error due to ineffective training / competency • low staff morale (25%-50% of staff)	• Unsafe staffing level greater than 5 days • Uncertain delivery of key objective/service due to lack of staff • 25% - 50% staff attendance at mandatory / key training • Serious error due to ineffective training and /or low morale (50%-75% of staff)	• On going unsafe staffing levels • Non-delivery of key objective / service due to lack of staff • Less than 25% attendance at mandatory / key training on an ongoing basis • Loss of several key staff • Clinical error due to lack of staff or insufficient training and/or competency • Very low staff morale (more than 75 % of staff)
Compliance: Statutory duty/ Inspection	• Small number of recommendations which focus on minor quality improvement issues • No or minimal impact or breach of guidance / statutory duty • Minor non-compliance with standards	• Minor recommendations which can be implemented by low level of management action • Breach of statutory legislation • No audit trail to demonstrate that objectives are being met (NICE, HSE etc)	• Challenging recommendations which can be addressed with the appropriate action plans • Single breach of statutory duty • Non-compliance with core standards <50% of objectives within standards met	• Enforcement action • Multiple breaches of statutory duty • Improvement notice • Critical report • Low Performance rating • Major non-conformance with core standards	• Multiple breaches of statutory duty • Prosecution • Severely critical report • Zero performance rating • Complete systems change required • No objectives / standards being met

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Adverse Publicity / Reputation	• Rumours • Potential for public concern	• Local Media – short term – minor effect on public attitudes / staff morale • Elements of public expectation not being met	• Local media – long term – Moderate effect – impact on public perception of Trust and staff morale	• National media more than 3 days – public confidence in organisation undermined – use of services affected	• National / International adverse publicity greater than 3 days • National / International adverse publicity greater than 3 days • MP concerned (questions in the House) • Total loss of public confidence
Business objectives/ projects	• Insignificant cost increase/ schedule slippage	• 5 per cent over project budget • Minor schedule slippage	• 5–10 per cent over project budget • Schedule slippage with moderate impact	• Non-compliance with national 10–25 per cent over project budget • Schedule slippage with major impact • Key objectives not met	• Incident leading more than 25 per cent over project budget • Schedule slippage with catastrophic impact • Key objectives not met
Finance including claims	• Small loss. • Risk of claim remote.	• Loss of 0.1–0.25 per cent of budget • Claim less than £10,000	• Loss of 0.25–0.5 per cent of budget • Claim(s) between £10,000 and £100,000	• Uncertain delivery of key objective/ Loss of 0.5–1.0 per cent of budget • Claim(s) between £100,000 and £1 million • Purchasers failing to pay on time	• Non-delivery of key objective/ Loss of over 1 per cent of budget • Failure to meet specification/ slippage • Loss of contract / payment by results • Claim(s) over £1 million

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Business / Service Interruption	• Loss/ Interruption of more than1 hour, no impact on delivery of patient care / ability to provide services	• Short term disruption of more than 8 hours with minor impact	• Loss / interruption of more than 1 day • Disruption causes unacceptable impact on patient care • Non-permanent loss ability to provide service	• Loss / interruption of >1 week • Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked • Temporary service closure	• Permanent loss of core service/facility • Disruption to facility leading to significant 'knock on' effect across local health economy • Extended service closure
Natural Environmental Impact	• Minor onsite release of substances • Not directly coming into contact with patients, staff or members of the public	• Onsite release of substances contained • Minor damage to Trust property – easily remedied less than £10K	• On site release no detrimental effect • Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K - £50K	• Off site release with no detrimental effect / on-site release with potential for detrimental effect • Major damage to Trust property – external organisations required to remedy – associated costs more than £50K	• Onsite. / Off site release with realised detrimental / catastrophic effects • Loss of building / major piece of equipment vital to the Trusts business continuity
Information Governance	• There is absolute certainty that no adverse effect can arise from the breach • Files were encrypted • Personal data is recovered from a 'trusted' partner organisation	• Potentially some minor adverse effect. • Cancellation of an appointment or visit but does not involve any additional suffering • Inconvenience to staff who need the data to do their job.	• Potentially some adverse effect. A release of confidential information to the public domain leading to embarrassment and adverse publicity or draws complaints from patients. • Prevention of staff doing their job e.g. a cancelled procedure that has the potential of prolonging suffering but	• Potentially pain and suffering / financial loss • There has been reported suffering and decline in health arising from the breach • Sanction or financial detriment occurred because of a ruling from a statutory body. • Loss of bank details leading to loss of funds • Loss of employment	• A person dies or suffers a catastrophic occurrence. • Loss of HSCN connectivity / NHS England intervention

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
			does not lead to a health decline • Any incident involving vulnerable groups even if no adverse effect occurred. • Vulnerable children or adults • Criminal convictions / prisoner information • Special characteristics • Communicable diseases • Sexual health • Mental health		
Cyber	• Minimal disruption: no sensitive data involved; no user impact.	• Localised system impact; low-sensitivity data; data or system quickly recoverable (within 4 hours).	• Disruption to non-critical services; potential exposure of sensitive data. Data or system recovered within 24 hours	• Extended downtime of critical systems (beyond 72 hours); confirmed data breach (e.g. PII/PHI).	• Widespread compromise of enterprise systems; major data loss; regulatory breach. • No known recovery time for data or systems or Data confirmed as not recoverable
Enablers (e.g. digital, estates)	• Minor work-rounds required to ensure services are delivered in-line with plans.	• Significant work-rounds incurring moderate additional costs to ensure services are delivered in line with plans.	• Significant work-rounds incurring moderate additional costs to ensure services are delivered in line with plans. Delay of key business initiatives.	• Major delays/derailment in implementing new service models. • One major change not deliverable.	• Several major plans not implementable. • Loss of critical service(s) for sustained period.

Consequence score (severity levels) and examples of descriptors					
Descriptor	**Negligible 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
	• Negligible impact on existing service delivery	• Occasional moderate impact on existing service delivery	• Existing service delivery impaired on a regular basis	• Reduced service in critical area / loss of service in non-critical area	

1.5 Table 3: Risk Scoring = likelihood x consequence

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

Risk Score	Risk Colour	Risk Level
1-3	Green	Low
4-6	Yellow	Medium
8-12	Amber	High
15-20	Red	Extreme

2. Adding a risk to Datix

1. Approval to add to Datix received and documented on the risk assessment template (stage 6 of the Risk Identification and Assessment process).

2. Add a new risk on Datix

- Select the option 'Add a New Risk' from the Datix Risk Register module.
- Using the information from the risk assessment complete the RISK1 form (New submission to the risk register). There are guidance notes within each section of the form to support accurate completion.
- Ensure the Risk Score Rationale field explains the rationale behind both the current and target scores, including:
    - The reasoning for the likelihood and consequence scores selected
    - Reference to the risk appetite for the risk type and how the target score has been determined.
    - Specify if an interim target score has been utilised for risks which require mitigation over an extended period.
- Upload the risk assessment document
- Submit the form. The submitted form will be saved as RISK2 (Risk review form)
- Add the actions to reduce the risk to the Action Plans section of the form (menu on left of the form)
- Link the risk to the Trust objectives and strategic risks on the risk description page
- Save the risk

3. Review and Approval of new risks

- Once a risk has been recorded on the risk register (on Datix), it is automatically given the status 'In Holding Area, Awaiting Review'.
- The Risk Manager reviews the proposed risk (using the Risk Register Quality Procedure, Appendix 3)
- For risks scoring 8 or above, the Risk Manager requests Director approval to add the risk to Datix. Approval provided by email will be retained by the Risk Manager and a note placed on Datix. Directors can place their own note on Datix to approve.
- If the Risk Manager and Director do not agree that the recorded risk is a risk, the Risk Manager will change the status to 'Rejected'. A note will be placed in the 'Progress Notes' field and the risk owner advised.
- Following satisfactory completion of the review procedure and Director approval (where required), the Risk Manager will change the status of the risk to 'Being Reviewed'

3. Risk Review Process (individual risks)

Risk owners must proactively review their assigned risks in advance or on the date of the review date and update their risks accordingly. The frequency of review must reflect the level of the risk.

Risk Score	Frequency of Review
15 – 25	Monthly review
8 – 12	At least quarterly
1 – 6	At least twice a year

Reminders will be sent to risk owners in the month the review is due and when high and extreme level risks (scored at 8 or above) review dates have lapsed.
Risk owner review will include:

- Review of the controls and actions,
- Impact of the controls and actions on the current risk score,
- Identification of any additional actions if the risk is increasing or not reducing in line with the target date set.
- The action plans must be updated, and changes to the risk reflected on Datix.
- The review must be summarised on Datix in the Latest Update field.

Where risks are not reducing as expected or are increasing, the risk owner will escalate to business unit senior leadership to be considered as part of the business unit risk review for decision on further action / decision on how the risk should be managed. Escalation and subsequent action / decision must be recorded as a progress note on the risk record on Datix.

4. Acceptance and Closure of Risks

Following the routine monitoring of risks, if it is considered that the risk is reduced and managed within appetite the risk should remain on the risk register and be reviewed at least annually. If a risk no longer exists, then it can be closed. Changes to the status of risks should be approved by the risk owner and the responsible Director.

Some risks will be routinely closed at year-end and a new risk raised from the 1st of April, e.g. the risk to achieving the financial control total in any specific year.

It is not always possible to identify and then fully implement actions that eliminate or minimise a risk. Where this is the case, it is essential that the significance of the risk that remains is understood, and the Trust confirms that it is prepared to accept that level of residual risk if it is above appetite. Following the completion of all actions, if a risk cannot be reduced to a risk score in line with, or less than the current risk appetite, the risk will require the TLT’s approval for acceptance. Accepted risks should remain on the risk register and be reviewed at least annually.

Reporting of the Trust risk profile will include the number of risks managed at target and the number of risks accepted above target. Such risks will be given the status ‘Managed’ on Datix to support review and reporting.

Leeds Community Healthcare NHS Trust

1. Agreement of Strategic Objectives and Strategic Risks

The Trust Board agrees the strategic objectives at the start of each financial year. Once the strategic objectives have been agreed the Trust Board will review and agree the strategic risks to ensure they remain relevant.

Strategic risk management is the process of recognising risks, identifying their causes and effects, and taking the relevant actions to mitigate them. Risks arise from internal and external factors. These factors can change year on year, and a Board should examine the context and environment that it is currently operating within, as well as its strategic direction, and consider whether the strategic risks recorded on the BAF are still valid. This process is undertaken at a Trust Board workshop following agreement of the strategic objectives.

Once revisions are agreed at Trust Board, the strategic risks will be assigned to an executive director and to a committee for oversight. Committees are provided with details of the strategic risks assigned to them for oversight at the first available meeting following agreement of the strategic risks.

2. Completion of the Strategic Risk template

The executive lead for each strategic risk ensures the strategic risk template is completed and reflects the current position. The updated BAF is reported to the Trust Board in June.

The strategic risk templates collectively form the Board Assurance Framework. The templates show a summary description of each risk and when this was reviewed. The assurance framework also shows the executive lead, the relevant committee, the direction of travel, controls in place, assurance received, gaps in assurance; and action being taken to address gaps and target rating to ensure that the measures in place will address the gaps to ensure the strategic risk appetite has not been exceeded/reduce the risk to the risk appetite. Material risks from the risk register are also referenced against each strategic risk. A copy of the template is provided below.

When considering how a risk will be managed to ensure that it is within the Trust's agreed risk appetite, it is important to understand the role of the risk's target score. The target score of a risk is the ultimate level of risk that needs to be achieved given the available means and resource.

Strategic Risk Ref:
Title
Description

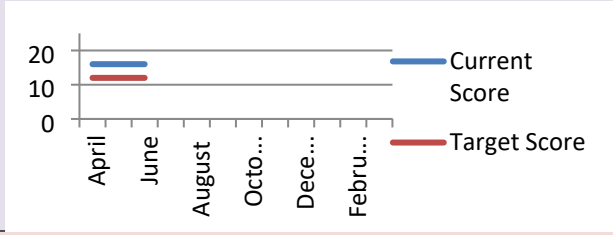
Strategic Objective:

Risk Appetite		**Status: In or out of Appetite**		**Lead Director/risk owner:**

Committee with oversight:

Date last reviewed:

Risk Rating
(likelihood x consequence)
Current score:
L x C = X
Target score:
L x C = Y



Rationale for current risk score:

Rationale for target score (including risk appetite and any constraints to reaching risk appetite within the next 12 months):

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

-

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

Action	**Owner**	**Due by**

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**
•	•	•

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):

3. Quarterly Review of Strategic Risks

The executive leads / TLT will review the framework quarterly and update it to ensure that it continues to provide the Board with assurance. The Board receives the full BAF quarterly. The quarterly review includes assessment of the existing controls and assurances and evaluation of the impact of the actions to address gaps in control and assurance on the risk score. The quarterly review will identify any additional controls or assurances that may be needed to manage the risk within appetite.

4. Reporting arrangements and assurance

4.1 Board Committees

The Board committees review the BAF in addition to receiving the Committee Risk Register for information, to avoid taking a fragmented approach to risks at this level.

The Board committees each focus on the risks which pertain to their remit and terms of reference. They seek assurance on behalf of the Board that key controls are in place and review risks through their annual work plans. The assurance framework is used to drive the agenda for the committees who will undertake occasional deep dives into specific areas that relate to the risks for which they are responsible.

There are three types of assurance (sometimes referred to as ‘three lines of defence’). Committees should seek to have all three types for each strategic risk if possible:

1. Service level assurance: Service delivery and day to day management (e.g. information provided by a service)
2. Specialist support, oversight responsibility (e.g. information provided by corporate support functions about other services)
3. Independent challenge (e.g. information provided by internal or external audit, CQC, patient feedback)

Committee bi-annual activity and assurance report
Each Committee is asked to review on a bi-annual basis the sources of assurance provided against the strategic risks for which they have oversight to ensure that the sources are of sufficient variety, focus, depth and frequency to enable the Committee to have an informed opinion when providing assurance to the Board.

In addition, the bi-annual report provides each assurance committee with information reflecting the previously agreed levels of assurance received within the six-month period and any agreed gaps in assurance and action taken.

At the end of every meeting the Committees are recommended to review the strategic risks they have oversight of and where there are insufficient sources of assurance presented at committee meetings, this should be remedied and reflected in the committee escalation and assurance report to Board.

Levels of assurance
Assurance is when information and the discussion at committee meetings provides reliable information (evidence) for the committee members and attendees to collectively judge whether all is well and if the strategic risks associated with the information being reviewed are being effectively managed (or not).

The last item on assurance committees' agendas at each meeting is a template that requires completing by the Committee Chair. This template lists the strategic risks that are assigned to that committee and the information that the committee has received during the meeting. Committee members and attendees should be invited to conclude the assurance level after due consideration and discussion.

Meeting chairs will need to record the level of assurance agreed. Operating in this way evidences positive (or negative) assurances for inclusion in the quarterly BAF summary report and committee escalation and assurance reports to the Board.

