Bundle Public Board Meeting 5 February 2026

Agenda

Final Agenda Public_Board_Meeting_5 February_2026

1 09:30 - Welcome, Introductions and Apologies (Acting Trust Chair)

2 09:35 - Declarations Of Interest (Acting Trust Chair)

Item 2 Declaration of interests 29 01 2026

3 Questions From Members Of The Public

4 Minutes Of Previous Meetings, Action Log And Matters Arising (Acting Trust Chair) *For approval*

4.a Minutes of the meeting held on: •4 November 2025 •8 January 2026 (Extraordinary meeting)

Item 4ai Draft Public Board Minutes 6 November 2025 v1HTSM Agreed

Item 4aii Draft Public Board Minutes extraordinary meeting 8 January 2026HTSM Agreed

4.b Action Log

Item 4b Public Board Action log 5 February 2026

5 09:45 - Children's Takeover (Children's Business Unit)

6 10:15 - Interim Chief Executive's Report (Dr Sara Munro)

Item 6 Chief Exectutive's Report - January 2026

7 10:25 - Medium Term Plan (Andrea Osborne)

Item 7i MTP Board cover paper

Item 7ii Appendix 1 MTP 5 year narrative

Item 7iii Appendix 2 summary of WIGS 26 27

Item 7iv Appendix 3 MTP key deliverables

Item 7v Appendix 4 BAS

8 10:55 - People Headlines and Strategy Update (Jenny Allen/Laura Smith) - reviewed by the People & Culture Committee on 11 December 2025

Item 8i TRUST BOARD People Headlines and Strategy Update Dec 2025 updated 28 Jan 2026 V1.0

Item 8ii TRUST BOARD People Headlines Appendix 1 Workforce Strategy progress

9 11:00 - Quality Committee Chair's Assurance Reports: 25 November 2025 and 27 January 2026 (verbal report) (Professor Ian Lewis)

Item 9 Quality Committee Chairs assurance report November 2025 v3

Item 9ii Chairs assurance report - Quality Committee January 2026

10 11:05 - Business Committee Chair's Assurance Reports: 27 November 2025 and 28 January 2026 (verbal report) (Lynne Mellor)

Item 10 Business Committee Chair's Assurance report 26 November 2025 v2

Item 10ii Chairs assurance report - Business Committee 28 January 2026 v2

11 11:20 - Audit Committee Chair's Assurance Report: 9 December 2025 (Khalil Rehman)

Item 11 Audit Committee Chair's Assurance Report December 2025

12 11:25 - Charitable Funds Committee Chair's Assurance Report: 16 December 2025 (Alison Lowe)

Item 12 Charitable Funds Committee Chair Assurance Report Dec 2025 v1

13 11:30 - Integrated Performance Report (Andrea Osborne)

Item 13i Cover paper - Performance Brief_Board Jan

Item 13ii IPR_Jan2026_Board

14 11:45 - National Operating Framework – Segmentation Update •Sickness Rate Trajectories •Staff Engagement Project •Wider Indicators (Dr Sara Munro)

Item 14i Trust Board Paper - NOF Sickness Absence Improvement Project Feb 2026

Item 14ii Public Board Paper - Staff Engagement Feb 2026 FINAL 040226

15 12:00 - People and Culture Committee Chair's Assurance Report: 11 December 2025 (Rachel Booth)

Item 15 P&C Committee Chairs assurance report December 25

16 12:05 - Freedom To Speak Up •Freedom to Speak Up Planning Toolkit (Dr Sara Munro)

Item 16i FTSU Toolkit cover paper

Item 16ii FTSU Reflection and Planning Tool Update (2) (1)

Item 16iii FTSU Toolkit planning tool (2)79 RG (2) (1)

17 12:10 - Guardian For Safe Working Hours - Quarterly Report (Dr Ruth Burnett to present)

Item 17 GoSWH Quater 2 Board Meeting Feb 2026 v2

18.a 12:15 - Board Assurance Framework – Quarterly Update Report (Dr Sara Munro)

Item 18ai Board Assurance Framework Quarterly update Jan 26 Cover v2

Item 18aii_2025_26_BAF_Jan_2026

18.b 12:20 - Significant Risks And Risk Assurance Report (Helen Robinson)

Item 18b Board Significant Risk Report 050226

19 12:25 - Updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions – for ratification approved by the Audit Committee on 9 December 2025 (Dr Sara Munro)

Item 19 Review of SOs SFIs and Scheme of Delegation Dec 2025

20 12:30 - 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.