To harmonise terminology, the statements of levels of assurance to be used are: *substantial, reasonable, limited* and *no.*

- **Substantial assurance** based on a conclusion that there is a robust system of internal control and governance in place which will deliver the Trust's corporate objectives (clinical, quality or business) and that controls and management actions are consistently applied

- **Reasonable assurance** based on a conclusion that there is a generally sound system of internal control and governance to deliver the clinical, quality or business objectives and that controls and management actions are generally being applied. Some weakness in the design and/or application of controls and management actions put the achievement of particular objectives at risk. Improvements are required to enhance the controls to mitigate these risks.

- **Limited assurance** based on a conclusion that the design and/or application of controls and management actions are insufficient, and the weaknesses put the achievement of clinical, quality or business objectives at risk. Significant improvements are required to improve the adequacy and effectiveness of the controls to mitigate these risks.

- **No assurance** based on a conclusion that there is a fundamental breakdown in or absence of controls and management actions which could result (or have resulted) in failure to achieve the clinical, quality or business objectives. Immediate action is required to improve the controls to mitigate these risks.

BAF process report to Audit Committee

In July each year a report is presented to the Audit Committee outlining how the BAF has been managed over the last year through a quarterly review process, and in particular the processes in relation to the annual review of the strategic objectives, strategic risks, risk appetite, controls and sources of assurance which combine to form the BAF for the following year. The Audit Committee uses this report to evaluate the effectiveness of the BAF process as described in this policy and procedure, in order to provide assurance to the Board.

4.2 Trust Board

Committee Escalation and Assurance reports to Board
The role of the committees that are assigned strategic risks is to determine whether the controls are working by agreeing the sources of assurance needed, reviewing the evidence (sources of assurance) and indicating to the Board whether those risks are being effectively controlled (assurance level: none, limited, reasonable, substantial).The Committees review the sources of assurance presented to them at each meeting and provide the Board with positive or negative assurance. The Committee Escalation and Assurance Report relays assurance levels to the Board, and the report is also used to advise the Board of any key issues discussed at the Committee. This is so that the Board is informed as to whether risks to the success of its strategic goals (objectives) are being managed effectively.

Full BAF report
The Board BAF reports (quarterly), as well as each committee's escalation and assurance reports (every meeting), give an overall picture of the assurance levels provided by the Committees to the Board over recent months.

Risk themed report
The risk themed reports that are reported to each Board connect the strategic risks with current and emerging risk themes from the risk register. Risks on the risk register are aligned to the Trust's strategic objectives. Risks can affect the achievement of more than one objective and ultimately the non-delivery of strategic objectives will affect the Trust's vision to 'provide the best possible care to every community we serve'. For the purposes of analysis for this type of report, each risk has been aligned with the one strategic objective it most directly affects. It should be noted that most, if not all strategic risks, if not managed well will ultimately put the primary strategic objective of delivering outstanding care at risk.

The emergence of material risks, strong risk themes and their correlation with BAF strategic risks could mean that the controls in place to manage strategic risks are not sufficiently robust. In this event, the Board and appropriate committees should seek additional assurance against these BAF strategic risks.

The table below summarises the reporting and assurance arrangements.

Report	Frequency / Timing
Committees	
Revised Strategic Risks	Q1
Activity and assurance report • Summarises assurance levels at each meeting in previous quarter • Review of sources of assurance	Bi-annually
Audit Committee	
BAF process report	July
Trust Board	
Committee escalation and assurance report	Bi-monthly
Risk themed report	Bi-monthly
Full BAF report	Quarterly

Appendix 3 Risk Register Quality Procedure

Risk register quality procedure

1. **Introduction**

This statement sets out the procedure to ensure that the risk register is maintained effectively.

2. **Risk Management: policy requirements**

The Risk Management Policy states:

- For quality assurance purposes, all risk registers and supporting documentation are subject to inspection and review, without notice, by the Risk Manager or internal audit. All changes to risk registers must be recorded onto the Datix system. Datix has in integral audit trail function therefore any changes made to the risk register are recorded (section 5.2).
- The Risk Manager role is to ensure the maintenance of a comprehensive risk register system (section 6.11).
- Senior Managers / Service Leads are responsible for the ongoing maintenance and review of the service's risks (section 6.12).
- Risk owners must ensure that their allocated risks on the risk register (regardless of score) and associated action plans are actively reviewed at the appropriate review frequency to ensure maintenance of an up-to-date risk register (section 6.13).

3. **Implementation of policy requirements**

The following quality procedures have been developed to support the maintenance of an up-to-date risk register.

New Risks

For all new risks the Risk Manager will:

1. Ensure a risk assessment has been fully completed (including action plan), approved by senior management / business unit senior leadership team and attached to the risk on Datix and supporting the risk score applied to the risk.
2. Check that the risk target allocated is appropriate when placing a risk in live status. Where the target risk is agreed to be higher than the apparent appetite, ensure the rationale for this is included within the 'rationale for risk score' section on Datix.
3. Ensure the review date (frequency) is realistic in terms of the severity of the risk.
4. Ensure the risk is aligned to an appropriate strategic risk.
5. For risks scoring 8 or above, ensure Director approval to add the risk to Datix has been obtained. Approval provided by email will be retained by the Risk Manager and a note placed on Datix. Directors can place their own note on Datix to approve.
6. Ensure that action plans have been added to the risk on Datix.

Review of Open Risks

Each month the Risk Manager will run a report of risks that have passed the review date, those with a review date due at the end of the previous month and those that have passed the target date:

a. An initial reminder is sent via Datix email to remind Risk Owners that the risk review is due or out of date.
b. For risks that are overdue by 2 weeks or more, a personal email is sent by the Risk Manager via Outlook to the respective Risk Owner (and the reminder documented on Datix notepad).
c. For risks that are more than one month overdue, the relevant director must be notified by the Risk Manager.
d. TLT will receive a monthly report from the Risk Manager concerning any risks, regardless of score, that have surpassed their update date and / or target date by more than one month.

Closed Risks

Each month the Risk Manager will identify any risks awaiting closure or closed in the preceding month to ensure appropriate approval to close has been obtained. Risks should only be closed where the risk no longer exists (see Appendix 1 Section 4: Acceptance and Closure of Risks)

a) Risks with risk score higher than the target risk require the TLTs approval to close; and

b) Risks that have been reduced to the target score require director approval to close.

Approval provided by email / at TLT will be retained by the Risk Manager and a note placed on Datix. Directors can place their own note on Datix to approve.

Quality Assurance

Key Performance Indicators

The Risk Manager will provide the TLT with KPIs monthly. The KPIs provide assurance on the management of risks. The following KPIs will be included in the monthly TLT report:

- % of risks with review overdue
- % risks with expired target date
- Number of risks with static score over 12 months

Quarterly Risk Register Review

The Risk Manager will review the risk register on a quarterly basis to highlight exceptions relating to:

- Frequency of review
- Risk owner
- Action plans
- Rationale for risk score / target score

- Overdue risk review
- Static risk score (over 12 months)

The quarterly review will include risks in the ‘Being Reviewed’ and ‘Managed’ risk statuses.

Following the quarterly review the Risk Manager will provide information to support business units to maintain oversight of the practical application of the risk management procedure. The information will also support identification of risk owner training requirements.

4. **Review**

The contents and operation of this procedure will be reviewed from time to time in response to the issue of new or amended guidance and/or arising from practical implementation of this procedure.

Version: 1

Author: Risk Manager
Date: July 2025

Policy Consultation Responses

Complete this template when receiving comments at various draft stages of the Policy.

Responder (Including job titles and organisation)	Version, Comment and Date	Response from Author
Diane Allison, Head of Facilities Management and Safety	V1 My only comment is that I don't agree with the idea of risks remaining open on Datix if they reach a target score and are within appetite. I would close them, and then there should be other means of establishing if the controls have continued to be effective – like incident data, waiting lists, budgets, training stats, complaints, etc. If anything suggests that the risk is not being managed at a tolerable level, then the risk would either be reopened, or re-recorded as a new risk. To leave a managed risk open on Datix means that the system/reports become overwhelmed with risks that do not need scrutiny. 15/8/25	• It is best practice not to close risks unless they have been removed completely • Provides full risk profile, risks within and outside risk appetite • Prompts review of managed risks as will have a review date on the system (propose annual review) • Retains the history of the risk in one place • Supports compliance with frameworks e.g. CQC, EPRR, DSPT We can mitigate against the system / reports being overwhelmed with risks that do not need scrutiny by using a managed risk status on Datix. Therefore, managed risks can be easily identified and separated from risks that are being reviewed (above target). Reports can be run on the risk status in Datix.
Helen Swales, Library Services Manager	V1 I've had a look through this policy, and my comment would be that there is just one reference, which is quite old now. We've had a look for other more recent documents that could be of use and have also found examples	Reference section updated

	of policies from other Trusts that might be of interest. 18/8/25	
Richard Slough, Assistant Director Business Intelligence	V1 Section 3 – include definition of 'strategic risk' Section 6 – adding the Risk Appetite statement as an appendix will become out of date, could the text reference the existence of the risk appetite statement and where it can be found? Section 9.1 How risk is recorded section – 'All risks within the scope of this policy must be recorded on Datix' – Does that include BAF risks as that uses a different template? Section 9.3 – Diagram should recognise that corporate risks aren't reviewed through a BU review but at Directorate level. 19/8/25	Comments actioned
Ann Henderson, Clinical Effectiveness and Compliance Manager	V1 Suggest separating the document into policy and a standard operating procedure (SOP) to make more user-friendly and adaptable, whilst retaining its core principles and helping to future-proof it against change. Section 4.14 – Is it possible to break this sentence up into 2? *In particular, all employees must ensure that identified risks and incidents are reported and dealt with swiftly and effectively, reported in line with relevant Trust policies and procedures to their immediate line manager and, if appropriate, their Health and Safety representative, in order that further action may be taken where necessary.*	Comments actioned. Regarding separating the risk management process (section 9) that is in the policy into a separate procedure, the procedural element of the process is separated into a separate appendix. Section 9 describes the risk management framework / principles rather than being a procedure / process – Section 9 has been renamed – Risk Management Principles The appendices will be saved and published as separate documents to enable future change to be made without making changes to the policy.

	Section 6 (risk appetite) - If this changes each year, would we be able to put this on MyLCH and have a link here so that we do not need to adjust annually. Section 9 – could this be separated out from the policy into a procedure? Section 13 – Change wording to: *The Clinical Audit & Effectiveness Team will support the dissemination of this policy by ensuring it is sent to the Quality Leads via email, uploaded to the LCH Intranet and shared via the Trust's weekly newsletter or the Trust's approved briefing.* 19/8/25	
Ram Krishnamurthy, Clinical Lead (CBU)	V1 Section 1 – add to paragraph – and provide best possible care to Leeds population Section 3 – add waiting times to examples of operational or clinical risks? Section 4.2 – include risks added by corporate teams as well as BU's? Section 6 – shall we reference NHS England – Principles for assessing and managing risks across integrated care systems? Section 9 – Is this process or Principles of risk identification and assessment? If process, we could move it to appendix? Section 9.3 This looks like a process which can be moved to appendix? Section 9.3 – BU review – Have we acknowledged this in the responsibilities section? Section 9.2 – Do we need a section or point about adding actions in Datix? 21/8/25	Comments actioned Regarding separating the risk management process (section 9) that is in the policy into a separate appendix, the procedural element of the process is separated into a separate appendix. Section 9 describes the risk management framework / principles rather than being a procedure / process – Section 9 has been renamed – Risk Management Principles. Section 9.3 now referred to as 'flow' – the process of how to review is included in the procedure (separate appendix)

Nikki Cooper, Local Counter Fraud Specialist	V1 I am currently looking at the failure to prevent offence and wonder if you would consider it a good idea to include reference to it in the policy too. Table 2 on page 9 of the guidance suggests a risk response 21/8/25	Section 2.1 Scope – states that all foreseeable strategic, clinical and operational risks are in scope and fraud risks have been included as example of operational risk in policy section 3 Definitions The Counter Fraud policy is listed in Section 16 Associated documents Added Guidance for NHS Organisations: Incorporating the Failure to Prevent Fraud Offence into Fraud Risk Assessments (FRAs) to policy section 17 References (with a link to the guidance) The specific responsibilities provided in Table 2 on page 9 of the fraud guidance apply to all types of risk and are reflected in policy section 4 Responsibilities in relation to all risks.
Em Campbell, Health Equity Lead	V1 Amendments to increase accessibility of policy and mitigate risks for how we record/monitor risks that could negatively impact particularly on people with visual impairments, who are neurodivergent or with low levels of literacy or numeracy. This should be reflected in the EIA section with associated mitigation. 30/8/25	Comments actioned
Ann Hobson, Transformation Lead, People Directorate	V1 Could the policy be split into key highlights for the Policy i.e. what do people need to know and refer to	It was always intended for the appendices (procedures / processes) to be separate documents, forming a separate toolkit that can be

	other parts as SOPs/processes or put these into a supporting Toolkit? 5/9/25	accessed without accessing the entire document. The policy and appendices were combined into one document purely to be sent out for the consultation. I will ensure that when the policy and procedure are sent to the CCPG the documents are separated so that it does not seem so daunting.

Policy Consultation Process

Title of Document	Risk Management Policy and Procedure
Author (s)	Anne Ellis, Risk Manager
New / Revised Document	New
Lists of persons involved in developing the policy	N/A
List of persons involved in the consultation process	Helen Robinson, Company Secretary Lynsey Ure, Executive Director of Nursing and Allied Health Professionals Sheila Sorby, Deputy Director of Nursing & Quality and Director of Infection Prevention & Control Caroline McNamara, Clinical Lead, Adult Business Unit Ram Krishnamurthy, Clinical Lead, Childrens's Business Unit Mandy Young, Clinical Lead, Specialist Business Unit Ann Hobson, Transformation Lead, People Directorate Beverly Wilson, Deputy Director of Finance Hannah Beal, Deputy Director – Allied Health Professionals, Integration and Clinical Education Claire Gray-Sharpe, Head of Clinical Governance Carolyn Nelson, Head of Medicines Optimisation & Controlled Drug Accountable Officer Stuart Murdoch, Deputy Medical Director Diane Allison, Head of Facilities Management and Safety Peter Ainsworth, Operational Support Manager Tim Baker, Head of Estates Richard Slough, Assistant Director Business Intelligence

	Geraint Jones, Chief Clinical Information Officer Lucy Shuttleworth, General Manager ABU Janet Addison, General Manager CBU Andrea North, General Manager SBU Steve Creighton, Head of IG & DPO Nikki Cooper, Local Counter Fraud Specialist Helen Swales, Library Services Manager Cara McQuire, Deputy Head of Safety Ann Henderson, Clinical Audit and Effectiveness Manager Karen Otway, ABU Quality Lead Sarah Hemsley, CBU Quality Lead Frankie Skirrow, SBU Quality Lead Em Campbell, Health Equity Lead

Leeds Community Healthcare NHS Trust

Agenda item:	2025-2026 (22i)

Title of report:	Board Assurance Framework Quarterly Update

Meeting:	Trust Board Held In Public
Date:	6 November 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. Any amends made during the October review remain in red font in the Appendix.

Previously considered by:	

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

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

Recommendation(s)	The Board is asked to: • 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_Oct_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 21 October 2025

Ref	Strategic Risk	Lead Director	Current Score (Oct 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	Six months into 2025/26 the score has not reduced, progress has been made against Well-led actions however there is further work relating to EQIA and CQC to complete.
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	Six months into 2025/26 the score has not reduced. Whilst actions are progressing, the placement of the Trust into segment 4 of the NHS Oversight Framework has necessitated the addition of further actions to manage this strategic 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	Six months into 2025/26 the score has not reduced. The actions are ongoing throughout the year.
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	Six months into 2025/26 the board is not yet assured regarding delivering recurrent savings in-year. Through the Medium-term Planning process, the Trust needs to move to a cycle where plans are 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 is developing its Medium-term Plan that is inclusive of a financial plan, expected to be in place by end of 25/26.
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	Six months in 2025/26 the score has not reduced, actions are ongoing, two new actions have been added in relation to readiness to manage the impact of climate events on business continuity and resilience of the EPRR function. While there are no material gaps in relation to cyber, the external environment warrants retaining the current score of 12.
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	Six months into 2025/26 the score is unchanged. The release of the National Oversight Framework scores and ranking have caused the Trust to apply additional focus in the areas of staff engagement and sickness absence, where LCH falls in the lower end of its comparator group. Correlated with an increase in protest activity and a number of attacks on places of worship elsewhere in the UK, the Trust is concentrating significant engagement activity on staff safety and support across all of its services.
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	Six months into 2025/26 the score has not changed, additional resource has been secured, work is ongoing to develop data and metrics relating to health equity.
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	Six months into 2025/26 the risk score remains at 8 as actions are progressed.

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				✓		Sep Quality Committee - Some areas of limited assurance - QAIG AAA not received, NOF waiting times, EQIA concerns, but committed to improving. Strong assurance in other areas. Therefore reasonable overall.
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				✓		Sep Quality Committee: Reasonable overall, however PSIRF discussion deferred to Nov meeting therefore limited assurance in that area.
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&C	3	3	9				✓		Sep Quality and Business Committees: reasonable assurance. Sep People & Culture Committee: reasonable assurance, Committee received the EDI report and people KPIs and was assured that statutory obligations were being complied with.
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				✓		
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				✓		
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			✓			Sep People & Culture Committee: The current NOF position and other issues put before the Committee including the audit report on appraisals meant that the Committee concluded there were some gaps in assurance. The expectations were discussed during the meeting.

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**			✓			Sep Quality Committee - Limited in terms of EQIA assurance and PSIRF being deferred to November meeting
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**				✓		

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.

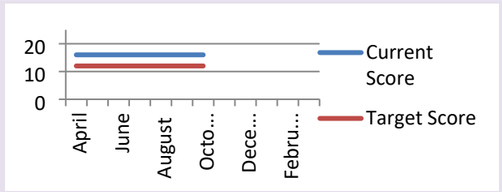
Strategic Objective: Work with communities to deliver personalised care / To embed equity in all that we do

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: 1/10/25

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.
Six months into 2025/26 the score has not reduced, progress has been made against Well-led actions however there is further work relating to EQIA and CQC to complete.

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
- AAA reporting from business units to QAIG

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. The gaps in control have been reviewed, SPC has been developed and embedded into BU quality meeting reports to QAIG. AAA reporting has been introduced for each aspect of quality governance.	Medical Director	~~Sept 25~~ Complete
Implementation of the new CQC Single Assessment Framework, aligned with the Quality Challenge+ programme will continue, to comply with best practice and CQC requirements. Progress: • CQC Readiness Board workshop scheduled for Jan 2026 • CQC engagement meeting regarding Single Assessment Framework – November 2025	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. Update QAIG meeting cycle, ToR updated and approved reflecting the changes. Board assurance provided through Well-led action plan reporting.	Executive Director of Nursing and AHP's.	~~Sept 25~~ Complete
As a result of Quality and Value service redesign, a gap in control has been identified relating to the leadership structure. To address this, a leadership restructure is underway. This will be a two-year process – the target date relates to part one of the process.	Executive Director of Nursing and AHP's.	March 2026
The Quality Committee in September 2025 was not assured by the EQIA paper, ongoing conversations with Board members and SLT members will take place to understand the gaps in control relating to the EQIA process further.	Executive Director of Nursing and AHP's.	Dec 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
• 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 (QC). Routine assurance reporting on EQIA oversight and escalation will be established and embedded. Quality Committee in September 2025 was not assured by the EQIA paper, an action has been added to improve control. Due date extended to accommodate further paper to QC in November.	Executive Director of Nursing and AHP's	~~October 25~~ Dec 25

Link to Risk Register (material scoring 10 or above):

1179: Impact/Management of Neurodevelopmental Assessment Waiting List (15)
1383: Mind Mate SPA backlog of referrals (neurodevelopmental) (15)
1384: Mind Mate SPA backlog of referrals (Emotional Wellbeing) (12)
1125: National Supply Issues with Enteral Feeding Supplies by Nutricia (12)
1042: Provision of Equipment from Leeds Community Equipment Service (LCES) (12)
1231: Failure to identify a child or young person experiencing clinical deterioration (12)
1198: Impact of ADHD medication waiting list (12)
1168: NatPSA/2023/010/MHRA: Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment (ABU) (12)
1356: Patient Safety Incident Investigations (12)
1295: Primary Care Industrial Action (12)
1353: Home Oxygen Fire Risk (10)
1354: Patients may not receive MRSA decolonisation as a result of GP collective action (10)

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.

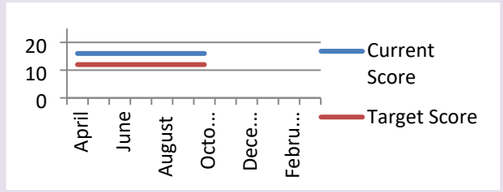
Strategic Objective: Work with communities to deliver personalised care / To embed equity in all that we do

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: 8/10/25

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.
Six months into 2025/26 the score has not reduced. Whilst actions are progressing, the placement of the Trust into segment 4 of the NHS Oversight Framework has necessitated the addition of further actions to manage this strategic risk.

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 is in the process of being implemented.	Executive Director of Operations	Sept - Dec 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 now in the implementation phase and the service will transfer 1st January 2026.	Executive Director of Operations	~~31 Oct 25~~ 1 Jan 2026
Further actions relating to the management of waiting lists include: • Waiting list initiatives have been identified and costed and are in the process of implementation with a view to eliminating 52 week waits and where possible 40+ week waits by end March 2026. • Waiting lists that require external support (neurodevelopmental assessment), working with the System to agree where routine children will go if not eligible for LCH service.	Executive Director of Operations	31 March 26
The NHS Oversight Framework has highlighted that work is required to identify data quality issues in terms of children accessing NHS funded MH services. This work is in process with a target of completion by the end of Q3.	Executive Director of Operations / Executive Director of Finance	Q3

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~~ Jan 2026

Link to Risk Register (material risks scoring 10 or above):

1179: Impact/Management of Neurodevelopmental Assessment Waiting List (15)
1383: Mind Mate SPA backlog of referrals (neurodevelopmental) (15)
1384: Mind Mate SPA backlog of referrals (Emotional Wellbeing) (12)
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)
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)

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.

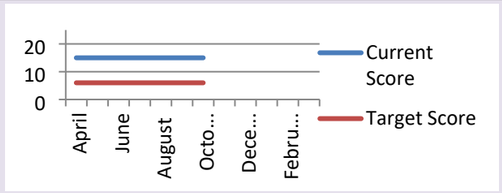
Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity 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: 29/9/25

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.
Six months into 2025/26 the score has not reduced. The actions are ongoing throughout the year.

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 legislative 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. The target date has been extended to Q3 to complete the Board capability assessment.	TLT	End of ~~Q1~~ Q3 2025/26

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

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

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

Action	Owner	Due by
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. Board workshop was held 10/7/25. The first update will be taken to the July Board workshop – subsequently has been scheduled on Board workplan (April and Oct). Next update will be taken to the November Board meeting. Further assurance on implementation of the action plan will be received from Audit Yorkshire, an audit will commence in Q3, to report in Q4 (due date amended accordingly).	Head of Strategy, Change and Development	~~End Q1 2025/26~~ Q4
A Board workshop on CQC Assurance – readiness for inspection at Board level has been scheduled for Jan 2026 to provide further assurance.	Executive Director of Nursing and Allied Health Professionals	Jan Board Workshop

Link to Risk Register (material risks scoring 10 or above):

1356: Patient Safety Incident Investigations (12)
1329: Failure to Deliver the Financial Plan (12)
1313: Climate Adaptability Resilience Planning (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)

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.

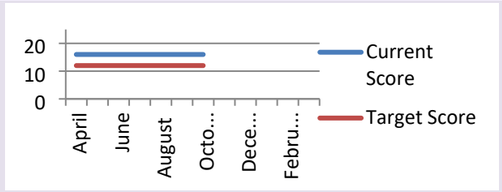
Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do

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: 7/10/25

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.
Six months into 2025/26 the board is not yet assured regarding delivering recurrent savings in-year. Through the Medium-term Planning process, the Trust needs to move to a cycle where plans are 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 is developing its Medium-term Plan that is inclusive of a financial plan, expected to be in place by end of 25/26.

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)

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. Develop a systematic approach to using benchmarking data to inform the Q&V programme	EDFR	Q4 25/26
3. Focus redirected onto reviewing the Well-led Finance Toolkit (NHSE)	EDFR	Q3 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. Completed - a risk-based forecast is now taken to Business Committee each month. NHSE guidance to be aligned to the Q&V programme re financial risk and programme risk. Completed Financial reporting will continue to be reviewed and developed during 25/26 Completed	EDFR	~~Q3 25/26~~ Complete
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 8* or above):
1329: Failure to Deliver the Financial Plan (12)
1327: Finance Team Capacity and Capabilities (12)
1328: Less capital resources available nationally (8)
1318: Corporate Funding Reduction (9)
* For this SR risks scoring 8+ due to smaller number involved

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.

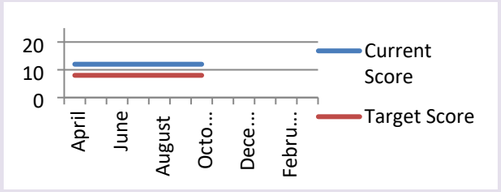
Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

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: 8/10/25

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.
Six months in 2025/26 the score has not reduced, actions are ongoing, two new actions have been added in relation to readiness to manage the impact of climate events on business continuity and resilience of the EPRR function.
While there are no material gaps in relation to cyber, the external environment warrants retaining the current score of 12.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
Ability to test Business Continuity plans with clinical services to test for prolonged service loss.
Deployment of the revised Cyber Incident Response Plan.

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

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

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

Action	**Owner**	**Due by**
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) In progress, extended to Q3.	Executive Director of Operations	End ~~Q2~~ Q3 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) Risk 1187 has been reduced from 12 to 8, a residual risk remains but is being managed.	Executive Director of Finance and Resources	~~Q2 2025/26~~ Complete
Improvements in controls relating to cyber resilience have been identified and are being enhanced through: • Recertification of Cyber Essentials Plus Certification once issues with non-compliant mobile phones addressed • Implementation of actions from the audit of the Cyber Incident Response Plan and DSPT – audit recommendations continue to be progressed in line with agreed timescales. • Cyber Security Board training session - complete	Executive Director of Finance and Resources	Sept 2025
There is a gap in control relating the Climate adaptability plan and the impact of climate events on business continuity. Development of the core components of the plan is planned to be complete by the end of Q3. Embedding and engagement with business units is dependent on capacity as the Sustainability and Environmental Manager role will be vacant from January 2026.	Executive Director of Finance and Resources	End Q3
There is a gap in control in resilience of the EPRR function, the EPRR Manager is single point of failure – the trust will enter conversation with partners in Leeds with a view to increasing resilience	Executive Director of Operations	End Q3

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) • Sustainability and Climate Adaptability Steering Group report (BC)	• 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 10 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.

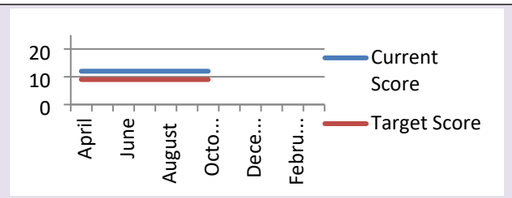
Strategic Objective: Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

Risk Appetite	Cautious (4-6)	**Status: In or out of Appetite**	Out	**Lead Director/risk owner:** Director(s) of People (DoP)

Committee with oversight: People and Culture Committee

Date last reviewed: 14/10/25

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.
Six months into 2025/26 the score is unchanged. The release of the National Oversight Framework scores and ranking have caused the Trust to apply additional focus in the areas of staff engagement and sickness absence, where LCH falls in the lower end of its comparator group.
Correlated with an increase in protest activity and a number of attacks on places of worship elsewhere in the UK, the Trust is concentrating significant engagement activity on staff safety and support across all of its services.

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: • A new dedicated staff engagement project is now in place, aimed at increasing LCH's staff engagement score. • Re-establishment of Leader's network and ongoing engagement across the organisation.	CEO / DoP	Dec 2025
Series of open spaces established to directly link with staff and leaders around safety and support. Direct liaison with Race EN and Trust leaders to ensure clear actions in place to enhance safety and support.	DoP	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 • New dedicated staff sickness project now in place aimed at reducing the Trust's sickness absence rate	DoP	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	• 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	• 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 Nov).	Head of Strategy, Change and Development	~~End Q1 2025/26~~ Complete
A People and Culture Committee has been established, the assurance reports to the committee have not yet been fully	DoP	~~Sept 2025~~ Complete

• Service spotlight/focus • Organisation Strategy Update (BC/QC) • People Key Performance Indicators and Data (including well-led Performance Brief Data) (PCC)	• People and Culture Committee workforce deep dives		determined. This will be refined and reflected in the committee workplan.		
			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.	DoP	~~Dec 2025~~ Complete

Link to Risk Register (material risks scoring 10 or above):
1379: Political Climate / protests, staff safety (12)

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.

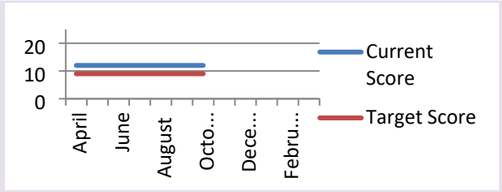
Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity 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: 9/10/25

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

Six months into 2025/26 the score has not changed, additional resource has been secured, work is ongoing to develop data and metrics relating to health equity.

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. Project management resource has been recruited.	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. Resource has been recruited to build resilience into the function.	TLT	~~3 Sept 2025~~ Complete

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~~ Complete
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. Minutes are taken to the Health Equity Leadership Group	Medical Director	~~End Q2 2025/26~~ Complete

	There is a gap in assurance in relation to system health inequality data as the Trust does not have access to the West Yorkshire ICB population health management data. To address this the Trust will obtain access to the data and make available to appropriate LCH staff.	Medical Director	June 2026
	There is a gap in assurance in that the health equity strategy 2021-2024 does not meet the recommendations of the NHS Providers report: United against health inequalities; moving in the right direction (May 2024). To address this the strategy is being revised to produce a health inequalities tactical plan.	Medical Director	End Q3

Link to Risk Register (material risks scoring 10 or above):
No risks linked to SR7 scoring 10 or above

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.

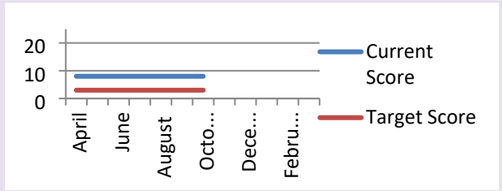
Strategic Objective: Collaborating with partners to enable people to live better lives / To embed equity in all that we do

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: 29/9/25

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.
Six months into 2025/26 the risk score remains at 8 as actions are progressed.

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~~ End Q3
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 - to report to Board • Fully engage in the Leeds provider partnership review - LCH CEO appointed SRO for the Leeds Provider Partnership review • Seek to understand implications and respond to changes in ICB functions - delay in implementation of the ICB future operating model, LCH Executive Directors actively involved in the review of the future operating model.	Chief Executive Officer	End ~~Q2~~ Q3

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 10 or above):
No risks linked to SR8 scoring 10 or above

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (23)

Title of report:	Board Service Visits Proposal

Meeting:	Trust Board Meeting Held In Public
Date:	6 November 2025

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

Executive Summary:	This paper proposes a new approach to Board service visits, to be trialled for the remainder of 2025/26 and then reviewed in early 2026/27. The proposal introduces a new framework of learning and leadership visits, supported by the Corporate Governance team, to run alongside the already existing Quality Walk process.

Previously considered by:	N/A

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

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

Recommendation(s)	• Approve the proposal of introducing learning and leadership visits for the remainder of 2025/26; and • Agree to review the process during Quarter 1 of 2026/27 once the first wave of visits has been mobilised.

List of Appendices:	Appendix 1 – Learning Visit Feedback Form Appendix 2 – Leadership Visit Feedback Form

Leeds Community Healthcare NHS Trust

BOARD SERVICE VISITS PROPOSAL

1 Introduction

Service visits to both clinical and non-clinical services provide an opportunity for Board members to engage with patients, relatives and staff, in order to get to know services better and understand what is going on in each area. This in turn, helps the Trust make better decisions in the best interests of the people who use our services, their carers and families and staff. Visits are also an opportunity to provide visible leadership by the Board and this remains an important feature in the CQC well-led framework.

Previously the Executive Directors (EDs) and Non-Executive Directors (NED) have provided feedback following service visits, which was then taken through the Quality Committee via which any actions were monitored. It was felt that the cycle of time between the visit, the Quality Committee reviewing the report and discussing actions, and then feeding back to Directors and services was too lengthy. Visits have continued over the last year, but the feedback loop has not been in operation. The Trust now has the opportunity to refresh the process and suggest a new approach.

The new approach proposes three different types of service visits. These are:

- Learning visits, for NEDs
- Leadership visits, for EDs and NEDs jointly
- Quality walks – a separate process is already in place for Quality walks, managed by the Clinical Effectiveness team, and therefore this is not covered in detail in this document.

2 Learning Visits

Learning visits will be undertaken by NEDs. A minimum of six learning visits will be scheduled per year, with at least one of the six visits being to a non-clinical service. The services visited will be determined by NED preferences which have been identified as part of their mid-year and annual reviews with the Chair of the Trust, and may be based on expert knowledge, gaps in knowledge, lived experience or a general interest.

These visits are not inspections. They are to provide an opportunity for NEDS to learn about a service, and provide an opportunity for the services to share what they are proud of, and also what might not be working well. NEDs will be provided with a briefing about the service prior to the visit to ensure they have a basic awareness of the service provided. Some visits may be virtual if a service requests this due to operational pressures.

The process for learning visits is outlined in the flow chart on the next page.

Process for learning visits:

Trigger

- Service areas to be visited will be identified in the NEDs mid-year or annual review with the Chair of the Trust
- Corporate Governance team arranges the visit and provides a brief on the service

Outcome of visit

- NEDs to learn about services
- Services may also benefit from the expert knowledge or lived experience that NEDs may have
- To connect with staff
- To triangulate information received at other meetings and forums
- To strengthen the relationship between NEDs and frontline staff
- Services able to showcase their work and achievements

Output

- Feedback form to be completed by the NEDs and returned to the Corporate Governance team
- Feedback form to be shared with executive directors and direct reports for discussion at SLT
- Feedback form to be shared with the service (Corporate Governance team)
- Any feedback received from the service will be used to inform future service visits

3 Leadership Visits

Leadership visits will be undertaken by Executive Director and NED pairs. At least six leadership visits will be scheduled per year (this will be subject to the availability of NEDs and EDs). The services visited will be determined by events that may occur throughout the year, new service developments, new premises, any concerns and any reoccurring themes or issues at Board of Directors' meetings.

The process for leadership visits is outlined in the flow chart below.

Process for leadership visits:

Trigger

- Event has occurred
  - New service
  - New premises
  - Service restructures
  - Concerns
  - Recurring issues or themes at Board of Directors' meetings
- Corporate Governance team notified of the need for a visit and makes arrangements

↓

Outcome of visit

- To seek assurance on clinical and non-clinical matters.
- To seek assurance on processes.
- To connect with and show appreciation / support to staff

↓

Output

- Feedback form to be completed by the NED/Exec pair and returned to the Corporate Governance team, to then be circulated to executive directors for discussion at TLT.
- Feedback form to be shared with the service and other NEDs.
- High level information about the services visited and when, to be included in the Chief Executive's report to the Trust Board

4 Quality Walks

Quality Walks are completed throughout the year to provide an independent assessment and peer review of a service's self assessment and improvement plan.

They are completed annually for each service, although services rated outstanding in the previous year are not offered a walk in the current year. Services rated as requires improvement or below are offered a re-walk in 3 – 6 months.

The Clinical Effectiveness team is responsible for arranging all Quality walks, providing training for walkers and collating the resulting reports.

5 Next Steps

The intention is to trial the new model for visits for the remainder of 2025/26, with a view to reviewing the process during Quarter 1 of 2026/27.

6 Recommendations

The Board is recommended to:

- Approve the proposal of introducing learning and leadership visits for the remainder of 2025/26; and
- Agree to review the process during Quarter 1 of 2026/27 once the first wave of visits has been mobilised.

Helen Robinson
Company Secretary
23 October 2025

Leeds Community Healthcare NHS Trust

Non-Executive Director Learning Visits

Learning visits to both clinical and non-clinical services provide an opportunity for board members to get to know services better and understand what is going on in each area, which in turn, helps the Trust make better decisions in the best interests of the people who use our services, their carers and families and staff.

These visits are not inspections, they provide an opportunity for NEDs to meet frontline staff across all departments and learn about their service and the work they do. They also provide an opportunity for the services to share what they are proud of, and services may be able to benefit from the expert knowledge, general interest or lived experience that NEDs may have.

The following template should be used to capture key points and reflections. This form will be shared with your executive director colleagues and the Senior Leadership Team.

Date of visit	
Non-Executive Director	
Areas visited (please list all)	
Staff member contact	
Key learning from the visit	

Reasons to be proud	
Anything to highlight to the Executive Team/SLT	
Any actions agreed	

Leeds Community Healthcare NHS Trust

Leadership Visits (Joint Exec and NED)

Leadership by walking around emphasises the importance of interpersonal contact, open appreciation, and recognition. It is one of the most important ways to build respect and performance in the workplace and demonstrates to staff that both they and the work they do is critical to the Trust's success.

The purpose of these visits is to: seek assurance on clinical and non-clinical matters; seek assurance on processes; support the Trust's staff engagement plan; ensure that senior leadership is visible and approachable to all staff; and reinforce a strong strategic narrative about the Trust.

The opportunity should also be used to meet frontline staff, across all departments, to observe and hear about what is working well and what isn't working so well. The following template should be used to capture key points and reflections. This form will be shared with the rest of the Trust leadership team who will review it at their regular Trust Leadership Team meetings.

The questions below should be used as a prompt, not a specific checklist of things to ask.

Date of visit	
Executive Director	
Non-Executive Director	
Areas visited (please list all)	
Staff member contact	
What are your positive observations and why?	
What is not working so well and why?	
What would you change if you could in relation to your service?	
Any health and safety matters identified	

Any staff health and wellbeing matters identified	
Other comments	

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (24)

Title of report:	Review of Procedure for emergency powers and urgent decisions (Chief Executive and Chair's actions and Committee urgent matters)

Meeting:	Trust Board Meeting Held In Public
Date:	6 November 2025

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

Executive Summary:	The procedure for emergency powers and urgent decisions ('Chief Executive and Chair's actions') and Committee urgent matters was last reviewed in August 2019. Whilst this is a procedure, rather than a policy, and does not require regular review, any amendments need to be approved by the Trust Board. The amendment is listed on the version history (page 4 of this document), correcting a reference number in the Standing Orders. No other amendments are indicated on review.

Previously considered by:	N/A

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

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

Recommendation(s)	The Board is asked to • Approve the amendment made to the procedural document

List of Appendices:	N/A

Procedure for emergency powers and urgent decisions (Chief Executive and Chair's actions and Committee urgent matters)

Leeds Community Healthcare NHS Trust

Executive Summary:
The procedure relating to urgent Board decisions is referred to as 'Chief Executive and Chair's action'. Chief Executive and Chair's action should only be used in "emergency" situations and/or time-critical situations. Similarly, Committees may also act on urgent matters arising between meetings of the Committee, in accordance with their terms of reference. This procedure outlines how requests for Chief Executive and Chair's action, and Committee's urgent matters should be managed.

Document History:

Version:	3
Date:	10 October 2025
Last version received by:	Trust Board 2 August 2019
Approved by:	Leeds Community Healthcare NHS Trust Board
Date approved:	6 November 2025
Name of author:	Company Secretary
Name of responsible committee:	N/A
Date issued:	Version 3: 6 November 2025
Review date:	October 2027
Target audience:	Leeds Community Healthcare NHS Trust Board members, senior managers, and Board and Committee administrative support

Version history

The table below logs the history of the steps in development and amendment of the document.

Version	Date	Author	Status	Comment
0.1	1 March 2013	Vicky Pickles Director of Corporate Affairs	Draft	Presented to Board for review

1	1 March 2013	Vicky Pickles Director of Corporate Affairs	Final	Approved by Board on 1 March 2013
2	13 June 2019	Diane Allison, Company Secretary	Draft	Updated roles, 'Chief Executive and Chair's action' defined for purposes of procedural document, Added 'time-critical situations' in addition to emergency situations to include for example the need for action when compliance documents need urgent Board approval. Added paragraphs to the introduction section to acknowledge the requirement for Committee's urgent matters. Added a section 6 'Committee's urgent matters' which had previously been confused within section 5 (which is about Board urgent decisions). Dissemination section - role descriptions have been amended to include senior managers, rather than General Managers. Added a requirement to document the reason for the urgency of a decision and the actual decision made - included on the Chief Executive and Chair's action form (appendix A) and on the Committee's urgent matters form (appendix B). Added a 'Committee's urgent matters' form (appendix B) – which was previously confused within appendix A, which was multi-use
3	10 October 2025	Helen Robinson, Company Secretary	Draft	Amended Standing Order reference in section 1.3

1 Contents

Section **Page**

Appendices

Procedure for emergency powers and urgent decisions (Chief Executive and Chair's actions and Committee urgent matters)

Introduction

1.1 Under Leeds Community Healthcare's Standing Orders, Board committees and other groups undertake work on behalf of the Board. At times it may be necessary for urgent matters that the Board, Board Committees and other groups would normally consider at meetings, to be dealt with between meetings. These matters would then be formally reported at subsequent meetings for ratification. For the purposes of this document, the procedure relating to such actions is referred to as 'Chief Executive and Chair's action' and 'Committees urgent matters'.

1.2 Chief Executive and Chair's action should only be used in "emergency" situations and/or time-critical situations. This procedure outlines how requests for Chief Executive and Chair's action should be managed.

1.3 The way in which the Board makes urgent decisions between meetings is set out in section 5.2 of the organisation's Standing Orders. This states:

'Emergency Powers and Urgent Decisions
The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.10) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-officer members. The exercise of such powers and decisions by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.'

1.4 To ensure there is a clear audit trail of any such decisions, the form contained at Appendix A should be used for urgent decisions by the Board.

1.5 Similarly, there are occasionally urgent matters requiring a Committee's consideration and action which arise between meetings of the Committee. The way in which a Committee takes urgent action between meetings is set out in its terms of reference, which are in accordance with the Trust's scheme of delegation.

1.6 To ensure there is a clear audit trail of any such actions, the form contained at Appendix B should be used for a Committee's urgent matters.

2 Aims and Objectives

2.1 This document clearly sets out the procedure that should be followed when requesting Chief Executive and Chair's action and that such requests are dealt with in a consistent and traceable manner.

3 Scope of the Procedure

3.1 This procedure must be followed by all Leeds Community Healthcare NHS Trust staff including those on temporary or honorary contracts, secondments, pool staff and students.

3.2 It applies to the Board, Board Committees and all groups within Leeds Community Healthcare NHS Trust.

4 Accountability

4.1 The Company Secretary will be responsible for monitoring compliance with and use of this procedure.

4.2 Directors will be responsible for ensuring that their staff make appropriate requests for Chief Executive and Chair's action and for Committee Chair's urgent matters and that these are reported to the next formal meeting of the Board / Committee.

4.3 The Company Secretary will be responsible for offering advice and support to staff.

5 Procedure for Chief Executive and Chair's Action

5.1 If a member of staff has an item that they consider is appropriate and sufficiently urgent to warrant requesting Chief Executive and Chair's action they should, in the first instance, obtain the approval of their Director.

5.2 A 'Request for Chief Executive and Chair's action form (see Appendix A) should be completed by the requester, including obtaining the signature of the responsible Director.

5.3 The completed form, together with a copy of the appropriate document/s should be submitted to the Company Secretary.

5.4 The Company Secretary will confirm that Chief Executive and Chair's action is appropriate.

5.5 If Chief Executive and Chair's action is not considered appropriate all the documentation will be returned to the originator with an explanation of why it is considered inappropriate.

5.6 The Company Secretary will contact the relevant people as described in the Standing Orders (section 5.2). to obtain their support for Chief Executive and Chair's action being taken. This will be the Chair, the Chief Executive and at least two non-officer members. Details of other members contacted, including Non-officer Members, will be recorded on the 'Request for Chief Executive and Chair's Action' form together with details of the next formal Board meeting that the Chief Executive and Chair's action will be reported to, for formal ratification.

5.7 Once a decision is made, the Company Secretary will advise the responsible officer of the approval of Chief Executive and Chair's action. The Company Secretary will then ensure that the item is presented for ratification at the next formal Board meeting.

5.8 The Company Secretary will retain a record of all Chief Executive and Chair's actions.

6 Committees' urgent matters

6.1 The Chair of a Committee in consultation with at least one other member may act on urgent matters arising between meetings of the Committee. Any such action will be reported to the next Committee meeting, to be recorded in the meeting minutes and in the Chair's assurance report to the Board. The Committee's delegated decision making will be in accordance with the Trust's scheme of delegation as approved by the Board and as reflected in the Committee's terms of reference.

6.2 A Committee's urgent matters form (see Appendix B) should be completed by the requester, including obtaining the signature of the responsible Director.

6.3 The completed form, together with a copy of the appropriate document/s should be submitted to the Company Secretary.

6.4 The Company Secretary will confirm that the request for Committee's urgent matters is appropriate.

6.5 If is not considered appropriate for Committee's urgent matters, all documentation will be returned to the originator with an explanation of why it is considered inappropriate.

6.6 The Company Secretary will contact the relevant people as described in the terms of reference for the Committee to obtain their support for the Committee's urgent matters. This will be the Committee Chair and at least one other member of the Committee. Details of all members contacted, will be recorded on the 'Request for Committee's urgent matters form.

6.7 The completed form, together with a copy of the appropriate document/s must be submitted to the Company Secretary, who will ensure the item is presented at the next Committee meeting for information.

6.8 The Company Secretary will retain a record of all Committee's urgent matters forms.

7 Monitoring Compliance with and the Effectiveness of Procedural Documents

7.1 The Company Secretary will monitor performance against this procedure.

8 Dissemination

8.1 Once approved by the Board, this procedure will be disseminated to all Board members, senior managers, and Board and Committee administrative support.

9 Associated Documentation

9.1 In all cases reference should be made to section 5.2 of the organisation's Standing Orders and the relevant section of the terms of reference for the Board Committees

Appendix A

LEEDS COMMUNITY HEALTHCARE NHS TRUST
REQUEST FOR CHIEF EXECUTIVE AND CHAIR'S ACTION

The top part of this form should be completed and submitted, together with supporting documents, to the Company Secretary.

SUBJECT *(please give a brief outline of the item that requires Chief Executive and Chair's action, describe why this is deemed to be an emergency or requiring an urgent decision, and provide a copy of any relevant papers):*

RESPONSIBLE DIRECTOR:

RESPONSIBLE MANAGER (if different):

DATE:

- -

(This part of the form will be completed by Company Secretary and a copy will be returned to the originator)

APPROVAL BY CHIEF EXECUTIVE AND CHAIR:

Describe the decision made:

Chief Executive Signature _____ Date

Chair Signature _____ Date

CONSULTATION WITH OTHER MEMBERS:*

1.Name _____ Date _____

2.Name _____ Date _____

To be ratified at [insert name of meeting) on _____ (insert date)

Copy returned to originator _____ (insert date)

***** For urgent Board matters at least two Non-Executive Directors should be consulted

Appendix B

LEEDS COMMUNITY HEALTHCARE NHS TRUST
COMMITTEE'S URGENT MATTERS

The top part of this form should be completed and submitted, together with supporting documents, to the Company Secretary.

SUBJECT (please give a brief outline of the item that requires a Committee's urgent action, describe why this is deemed an urgent matter, and provide a copy of any relevant papers):

RESPONSIBLE DIRECTOR:

RESPONSIBLE MANAGER (if different):

DATE:

- -

(This part of the form will be completed by Company Secretary and a copy will be returned to the originator)

APPROVAL BY COMMITTEE CHAIR:

Describe the decision made:

Committee Chair Signature _____
Date

CONSULTATION WITH OTHER MEMBER(s):

1.Name _____ Date _____

2.Name _____ Date _____

To be noted at [insert name of meeting) on _____ (insert date)

Copy returned to originator _____ (insert date)

* For Committee's urgent matters at least one other Committee member should be consulted.

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (26) Blue Box

Title of report:	Patient safety (including patient safety incident investigations) update report – reviewed by Quality Committee September 2025

Meeting:	Trust Board Meeting Held In Public
Date:	6 November 2025

Presented by:	Lynsey Ure Executive Director of Nursing and AHPs					
Prepared by:	Sarah Yeomans - Patient Safety Manager					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	Within this reporting period: • Eleven incidents were declared as Patient Safety Incident Investigations (PSII). Six of these a PSII is underway, the remaining five will form part of a death's exception report due to similar themes of learning. • Two PSII from the previous reporting period remain in process. • Of all the PSII that remain in process, six have not met the initial timescale for completion. A formalised governance process for extensions will be developed. • Three PSII concluded, including one MRSA Bacteraemia with LCH input that was not attributable to LCH care. • Three incidents did not meet the criteria for PSII but required another learning response. • There were no Never Events recorded for the trust. • There was one incident that has been escalated to the ICB as requiring a system level response, discussion is underway to establish the review process that this investigation will follow.

Previously considered by:	Quality Committee 23 September 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	

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?	This will be reviewed using the Patient Safety Dashboard once available.

Recommendation(s)	Receive for information/assurance, having previously been scrutinised by Quality Committee.

List of Appendices:	Appendix 1 - Patient Safety Incident Investigations declared. Appendix 2 – Patient Safety Incident Investigations breaches to timescale. Appendix 3 –Patient Safety Incident Investigations concluded. Appendix 4 – Patient Safety Incident Response Policy Appendix 5 - Other Learning Responses Appendix 6 - Incidents being externally investigated/escalated to the Integrated Care Board (ICB). Appendix 7 – Sharing Learning

Report title- Patient Safety including Patient Safety Incident Investigations update report March 2025- August 2025

1 Introduction

A report on Patient Safety and Patient Safety Incident Investigations (PSII) is produced bi-annually to provide Quality Committee with the assurance that patient safety is well managed, that incidents are appropriately investigated, and that learning is acted upon to improve patient care. The report will also escalate concern and risks.

2 Current position/main body of the report

Patient Safety Incident Investigations declared in reporting period

(based on the date the incident was declared a PSII)

	Implementation of care or ongoing monitoring/review	MRSA Bacteraemia	Skin Damage	Total
Mar 2025	0	0	0	0
Apr 2025	7	0	1	8
May 2025	1	1	0	2
Jun 2025	0	0	0	0
Jul 2025	0	1	0	1
Total	8	2	1	11

See **Appendix 1** for details of the incidents.

Seven of the eleven incidents were identified in April 2025 during a retrospective review of deaths. Two of the seven have progressed as individual PSII reports due to significant engagement with relatives and the remaining five are being reviewed as part of a death's exception report due to similar themes in the learning identified from these incidents. This will inform a comprehensive plan of the recommendations and actions required or assess where actions are already held in the Trust. This approach deviates from the national criteria under the Patient Safety Incident Response Framework (PSIRF) for a PSII to be completed for any death identified as "more likely than not due to problems in care". A risk has been logged on the risk register (risk 1333, score 4, low risk of minor reputational harm) and this has been discussed and approved at TLT. The approach has also been discussed with CQC at the June 2025 LCH/CQC engagement meeting with the LCH CQC Relationship Manager, Executive Director of Nursing and AHP, Executive Medical Director,

Deputy Director of Nursing and Head of Clinical Governance, with no concerns raised.

All eleven incidents remain in process and have not yet concluded. Four of the eleven incidents have breached the initial timeframe for completion, please see below.

Patient Safety Incidents declared prior to the reporting period which remain in process
(based on the date the incident was declared a PSII)

	Medication	Implementation of care or ongoing monitoring/review	Total
May 2024	1	0	1
Nov 2024	0	1	1
Total	1	1	2

Both Patient Safety Incident Investigations remain in process and are breaches to the initial timescales for completion. Support is being provided to the Learning Response Lead to ensure these are concluded.

Since the launch of the Patient Safety Incident Response Framework it has been noted that timescales set for completion of Patient Safety Incident Investigations have not been met. This risk is held under an overarching Patient Safety Investigations risk 1356, currently scored at 15, possible, catastrophic harm due to incident reviews relating to deaths. This risk score is due to be reviewed following a deep dive in patient safety that highlighted Patient Safety Incident Investigations relating to deaths were similar to the numbers reported pre PSIRF. However those identified as potentially contributed to or caused by LCH care post PSIRF introduction appear higher, the majority of these incidents are still in progress and on conclusion it will be confirmed if that still stands and will be reported to QAIG. The risk score may remain as 15 on review as it also includes other elements held under the same risk that relate to the capacity of the Business Units to support investigations and the quality of reports that require significant support from the Clinical Governance Team, that would rate as 15, almost certain, moderate impact.

The Patient Safety Team are developing a formalised extension process within the governance for Patient Safety Incident Investigations; this will include key points of escalation in the timeline, including roles and responsibilities within Clinical Governance, Business Units and the Corporate Team to ensure decisions are made and plans in place before a PSII becomes overdue. The plan is for this to be drafted by end of September 2025 with the aim for approval and implementation by end of October 2025.

A contributory factor to the delays includes the development of actions and allocation of responsible leads for these actions which has been a factor in two of the significantly delayed PSII. The Patient Safety Team have now included an Action Planning Meeting in the PSII process prior to 45 day review meetings which will prevent delays in action development. An additional contributory factor in three of the incidents was the need for reallocation of the Learning Response Lead due to unforeseen circumstances. Recent investigations where Learning Response Lead

allocation has been delayed have been escalated to the Executive Director of Nursing and AHP, via the Head of Clinical Governance and the Deputy Director for Nursing and Quality in addition.

Four of the incidents met the criteria for Statutory Duty of Candour, three were compliant and one was a breach, but this was not as an outcome of the delay in the PSII meeting the timescale as it was completed prior to the investigation commencing. This was reported as a breach via performance reporting at the time it was identified.

Four of the six breaches to timescale have patient or family involvement, one has been updated, one is pending confirmation of whether an update has been provided, for one there have been multiple failed attempts to make contact, and one has since declined any further engagement as part of the investigation process.

See **Appendix 2** for details of the six incident breaches of timescale and impact.

Patient Safety Incident Investigations concluded in reporting period
(based on date the report was signed off by a Director)

	Implementation of care or ongoing monitoring /review	Fall	MRSA Bacteraemia	Total
March 2025	0	0	1	1
Jul 2025	1	1	0	2
Total	1	1	1	3

See **Appendix 3** for details of the incidents.

Other Learning Responses

After Action Review	2
Multidisciplinary Review Meeting	1
Total	3

Other Learning Responses are system-based learning response methods which allow us to respond to a patient safety incident or cluster of incidents, in line with the national patient safety syllabus methodology and tools. Further information on the types of learning response used by LCH can be found in the Patient Safety Incident Response Policy **(Appendix 4).**

See **Appendix 5** for details of the findings and action taken.

Incidents escalated to the Integrated Care Board (ICB)
There has been one incident ID108491 which has been highlighted to the ICB as requiring a system level response. This is pending confirmation of whether a

Safeguarding Adult Review will be undertaken and a Terms of Reference Meeting will be planned to establish the areas of focus for each organisation involved in the patients care.

See **Appendix 6** for details of the incident

Never Events

There were no Patient Safety Incidents occurring under the care of LCH which met the criteria for a Never Event.

Service acquired infection rates

The MRSA Bacteraemia PSII with LCH service involvement that has concluded was not attributable to LCH care.

Sharing Learning

The Patient Safety Summit continues to be held quarterly and well attended by a variety of staff due to the organisation wide invitation. The Safety Snapshot Newsletter continues to be produced and circulated after each meeting with the key highlights and learning. There are conversations underway to further formalise the Patient Safety Summit within the trust formal governance arrangements, aligned with the MIAA Well Led Recommendations.

The Trust 'Sharing Learning in LCH' Newsletter which is supported by our library services continues to evolve and now includes learning from Equity and Quality Impact Assessments (EQIA), Inquests and Safeguarding in addition to the already featured learning from:

Patient Safety Summits
Patient safety incidents
Positive practice examples
Making Stuff Better share and learn sessions

See **Appendix 7** for links to where these documents and pages can be found on myLCH.

In addition, the reporting to QAIG has been reviewed and includes a stronger approach to articulating risk, advice and assurance via the AAA method. Patient safety is heard quarterly for a dedicated patient safety themed business meeting. The new format was tested in August 2025 and started with patient safety. Feedback of the new process was positive as it promoted greater discussion of the key points being escalated.

The Patient Safety Manager now attends the Adult and Specialist Business Unit Mortality Meetings quarterly to share any learning from Inquests to improve the sharing of learning from deaths across LCH.

Following feedback from services the Patient Safety Manager is in the process of creating two support documents to provide guidance and useful tips to support staff who provide written information for patient safety incidents and coroners inquest

with the aim of equipping staff with the knowledge, improving the quality of reports and reducing the time required within the Clinical Governance Team for reviewing and providing support to authors.

5 Recommendations

The Board is recommended to:

- Receive for information/assurance, having previously been scrutinised by Quality Committee.

Sarah Yeomans
Patient Safety Manager
15/09/2025

Appendix 1 - Patient Safety Incident Investigations declared

Summary of Incident – Implementation of care – delay or failure to monitor (101027)
The patient was under the care of the Meanwood Neighbourhood Team and Podiatry for wound care to the lower limb. The patient was also historically known to the vascular team. The patient was admitted to hospital and reviewed by the vascular team due to a severe diabetic foot infection and confirmed likely unfit for major lower limb amputation. This incident will be included in the Deaths Exception Report being completed by the Head of Clinical Governance and Patient Safety Manager
Outcome
The patient died 10 days after admission with the cause of death recorded as: 1a Sepsis 1b Diabetic Foot Gangrene 1c Type 2 Diabetes Mellitus 2 Atrial Fibrillation, Ischaemic Heart Disease
Areas of Learning identified
Diabetic foot pathway and lower limb framework not followed – Delay in referral being made to Diabetic Limb Salvage Service Lack of escalation to Senior Clinician/ GP for review of necrotic heel Doppler not fully performed
Action Taken
The PSII for this investigation remains ongoing however actions linked to this investigation that are underway in the organisation are as follows: The lower limb framework has been reviewed and updated and is currently being trialled for end user feedback before launching the revised version in practice.

Summary of Incident – Implementation of care – delay or failure to monitor (103066)
The patient was under the care of the Woodsley Neighbourhood Team, Podiatry and Tissue Viability for chronic ulcerations to the legs and feet. The patient was known to the vascular team and had been advised she required bilateral above knee amputations but had declined this intervention and was discharged from the vascular team. The patient was found by her carers at home confused with slurred speech and was admitted to hospital via emergency ambulance. This incident will be included in the Deaths Exception Report being completed by the Head of Clinical Governance and Patient Safety Manager.

Outcome

The patient died 2 days after admission with the cause of death recorded as:
1a Sepsis
1b Venous Leg Ulceration Infection
1c Peripheral Vascular disease

Areas of Learning identified

Missed opportunities were identified in relation to:
Review and management of pain
Taking clinical observations
Escalation of deteriorating wound and identifying soft signs
A lack of professional curiosity around the patients deteriorating wound and revisiting of option for limb amputation as it is noted in the record that the patient was reconsidering this.
Antimicrobial dressing was not in place due to delay in prescription from GP.

Action Taken

The PSII for this investigation remains ongoing however actions linked to this investigation that are underway in the organisation are as follows:

The wound infection framework has been reviewed and updated and is currently in the process of being trialled in two Neighbourhood Teams to obtain end user feedback prior to launching the revised version in practice.

Deteriorating patient policy has been created and ratified.

Summary of Incident – Implementation of care – delay or failure to monitor (101837)

The patient was under the care of the Pudsey Neighbourhood Team for wound care to the breast, buttocks and sacrum. The wound to the sacrum continued to deteriorate and on a visit from carers and the Community Matron the patient was unwell and drowsy observations were taken and the patient had a National Early Warning Score (NEWS) of 12. An emergency ambulance was called, and the patient was admitted to hospital with ? sepsis

Outcome

The patient was admitted onto a ward where she was treated palliatively with a diagnosis of sepsis (likely chest or infected pressure sore) with multiorgan failure and a new requirement for oxygen therapy on a background of lung and breast cancer.
The patient died the following day in hospital with cause of death recorded as:
1a Breast Cancer
2 Frailty of old age, Cardiac Failure

Areas of Learning identified

Review of Triage processes to ensure we have the right information.
Allocation of the right person with the right skills for visits
Wound infection framework not followed
Identification of the deteriorating patient
Lack of clinical observations
Clarity on swab timings and if they are urgent could we use an alternative process.
Lack of wound photography to show deteriorating wound.

Action Taken

The PSII for this investigation remains ongoing however actions linked to this investigation that are underway in the organisation are as follows:

The wound infection framework has been reviewed and updated and is currently in the process of being trialled in two Neighbourhood Teams to obtain end user feedback prior to launching the revised version in practice.

Deteriorating patient policy has been created and ratified.

Summary of Incident – Implementation of care – delay or failure to monitor (102854)

The patient was known to the Yeadon Neighbourhood Team for wounds to her feet and legs. The patient was found by her carers during their visit to be unwell and less responsive. An emergency ambulance was called and the patient was admitted to hospital with ? sepsis.

Outcome

The patient died the following day in accident and emergency with her cause of death recorded as:
1a Sepsis (strep canis) of unknown aetiology
2 Frailty of old age

Areas of Learning identified

Lack of process for rescheduling visits
Lack of application of essential visits guidance
Lack of adherence with the wound infection framework
Inadequate management of leaking legs with no referral to the Tissue Viability Service
Lack of case management
Reliance on the non-registered workforce
Pain assessment not considered

Action Taken

The PSII for this investigation remains ongoing however actions linked to this investigation that are underway in the organisation are as follows:

Essential visits criteria has been updated

The wound infection framework has been reviewed and updated and is currently in the process of being trialled in two Neighbourhood Teams to obtain end user feedback prior to launching the revised version in practice.

The lower limb framework has been reviewed and updated and is currently being trialled for end user feedback before launching the revised version in practice.

Summary of Incident – Implementation of care – delay or failure to monitor (105009)

The patient was known to the Beeston Neighbourhood Team for support with insulin administration. The patient had been diagnosed with shingles however had been declining to take medications for this as it made him feel unwell. His Blood Glucose Levels had been running high leading up to the incident. A Nurse from the Neighbourhood Team visited the patient in the care home to find him unwell with Blood Glucose Levels reading as HI, observations were taken, and National Early Warning Score (NEWS) was 8, patient was declining hospital admission, so a GP visit was requested. The GP reviewed the patient and arranged for an ambulance to take the patient to Accident and Emergency ? DKA ? Chest Infection.

Outcome

The patient had a cardiac arrest in the care home prior to the ambulance transporting the patient to hospital.
The patient's death was referred to the coroner and postmortem confirmed medical cause of death as:
1(a) Cause of Death:
Pneumonia
2 Contributing Causes
Chronic obstructive pulmonary disease, type 2 diabetes mellitus, previous stroke with reduced mobility

Areas of Learning

Learning around contacting specialist colleagues for support and advice for diabetic patients.
Learning around escalation/handing over concerns of patients with consistently high blood sugars.
Missed opportunity to escalate a deteriorating patient, as the patient had high blood sugars on days leading up to the death, and patient reported feeling unwell.

Action Taken

The PSII for this investigation remains ongoing however actions linked to this investigation that are underway in the organisation are as follows:

An initial meeting has been held to commence work on an LCH Diabetes Pathway. This was attended by colleagues across Clinical Governance including Patient Safety Team and Patient Safety Specialists and colleagues within the Adult Business Unit and Specialist Business Unit including the Diabetes Service. This work will be progressed with liaison with Acute and Primary Care Colleagues to ensure the pathway aligns to appropriate, timely care provision for patients with diabetes across the Leeds System

Summary of Incident – Implementation of care – delay or failure to monitor (98584)

The patient was known to the Woodsley Neighbourhood Team for wound care to the lower limb. Compression bandaging had continued to be applied to the patient's legs when wound had started to deteriorate, and concerns raised by family that the dressings were potentially contributing to this. The patients wounds to legs continued to deteriorate and the GP, Tissue Viability and Vascular team were then involved in the patient care. Vascular discussion with family was that due to patient health he would not be suitable for any intervention. It was decided alongside family that it would be in the patients best interest to stay at home and be treated with antibiotics for leg wounds.

Outcome

Daily wound care visits continued from the Neighbourhood Team until the patient passed away at home.
Cause of death was recorded as:
1a. Severe frailty of old age.
ii. Lewy body dementia

Areas of Learning

Possible earlier referral/consideration of referral to vascular team
Earlier escalation to the GP around the deteriorating wound.
Pain was not explored.
Family escalated concerns regarding the use of compression bandaging however this was still applied.
Lack of adherence with the wound infection framework
Lack of adherence with the lower limb framework
To understand training and competency for staff providing care of the lower limbs

Action Taken

The PSII for this investigation remains ongoing however actions linked to this investigation that are underway in the organisation are as follows:

The wound infection framework has been reviewed and updated and is currently in the process of being trialled in two Neighbourhood Teams to obtain end user feedback prior to launching the revised version in practice.

The lower limb framework has been reviewed and updated and is currently being trialled for end user feedback before launching the revised version in practice.

Deteriorating patient policy has been created and ratified.

Summary of Incident – Pressure Ulcer (104769)

The patient was previously known to the Yeadon Neighbourhood Team for wound care following spinal surgery. She was then rereferred due to a wound that had developed to the sacrum. The wound deteriorated whilst under the care of the Neighbourhood Team, the patient was admitted to hospital due a suspected opioid overdose.

Outcome

The patient was admitted to hospital for a potential overdose and during the admission was treated for infection. The patient deteriorated whilst in hospital and died 3 weeks later, the provisional cause of death was recorded as:
1A Osteomyelitis
1B Pressure Ulcer
1C Immobility secondary to spinal operation
It is unclear in the medical records regarding clinical diagnosis of osteomyelitis this will form one of the terms of reference as part of the investigation

Areas of Learning

Multiple NCA visits through the timeline (known learning)
Lack of overall assessment of patients' needs to include 24-hour needs/repositioning/sitting out.
Repose cushion had been ordered and delivered however the team were unaware it had been delivered as had not followed up/ were not informed by LCES or the family that it was in the house. However this would not have impacted on the wound given the area that the wound was.
Wound assessments rescheduled (known learning)
Delay in CHC checklist been completed, non-contributory learning.
The Airflow mattress was initially removed to support the patients transfers however this could have been reassessed throughout the episode of care including when concerns were raised by the patients family.

Action Taken

The PSII for this investigation remains ongoing

Summary of Incident – Implementation of care – delay or failure to monitor (105163)

The patient was referred to the Homeless and Health Inclusion Team whilst an inpatient and they remained involved in his care following discharge. There were multiple organisations involved in the patients care throughout their journey leading up to readmission to hospital. The patient had wounds to his lower limb and was experiencing significant pain, deteriorated whilst in the community and was readmitted to hospital due to potential sepsis and a National Early Warning Score (NEWS) of 9.

Outcome

The patient was admitted to hospital and died four days later. The cause of death was recorded as:
1a Heart Failure
1b Gangrene, lower limb necrosis

Areas of Learning

Missed opportunity to communicate across services and highlight the level of risk for this individual
Concerns around the current process for accommodation
Lack of communication between services
Dealy in admission when the patient deteriorated

Action Taken

PSII remains in the process of completion as a multiagency review led by LCH

Summary of Incident – Implementation of care – delay or failure to monitor (106392)

The patient was known to the Leeds Mental Wellbeing Service. Due to staff absence the patient did not receive an appointment in the service standard timeframe and significant information in relation to the patients presentation and escalating risk was not received as it was sent to an individual not to the service.

Outcome

The patient took her own life prior to being seen by the service

Areas of Learning

Information being sent to individuals which is a single point of failure
Gaps in the standard operating procedure for the Clinical Management of unplanned absence

Action Taken

To review the Standardised Operating Procedure to include:

- How new patients are managed in case of cancellation – particularly priority patients who should be considered in line with current high-risk patients.
- How clinical risk is reviewed for cancelled appointments when a clinician is unable to advise on this.
- How multiple episodes of sickness are reviewed and considered in relation to the impact on cancelled appointments.

To make changes to web referral form with information regarding seeking urgent support.
To have a standardised Out of Office response/process. With clear guidance for patients and carers.

Summary of Incident – MRSA Bacteraemia (107132)

The patient was under the care of the Armley Neighbourhood Team for catheter management. The patient attended Surgical assessment unit following a traumatic catheterisation earlier in the day where they were re- catheterised and bladder irrigation performed. The patient spiked a temperature following this and blood cultures were taken which grew *mirabilis* and MRSA.

Outcome

The patient was treated for urosepsis and three subsequent sets of blood cultures were collected and were negative. Due to the patient's condition deteriorating, including the onset of fever, after the in-hospital catheter manipulations, this was considered the most likely source of the bacteraemia and the infection might have been prevented if antibiotics had been given before the procedure.

Areas of Learning

Potential delays in offering prophylactic antibiotics to patients with post-catheter change-associated trauma managed in the community were identified as a safety risk for future cases. LCH will review current practices and explore pathways to ensure timely prophylaxis where appropriate. Whilst this did not have an impact on the patient in this case as they were transferred to hospital it has the potential to cause harm in future so an action will be taken to prevent this.

Action Taken

To develop a robust process and associated guidance to support staff in prescribing/requesting the timely administration of prophylactic antibiotic therapy post-traumatic catheterisations in the community setting.

To improve staff awareness of the correlation between traumatic catheterisation and increased risk of bacteraemia

Summary of Incident – MRSA Bacteraemia (108295)

The patient was under the care of the Seacroft Neighbourhood Team for wound care to neuropathic ulcers to the left foot. The patient was admitted to hospital following a call made to the Yorkshire Ambulance Service by his carers. The patient presented with delirium and left leg cellulitis with associated osteomyelitis (bone infection) of the 3rd Metatarsophalangeal (MTP) joint. Blood cultures collected on were subsequently positive for Meticillin-resistant Staphylococcus aureus (MRSA).

Outcome

Upon identification of the MRSA bacteraemia, the patient started on treatment to treat left leg osteomyelitis. He was also reviewed by the vascular surgery team, who advised that definitive source control would require a transmetatarsal amputation (TMA), the patient underwent this procedure for amputation.

Areas of Learning

Ongoing

Action Taken

Not yet identified

Appendix 2 – Breaches to the PSII timescale for completion

Incident ID	Business Unit	Date Declared a PSII	Agreed Timescale for Investigation	Details of breach
98584	ABU	7/4/2025	3 months	The Terms of Reference Meeting for this incident (where timescale for investigation is agreed) was held on 4/6/2025 this was delayed by diary availability of required attendees. The learning response lead for this investigation was reassigned due to unplanned leave however due to capacity within trained investigators with experience this was reassigned to a less experienced investigator. When the initial investigator returned to work this was assigned back to them which has led to delays in progression of the investigation in the initially agreed timescales. Contact has been made with the patient's daughter to keep her updated on the delays and progress. A final review meeting is booked for 30/9/2025 to review the final draft of this investigation. Statutory Duty of Candour was met for this incident.
104769	ABU	2/4/2025	3 months	The Terms of Reference Meeting for this incident was held on 23/4/2025 this was slightly delayed by diary availability of required attendees. Due to unplanned absence the learning response lead for this investigation has been reallocated. There have been delays since in progressing the investigation due to capacity of the Learning Response Lead due to service pressures and volume of high priority tasks. This has been escalated in the Clinical Governance Team and communicated with Adult Business Unit. This incident is also linked to an Inquest and a Complaint. Contact attempts have been made with the patient's daughter who had initially requested contact via email but has since advised that they do not want to be contacted in relation to the investigation as they were unhappy that contact had been made with the patient's husband and care agency as part of the investigation. A copy of this report is required for the coroner to inform the inquest; updates have been provided to the coroner's office regarding delays. An initial draft review meeting is booked for 17/9/2025. Statutory Duty of Candour was met for this incident.
105163	SBU	28/4/2025	2 months	The Terms of Reference Meeting for this incident was held on 16/6/2025. This was delayed due to the requirement for the PSII to be completed as a multiagency review and attendance of five other organisations at the Terms of Reference Meeting. The 25-day review meeting was cancelled as the Learning Response Lead required more time to complete the initial draft and was awaiting information from other organisations to build into the report. The Learning Response Lead contacted the Patient Safety Team to advise they could not longer lead the investigation. This was escalated to Senior Colleagues within Clinical Governance and the Specialist Business Unit to request the author be reassigned with an outcome of no resource identified due to limited capacity of the available investigators in the trust due to commitments in core roles, conflicts in terms of links with the team the

				incident is for or already leading on a PSII. Following escalation to the Deputy Director of Nursing and Quality (DDONaQ) the PSII has been assigned to a CBU Learning Response Lead who will be supported by the DDONaQ to progress this report and a review meeting will then be booked. The Patient Safety Team have requested an update on the communication that has been made with the patient's mother to inform her of the change in Learning Response Lead and delays in progression of the investigation. Statutory Duty of Candour was met for this incident.
107132	Corporate IPC	27/5/2025	3 months	All meetings were held within an appropriate timeframe for this investigation. The report is complete and is awaiting an update from the Learning Response Lead in relation for the dates of completion for the actions identified, the report will then be sent for approval and sign off. Contact has been made with the patient as part of the investigation however they did not want any further input or feedback. This incident did not meet the criteria for statutory Duty of Candour.
98241	ABU	20/5/2024	3 months	The Terms of Reference and 25 day meeting for this incident were timely. There was a delay to the 45 day meeting as this had to be rescheduled twice (Aug and Sept 2024) as the report was not in final draft format. 45 Day meeting was held on 17/10/2024 with actions agreed to be updated and added to the report by the Learning Response Lead. There were significant delays in receiving the report back with updated actions, the Patient Safety Team had chased this with the Learning Response Lead however there were gaps in escalation to Senior Managers alongside this. The report had been reviewed by multiple people to advise the author who was unclear around the actions as an output of the investigation. This led to further delays as there were differing opinions in terms of what should be included as actions as an output of the investigation. The Head of Clinical Governance is now working with the Learning Response Lead to conclude the incident which will then be sent for approval and sign off. The patient declined any input in the investigation process at the initial duty of candour conversation. This incident did not meet the criteria for statutory Duty of Candour.
103038	ABU	6/11/2024	3 months	The Terms of Reference Meeting for this incident was held on 23/4/2025 this was slightly delayed due to confirming external organisation availability. The 45-day review meeting was held on 14/3/2025 with an action for the Learning Response Lead to update the findings and summary and add the 2 agreed actions. Between April 2025 and June 2025 the report required multiple updates and was reviewed by multiple people involved at various stages of the investigation, this led to delays in the finalised report. There was then a further delay in the allocation of action owners. This report was reviewed for sign off but required further updates before it could be approved. The Head of Clinical Governance is now working with the Learning Response Lead to conclude the incident which will then be sent for approval and sign off. A copy of this report is required for the coroner to inform the inquest; updates have been provided to the coroner's office regarding delays. Multiple unsuccessful attempts have been made to contact the patients daughter to provide an update. This incident was a breach of Statutory Duty of Candour however this was prior to the investigation commencing and is not as an impact of the delay in timescale for the report

Appendix 3 - Patient Safety Incident Investigations concluded

Summary of Incident – Implementation of care – delay or failure to monitor (97974)
The patient was known to the Children's Community Nursing Team due to his complex health needs. The incident relates to missed opportunities to identify the patient's risk of clinical deterioration, and to identify a presenting clinical deterioration during the episode of care. The investigation was completed with input from the acute trust with LCH as the lead investigator.
Outcome
The patient was admitted to hospital and found to have a reduced level of consciousness, peripherally shut down and had low oxygen saturations indicating significant illness and deterioration of his health.
Areas of Learning
Learning was identified around: communication and escalation across the system observations and staff confidence and competence in the use of equipment for taking observations and a lack of availability of equipment. If and how parental support can be recorded on children's records Recording of Safeguarding supervision Increasing the awareness of disguised compliance and using curious conversations.
Action Taken
Develop a process that ensures deputies are able to attend discharge meetings if core professionals cannot join. Develop process to ensure other core professional are in attendance at discharge planning meetings. Assess use of CCN email account Process for Lead caseload holder to attend MDT for children of concern Assess potential to add an escalation to Caseload Manager trigger to S1 that automatically tasks the Caseload Manager for concerns and transitions in care. Sepsis training and confidence building, and survey to staff to assess confidence levels before and after. Competencies to be attached to training for all staff. Completed. Review the audit standards to assess for any ongoing risk of harm to patients on caseload All complex children need a care plan re deterioration. Baseline observations for all admissions, and re admissions to caseload. One set per week for three weeks for high complex children, one set for all others. All about me section to include what deterioration means to the patient and how they will present. Ear probes for observation kits to be ordered and must have the safety alert point of use poster with it To assess potential for linkage of child/parental records or have element in communication template. Assess in line with GDPR. This action is also replicated within the Child Death Overview Panel in relation to another case The supervision policy will be reshared across the service with direction to complete the template fully.

An examples page will be added to the Safeguarding Team intranet with good examples of records including safeguarding supervision.
The process for recording a social care referral should be reviewed.
Disguised compliance will be added as a 25/26 60-minute briefing by the Safeguarding Team. CCN to attend.
Share LSCP Teams session dates on Challenging Conversations
Opening conversation techniques crib sheet to be shared.

Summary of Incident – Fall (97974)

The patient was known to the Yeadon Neighbourhood Team Nurses and Therapy. The patient had a fall at home and was admitted to hospital

Outcome

On admission to hospital the patient was found to have cord compression and collapse of the L3 vertebrae of his spine. This resulted in the patient's mobility becoming significantly reduced and he is now nursed in bed within a nursing home.

Areas of Learning

Consideration of the patient's capacity and how this was documented within the patient record especially if best interests decisions are made. This learning was non – contributory to the incident occurring.

Action Taken

There were no actions for this incident.

Summary of Incident – MRSA Bacteraemia (106118)

The patient was under routine care of the LCH podiatry team and was also receiving care from an acute provider for Podiatry and Diabetes prior to admission to hospital. The patient was admitted to hospital with a diagnosis of delirium secondary to right sided community acquired pneumonia and hyperglycaemic ketosis. Blood cultures taken on admission were positive for Methicillin-Resistant *Staphylococcus aureus* (MRSA).

Outcome

The patient died and 25 days after admission and cause of death was recorded as: 1a) methicillin-resistant staphylococcus aureus sepsis of uncertain aetiology. It is understood from the timeline that the original MRSA bacteraemia had resolved and a blood culture 13 days before the patient died showed no growth. Microbiology expert opinion was that there was no clear source of the bacteraemia in this patient.
Areas of Learning
No learning for LCH
Action Taken
N/A

Appendix 4 - Patient Safety Incident Response Policy

PL399 Patient Safety Incident Response Policy (lch.oak.com)

Appendix 5 - Other Learning Responses

What we identified at Rapid Review Meeting	What we have done
ID 107210 There was a missed visit to a patient and on the following visit the patient was unwell and was admitted to hospital. Learning identified in relation to:	An After-Action Review Meeting was held with Clinical Staff in the service, Subject Matter Experts and the Clinical Governance Team to review What happened, What should have happened, Why there was a difference and What could be learnt. Actions: Follow up progress of the review and update of the no access visits SOP.

<table>
<tr><td>Missed opportunity to swab the patients wound when deterioration was noted.
No access visit Standard Operating Procedure was not followed
Visit were not rescheduled appropriately.
Documenting conversations and actions clearly in the record.</td><td>Assess the need for a no access visit audit pre and post updated SOP launch.
Consider what information is supplied to patients to agree expectations around when to escalate and roles and responsibilities around care.</td></tr>
<tr><td>ID 102927
There was a patient who had visited LSH and had a Hormonal Intrauterine device inserted instead of the Copper Coli that she was expecting to have.</td><td>An After-Action Review Meeting was held with Clinical Staff in the service and the Clinical Governance Team to review What happened, What should have happened, Why there was a difference and What could be learnt.

We discussed learning related to documentation, Local Safety Standards for Invasive Procedures (LocSSIP), Consent, Time allocated for appointments, patient understanding of the device options available and training.

The following recommendations were confirmed:
<u>Documentation and consent</u>
A review of EPR on SystmOne required for the process of inserting an IUD
Action Taken
Service to meet with Clinical Systems to review the current process and
identify how to improve this to support staff with the flow of the consultation and consent
<u>Documentation and consent</u>
There should be a SOP to support staff in the documentation of IUD
consultation and insertion
Action Taken
Complete SOP
<u>Documentation and consent</u></td></tr>
</table>

	Staff understanding of the documentation process is consistent and embedded **Action Taken** SOP to be shared with staff Audit of the documentation completed for IUD procedure to ensure adherence to the SOP
	Consent The consent form should evidence that the patient has fully understood the treatment options discussed and that they have made an informed decision on the device that will be inserted. **Action Taken** Review the current local LSH consent template for procedure.
	LocSSIP All Staff adhere to the LocSSIP **Action Taken** Review the current LocSSIP SOP Appendix 4 LocSSIP to be disseminated LocSSIP appendix/flowchart to be visible in all clinic rooms
	Time Appointment time allocation should be based on patient's individual need and identified at the earliest opportunity. **Action Taken**

	Review the appointment allocation process to include completion of the communication template on SystmOne **<u>Competency and support</u>** There should be a consistent approach to the induction and training of staff for IUD **Action Taken** SOP/LocSSIP to be built into the induction process. Process for assessing staff competency in IUD consultation and insertion
ID 104159 Patient was referred for therapy by carers requesting a moving and handling assessment however was added to a waiting list and not contacted until 2 weeks later in which time the patient had a fall and had been admitted to hospital with a fractured neck of femur. Learning had been identified in relation to: Not visiting the patient within the 72 hours as per plan. Unclear referral processes/pathways of who can refer to which service and lack of robust processes of where to refer a patient to? Multiple people triaging the same referral which then changed the plan of care, felt was	A Multidisciplinary Meeting will be planned to review the current processes and identify any gaps or changes that are required. This will include the use of a Hierarchical Task Analysis as a methodology to support the review of work as imagined vs work as done.

put on the incorrect pathway through the second triage. Didn't respond to the carers concerns around patients change in condition or deterioration/struggling in mobility.	

Appendix 6 – Incidents escalated to the ICB

Summary of Incident – Implementation of care
The patient was referred to the Seacroft Neighbourhood Team for catheter care and was receiving care from Active Recovery. The patient who was initially engaging with cares but then disengaged, she stopped mobilising and spent all of her time in bed she had stopped eating or drinking through choice and disclosed she was doing so with an intention to end her life. The patient was seen by an Out of Hours GP who prescribed her anticipatory medications to be used if required which were then administered by the NT, her oral diabetic medications were also stopped. Fast Track funding was completed by GP and a syringe driver prescribed and commenced despite there being no existing co morbidities or palliative condition recorded for the patient.
Outcome
Following the Neighbourhood Team escalating to the crisis team and Safeguarding Team in relation to concerns that the patient had been commenced on an end of life pathway despite a lack of palliative diagnosis and with intent to end her own life the syringe driver was stopped and the patient was taken to hospital via 999 ambulance for treatment for reversible causes. The patient died in hospital two days after admission. Discussions are ongoing regarding the further learning response to be undertaken to be confirmed if this will be completed as a Safeguarding Adults Review, Patient Safety Incident Investigation or an alternative learning response. This is a multiagency incident with care provided to the patient from: Leeds Community Healthcare, Leeds and York Partnership Foundation Trust, Leeds Teaching Hospital Trust, Out of Hours GP, GP, ASC and Yorkshire Ambulance Service.
Areas of Learning

Action Taken

Appendix 7 – Sharing Learning in LCH Newsletter, Love to Learn and LCH Learns

Sharing Learning at LCHT (lch.oak.com)

Love to Learn

LCH Learns (lch.oak.com)

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (27) Blue Box Item

Title of report:	Health and Safety Annual Plan 2025-26

Meeting:	Blue Box Item: Trust Board Held In Public
Date:	6 November 2025

Presented by:	Sam Prince, Executive Director of Operations					
Prepared by:	Cara McQuire, Deputy Head of Safety					
Purpose: (Please tick ONE box only)	Assurance	X	Discussion		Approval	

Executive Summary:	This report has been approved by the Health and Safety Group prior to submission to the Business Committee. The report provides an update on the agreed focus areas for 2025-26. The Business Committee is particularly asked to note: • The provision of first aiders across the Trust remains a risk due to the increase in transient staff • The Trust has successfully appointed to the Safety Advisor (Training and Audit) position • A Datix test page is being configured to address the configuration problems relating to safety incidents • Work continues to zone buildings for fire evacuation • The violence, prevention and reduction standard review is underway • Moving and Handling risk assessments and method statements have been developed and published.

Previously considered by:	Business Committee September 2025

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

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)	• Note the progress made towards achieving the action

List of Appendices:	Appendix One - Health and Safety Annual Plan 2025-26 (update July 2025)

Health and Safety Annual Plan 2025-26

➢ Introduction

Workplace health and safety is all about sensibly managing risks to protect staff, visitors and LCH. Good health and safety management is characterised by strong leadership involving managers, workers, suppliers, contractors and patients.

The Health and Safety at Work etc Act 1974 is the primary piece of legislation covering occupational health and safety in Great Britain. It's sometimes referred to as HSWA, the HSW Act, the 1974 Act or HASWA.

1. Improving our safety culture and competence

The foundations of a suitable health and safety management system (plan, do, check, act) is now in place for health and safety. Many policies have been removed, and replaced by clear procedures and guidance, so staff are able to react to similar situations in a particular way. This enables the team to audit against the procedures and identify areas of improvement.

The Security, Crime Prevention and Counter Terrorism Policy is due to return to the Clinical and Corporate Policy Group. Once approved, supporting procedures will be developed to enable the Trust to meet its policy aims and objectives.

The Fire Safety Policy is in the process of being updated and transferred onto the newest policy template. Once approved, there will be a review and gap analysis of the supporting protocols

To improve safety performance and compliance with legal requirements, the Safety Team continue to focus on actions that will have the greatest impact during 2025/26.

The main areas of focus include the following:

- Provision of suitable and sufficient information, instruction and training
- Accident and incident reporting
- First Aid at Work
- Audit
- Fire Evacuation
- Fire training needs
- Emergency preparedness and emergency response
- Violence, Prevention and Reduction Standard
- Moving and handling generic risk assessments and method statements

➢ Further details relating to the progress of developing these focus areas can be found in Appendix One, Health and Safety Annual Plan 2025-26 (update July 2025)

➢ Recommendations

The Health and Safety Group is recommended to note the progress made towards achieving the actions detailed in the annual plan.

Name of author/s Cara McQuire
//Title/s Deputy Head of Safety **Date paper written:** 7 July 2025

- **Appendix One**

- **Health and Safety Annual Plan 2025-26 (update July 2025)**

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
Health and Safety					
1.1	**Provision of suitable and sufficient information, instruction and training.** Delivery of the new Health and Safety Training for Managers. Driver: to increase the Trust's health and safety maturity.	Appointment to the Safety Advisor (Audit and Training) vacancy - to ensure sustainable delivery of health and safety, fire safety and security training across the Trust	April 2025	January 2025 - job role is out to advert June 2025- successful appointment of Safety Advisor (training and audit) **COMPLETE**	Cara McQuire, Deputy Head of Safety
		Continue to roll out the Level 2, Health and Safety Managers Training	Ongoing	Training sessions are available to book on the Events page of MYLCH. As of 3 July 2025, 83 managers have attended the sessions.	
		Introduction of Activity Risk Assessment Training (including the use of Assure software)	Ongoing	March 2025 - After a successful trial of the package, the risk assessment training is now available to book on the Events page of MYLCH.	
		Set up a series of ongoing workshops/sessions with the Safety Champions to consider progress with	Commencing from March 2025	March, April, May, June 2025 - Delayed due to lack of resources within the Safety Team (2 x vacancies out of a team of 3).	

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
		action plans, discuss lessons learnt from incidents, understand concerns.			
1.2	**Accident and Incident Reporting (Reporting of Injuries, diseases and dangerous occurrences regulations)** The Datix incident reporting module needs to align with the Health and Safety incident reporting and investigation procedure Driver: to improve the speed and quality of safety incident analysis.	Continue to work with the Governance Systems Manager to ensure that health and safety, fire and security categorisations are suitable and can assist in trending and analysis of performance. Seek alternative solutions if/as required.	September 2025	Drafted reporting procedure with all health and safety, fire and security categories and classifications documented. Meeting with the Governance Systems Manager held. Changes to the system have begun. **June 2025** - A trial page on Datix has been developed to understand the feasibility of altering the interface to meet safety requirements. Initial changes are promising, but further alterations are required to meet the Safety Team requirements. A risk has been submitted onto the Trust risk register to reflect the current situation of the safety team not being able to gather analyse, trend or make informed decisions with the current data that is obtained.	Cara McQuire, Deputy Head of Safety

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
1.3	Ensure the Trust is compliant with the **First Aid at work** regulations. Resolve gaps in first aid provision across the Trust due to there being few static people in buildings by encouraging additional staff to undertake first aid training courses. Driver: recent gap analysis conducted. Risk has been assessed and is to be added to risk register.	Identify any premises that are not covered by Qualified First Aiders or Registered Nurses Publish the list of First Aiders on MYLCH Hold sessions with Qualified First Aiders to ensure they understand their duty to check first aid kits and to sign into a building as a first aider Communication Campaign to ensure everyone knows who the first aiders are, and how to access the courses via the Safety Team	 February 2025 March 2025 April 2025	**July 2025** We are still struggling to ensure first aiders are available in some premises, such as St Mary's, due to transient staff. We are working with teams and services on a case-by-case basis to understand how we can overcome this, possibly by utilising other providers working on the same site. Complete In the process of writing a document to share and add to the intranet. Delayed due to lack of available resources (vacancies within the health and safety specialism)	Rebecca Mazur, Health and Safety Manager

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
		Review training provision with St Johns, and look for alternative suppliers; ensuring a contract is in place	October 2025	Procurement have confirmed we do not require a contract in place and can use our preferred cheaper providers.	
1.4	Develop and deliver an **Audit Schedule** (risk based) to review the Trust's legal compliance	Appointment of the Safety Advisor (Audit and Training) Development and approval (at the Health and Safety Group) of the legal compliance audit schedule Commencement of the audit process & reports received by the Health and Safety Group. Health and Safety Group to monitor action plans.	April 2025 June 2025 September 2025 Ongoing Ongoing Ongoing	June 2025 – Successful appointment of a Safety Advisor (audit and training) on the second round of interviews. Delayed due to the delayed appointment of the Safety Advisor (Audit and Training). Familiarisation with the various training packages, policies, procedures and Trust services is underway.	Rebecca Mazur Health and Safety Manager

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
		Update of the Trust's legal register as required and new information is identified through audit.			
Fire Safety					
2.1	**Fire Evacuation Plans** review of all evacuation plans Driver: Risk register risk 1178: adequate and consistent fire evacuation arrangements in shared premises Risk 1242 Fire evacuation arrangements in LCH owned premises	Working with the Facilities Officers, zone all owned premises in alignment with the established Fire Alarm Panel zones (preventing confusion) Working with Estates, update site plans with Fire Zones Develop fire zone sweeping plans/documents Identify suitable areas for Fire Warden jackets and maps to be located Work with any occupiers to agree fire evacuation arrangements and gain	December 2025	June 2025 A schedule is in place to work with the relevant Facilities Officers and third-party occupants to understand the building, the current alarm panel zones, and to get agreement to work together. As there is only one specialist for Fire within the Trust, progress is limited.	Charles Okonma, Fire Safety Advisor

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
		their support for using this fire evacuation method. Update each Fire Evacuation Plan as the zones are agreed.			
2.2	**Fire training needs analysis -** Document a Trust Needs Analysis for all groups of staff relating to fire training Driver: Risk register risk 1178: adequate and consistent fire evacuation arrangements in shared premises. Risk 1242 Fire evacuation arrangements in LCH owned premises	Fire training is already provided within the Trust; however the training provision requires a review to ensure that all staff are receiving an appropriate level of training, including fire marshals, safe evacuation of patients	December 2025	Development of a training needs analysis is underway.	Charles Okonma, Fire Safety Advisor
3. Security					
3.1	**Emergency Prevention**	Support the Emergency Planning Manager, and work with the wider	July 2024	Threats, Risks and Vulnerability assessments on LCH owned and leased	Andrew Stephenson,

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
	Preparedness and Response (EPRR) Driver: EPRR national audit has identified additional requirements of all trusts for immediate response to emergency incidents.	specialisms (Fire, Facilities and Estates) to ensure that significant security threats, risks and vulnerabilities for each occupied building are incorporated into EPPR risk assessments Once the EPPR risk assessments are in place, assist with the development of the evacuation and invacuation plans as appropriate.	Dependant on development of the above	buildings have commenced (August / September 2024) **July 2025**: The TRVAs were completed last Autumn as planned. As we approach mid-summer, we are now planning to carry out this year's round of surveys during September 2025, again. Significant Threats, Risks and Vulnerabilities are identified annually in the TRVA surveys. A series of meetings have taken with the Emergency Planning Officer regarding Evac / Invac planning and projects are underway, including; Implementation of Myo2Bus all call-signs alert system using 3,200 mobile telephones. Successful exercise completed in March this year using an 'Active shooter' scenario. Installation of loudspeaker (pre-recorded messages) system at all retained estate HCs for activation of EPRR lockdown procedures. As at July 2024 engineering work is complete, installation finished and now awaiting procedural roll	Security Manager

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
				out and training late this summer (avoiding long school holidays). 'Pilot' electronic access control door access system (utilising LCH ID cards) installed at Chapeltown HC as an aid to EPRR lockdown in the event of Active Shooter / Roving Terrorist incident. Installation complete awaiting procedural role out in August / Sep this year. Results of 'pilot' assessment will determine likelihood and value of full role-out across all LCH HCs. Working with the Emergency Planning Manager it is agreed forthcoming EPRR exercise will be based on lockdown scenario. Exercise to be organised by EPO in compliance with NHSE requirements and supported by Security Service.	
3.2	**Action Counters Terrorism (ACT)** Driver: as above	Manage and lead the roll-out of ACT (action counters terrorism) training making it available to all staff across the Trust.	TBC (depending on availability)	The ACT training course will exceed any training requirements imposed by the new Act (Bill). The roll-out of ACT is planned and will begin with a communication campaign in September 2025.	Andrew Stephenson, Security Manager

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
				A series of counter terrorism posters are to be produced and distributed to the Health Centres as part of the roll-out.	
3.3	**Violence, Prevention and Reduction Standard** Driver: A new violence, prevention and reduction standard assessment was published in December 2024	Review the new violence, prevention and reduction standard assessment to identify gaps in compliance	February 2025	**July 2025** An initial self-assessment against the Violence, Prevention and Reduction standard is underway. Several stakeholders have been asked to comment on LCH's current position. All returns are to be collated, and an improvement plan developed to close the identified gaps.	Andrew Stephenson, Security Manager
3.4	**Supporting the development of a Mandatory Security Management Standard to be introduced in 2025** Driver: Mandatory Security Management Standard to be introduced in 2025	Monitor and actively participate in the national project work being done by NHS England, NAHS and NPAG to develop the new Mandatory Security Management Standard to be introduced in 2025 which will impose very specific duties and responsibilities on the Trust. In doing so position the Trust to be ready to adopt the	Ongoing	**July 2025** We continue to monitor developments both organisationally and politically. The abolition of NHS England (who were the drivers behind this) has created something of forecasting vacuum and it is currently unclear about the direction to be taken by Dept. of H & SC in light of the newly published ten-year plan. We continue to monitor and will respond as required.	Andrew Stephenson, Security Manager

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
		standard on time and to the required level			
4. Manual Handling					
4.1	**Identify and appoint new Moving and Handling Training Provider** Driver: Workfit have given notice that they will cease to provide LCH with moving and handling training from 18 March 2025. There is no current contract in place.	Identify specification of moving and handling training requirements Work with Procurement Manager to draft contract & go out to tender for a new moving and handling training provider. .	October 2025	Appointment of interim contractor (for 8 month period) is underway. **July 2025** draft contractual requirements have been documented and provided to Procurement.	Matt Freeman, Moving and Handling Lead
4.2	**Manual Handling Operations Regulations 1992 (as amended)** **Ensure that there are suitable and sufficient Manual Handling Risk Assessments and associated procedures** - staff are aware of the risks, and the necessary precautions/control	Development of Generic Moving and Handling risk assessments Add the generic risk assessments to Assure, and publish to the portal so all staff have access Using the risk assessments develop generic method statements for the	June 2025 June 2025	In progress **July 2025** Generic Moving and Handling risk assessments have been developed and published on the Assure Portal. Evotix (owners of the software) are considering improvements that can be made to navigating and locating published risk assessments. Associated method statements have been developed.	Matt Freeman, Moving and Handling Lead

No.	Workstream OBJECTIVE	ACTION	DATE DUE	UPDATE	Lead
	measures have been documented. Driver: As above	Work with the moving and handling training provider to ensure that the correct lifting techniques and equipment are incorporated into the training.	October 2025		

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (28) Blue Box Item

Title of report:	Mortality and Learning from Deaths Report Q1 2025/26

Meeting:	Trust Board Meeting Held In Public on 6 November 2025
Date:	

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

Executive Summary:	The Trust continues to demonstrate strong performance in mortality review processes, exceeding national requirements and embedding learning into clinical practice. The updated ABU mortality review process, aligned with Datix incident reporting, has improved data accuracy and governance. Assurance is provided that deaths are being reviewed appropriately, learning is shared, and no care-related deaths have been identified this quarter.

Previously considered by:	Quality Committee September 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?	**Equity Summary:** Mortality in IMD deciles remains aligned with neighbourhood populations. Cultural and ethnicity challenges remain, and a review of this data may provide further opportunities for change and improvement.
	No		Why not/what future plans are there to	

			include this information?	

Recommendation(s)	1. Accept this report. 2. Note the assurance that no deaths were attributable to care provided by LCH. 3. Support the implementation of the updated mortality policy following consultation. 4. Acknowledge the Trust's improvement in review rate and commitment to learning.

List of Appendices:	

WHAT – Current Position

In quarter 1 there were adult 767 adult deaths across Leeds Community Healthcare a 3% rise from the previous quarter. 641 under the care of neighbourhood teams and 116 under only the care of the specialist services. 34 deaths were recorded as unexpected (4%) this is below the Trust average of 7%. In general unexpected deaths are over reported as unexpected-expected deaths are recorded as unexpected.

55 deaths were reviewed at level 2, this includes all the MUST review cases of inpatients (2), custody/coroner cases (0), Severe Mental Illness (0), Learning Disability (7) and any unexpected deaths (34). Additional expected deaths are included above the national requirements to optimise learning opportunities. Learning continues to be shared at the Mortality Case Review meetings. A coroner case highlighted challenges in accessing chaplaincy and religious support in the community.

A system wide PSII has been initiated following a death involving all providers within the city. An after-action review has been arranged with feedback expected at the end of Q2.

It is a national requirement that all child deaths are reviewed, of the nine Children who died this quarter, all have reviewed using the rapid review process. Learning from last quarter on communication of foetal defects has been implemented with no further incidents being raised in 0-19.

The Medical Examiner (ME) role is now integrated into the review of all deaths, primary and secondary care. All deaths were reviewed by a ME regardless of location or if expected or unexpected. No concerns raised.

Audit Outcome: Internal Audit requested further clarification to gain assurance of the Trust's Learning from Deaths process. The Mortality and learning from deaths policy is being updated to clarify inclusion/exclusion criteria following Internal Audit feedback. Clarified that reviews are conducted for all patients meeting the Learning from Deaths mandatory review requirements.

Data Quality: The issue around Mortality data in datix raised in the previous report has now been cleansed, the new process implemented ensures only incidents are reported via datix not all deaths.

Equity: No change in expected data regarding IMD data. This is static in relation to mortality and population.

SO WHAT – Impact and Risks

Assurance of Safe Care: No deaths were found to be attributable to care provided by LCH.

Policy review: Updating the policy addresses Internal Audit questions, aligns with national guidance and provides clarity on reporting requirements to enable greater time to be on focused learning and improvements in safety, care and effectiveness.

Review Volume: LCH has improved mortality review rates from 2024/25. All mandated deaths are reviewed with additional reviews of expected deaths enabling broader Trust and system learning and supporting assurance of safe care. Investigation into drop in death and review rate in June is planned as likely data quality issue.

Data Quality: Enhanced Datix reporting now supports national dashboard accuracy and internal trend analysis.

Increase in Learning Disabilities noted but in line with improved documentation. LEDER process being reviewed at City level.

Equity: Mortality rates against IMD remain stable across the Leeds population aligned with known neighbourhood populations. This will continue to be monitored a change in focus to cultural and ethnicity impact may provide increased opportunities to improvements.

Now What – AAA

Alert areas to escalate as potential areas of non-compliance, that need addressing urgently, or it is felt that QAG need to be sighted on		**Action** what is being done, by who, by when	
1.	Identified gap in community chaplaincy access and religious support at end of life.	Q3	Review training needs staff on culturally sensitive end-of-life care, including religious and spiritual support in community settings. Strengthen partnerships with local faith leaders and chaplaincy services to improve access to spiritual care in the community.
2.	Internal audit raised concerns about review scope; will be clarified through policy revision.	Q3	Finalise and implement the revised mortality policy following consultation, ensuring clear communication and training on inclusion/exclusion criteria. Continue collaboration with Business Intelligence to enhance mortality data and trend analysis at both Trust and Business Unit levels.
3.	The Trust continues to review deaths beyond mandated categories, enhancing learning opportunities.	Q4	Maintain current review volumes however monitor reviewer capacity and consider if adjustments need to be made to ensure long term sustainability of current levels of review while ensuring meaningful learning and improvements made.
Advise any new areas of monitoring or existing areas of monitoring where there is an update			
1.	The revised mortality policy is under consultation, incorporating audit feedback and national guidance.		

2.	Medical Examiner reviews are now integrated into the Trust's mortality governance process.
3.	Staff are identifying and escalating learning at the point of review, strengthening real-time feedback loops.
Assure areas of assurance that have been received	
1.	No deaths attributable to Trust care.
2.	Learning is shared promptly and escalated via QAIG.
3.	Medical Examiner process now embedded in Trust's review pathway.
4.	Work is underway to improve data reporting and trend analysis at both organisational and business unit levels.
5.	Datix reporting accuracy improved, supporting national and internal dashboards.
6.	One coroner case raised due to a complaint: no case to answer.

Risks Discussed and New Risks Identified

Risk description	Initial risk score	Existing controls	Current risk score	Actions	Action by	Due date
There is a risk that patients and staff do not have access to religious/cultural support at end of life				Staff training and community engagement		
There is a risk that compliance data may be misinterpreted without clear definitions of requirements for review, robust process for				Policy updated with new definitions, must do review triggers and data requirements for accurate reporting: under consultation		

reviews and accurate data.						
There is a risk that Data used in mortality reporting is not of high enough quality to provide accurate reporting of deaths to enable clear identification of trends and opportunities for learning.				Ongoing collaboration with Business Intelligence to identify data requirements and appropriate data sources and accurate data dictionary for effective mortality data.		

Leeds Community Healthcare NHS Trust

Agenda item
2025-26
(29)

Public Board workplan 2025-26
Version 4: 30 10 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	6 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 Lived Experience	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
Organisational Strategy Development	Annual (October)	EDO						Deferred			
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 Nov)	EDFR	SR 4,6		X -end of year update				X	X	
Estate Strategy	2xyear (April and Nov)	EDFR			X -Blue box				Not presented to Board at this meeting		
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 Nov)	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 November 2025	X -Blue box Q1 Report	X	
Patient safety (including patient safety incident investigations) update report	2 x year (April and Nov)	EDN&AHPS	SR 2,3	X -Blue box					X -Blue box		X -Blue box
Infection prevention control assurance framework	Annual (April)	EDN&AHPS	SR 1,3	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	X
Chartitable Funds Annual Report and Accounts	Annual (November)	EDFR	N/A							X Defer to February 2026	
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 Report	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					
National Operating Framework -Segmentation Update		CEO							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			
People Inclusion Improvement Plan 2025 – 2026(incorporating WRES / WDES and Pay Gap reporting)	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 TBC	CS	N/A								
Going concern statement	annual	EDFR	N/A	X							X
Declarations of interest/fit and proper persons test		CS	N/A	X							X
Register of sealings	As required (from February 2025)	CS	SR 4		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 presented in November 2025	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 Nov 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 - new proposal	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