21 Blue Box: Mortality Quarterly Report Q3 – Reviewed by the Quality Committee 27 January 2026 – Reviewed by Quality Committee January 2026

Item 21i Blue Box Mortality Report Q3_2526 v2

Item 21ii QAIG flash report CBU Child Death Q3 24 - 25 FINAL

Item 21iii Adult Mortality Report Q3 24-25 FINAL V

22 Blue Box: Resident Doctors - 10 Year Plan – Reviewed by People and Culture Committee December 2025 – Reviewed by P&CC Committee December 2025

Item 22 10 point plan for Resident Doctors - Update to LCH Trust Board FINAL

23 Blue Box: Quality Strategy – Reviewed by Quality Committee November 2025

Item 23i Quality Strategy Nov 2025 (002)

Item 23ii Quality Strategy_Quality Committee Report Nov 25 Master

24 Blue Box: Sustainability Six Monthly Update – Reviewed by Business Committee January 2026 - update included in Business Committee Assurance report for January 2026

25 Blue Box: Workplan – To Note

Item 25 Public Board workplan 2025-26 v4 30 10 2025

Leeds Community Healthcare NHS Trust

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

Date 5 February 2026
Time 9.30am – 12.30pm
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 meeting held on: • 4 November 2025 • 8 January 2026 (Extraordinary meeting)	**Y** **Y**
4b		Action Log	**Y**
STRATEGY AND PARTNERSHIPS			
2025-26 5	9.45	**Children's Takeover** *(Children's Business Unit)*	**N**
2025-26 6	10.15	**Interim Chief Executive's Report** *(Dr Sara Munro)*	**Y**
2025-26 7	10.25	**Medium Term Plan** *(Andrea Osborne)*	**Presentation**
2025-26 8	10.55	**People Headlines and Strategy Update** *(Jenny Allen/Laura Smith)* - reviewed by the People & Culture Committee on 11 December 2025	**Y**
QUALITY AND SAFETY			
2025-26 9	11.00	**Quality Committee Chair's Assurance Reports:** 25 November 2025 and 27 January 2026 *(Professor Ian Lewis)*	**Y**
BREAK – 10 minutes			
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2025-26 10	11.15	**Business Committee Chair's Assurance Reports:** 27 November 2025 and 28 January 2026 *(Lynne Mellor)*	**Y**
2025-26 11	11.20	**Audit Committee Chair's Assurance Report:** 9 December 2025 *(Khalil Rehman)*	**Y**
2025-26 12	11.25	**Charitable Funds Committee Chair's Assurance Report:** 16 December 2025 *(Alison Lowe)*	**Y**
2025-26 13	11.30	**Integrated Performance Report** *(Andrea Osborne)*	**Y**

2025-26 14	11.45	**National Operating Framework – Segmentation Update** • Sickness Rate Trajectories • Staff Engagement Project *(Dr Sara Munro)*	**Y**
		WORKFORCE	
2025-26 15	12.00	**People and Culture Committee Chair's Assurance Report: 11 December 2025** *(Rachel Booth)*	**Y**
2025-26 16	12.05	**Freedom To Speak Up** • **Freedom to Speak Up Planning Toolkit** *(Dr Sara Munro)*	**Y**
2025-26 17	12.10	**Guardian For Safe Working Hours - Quarterly Report** *(Dr Ruth Burnett to present)*	**Y**
		GOVERNANCE AND WELL LED	
2025-26 18a	12.15	**Board Assurance Framework – Quarterly Update Report** *(Dr Sara Munro)*	**Y**
2025-26 18b	12.20	**Significant Risks And Risk Assurance Report** *(Helen Robinson)*	**Y**
2025-26 19	12.25	**Updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions – for ratification approved by the Audit Committee on 9 December 2025** *(Dr Sara Munro)*	**Y**
		CLOSING BUSINESS	
2025-26 20	12.30	**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 20.

***Blue Box**		
2025-26 21	**Mortality Quarterly Report Q3 – Reviewed by the Quality Committee 27 January 2026**	**Y**
2025-26 22	**Resident Doctors - 10 Year Plan – Reviewed by People and Culture Committee December 2025 – Reviewed by P&CC Committee December 2025**	**Y**
2025-26 23	**Quality Strategy – Reviewed by Quality Committee November 2025**	**Y**
2025-26 24	**Sustainbility Six Monthly Update – Reviewed by Business Committee January 2026 – update will form part of the Chair's assurance report for 28 January taken under Item 10**	**N**
2025-26 25	**Workplan – To Note**	**Y**

Employee	Role	CSU	Interest Type	Date Arose	Year	Interest Description (Abbreviated)	Provider
Samantha Princ	Operational Dire	Executive	Outside/Second	01/04/2024	2024/25,2025/26	Justice of the Peace for England and Wales (West and North Yorkshire	HM Courts and Tribunals Service
Ruth Burnett	Medical Directo	Executive	Outside/Second	01/04/2024	2024/25,2025/26	Executive Medical Director and Caldicott Guardian	Leeds GP Confederation
Ruth Burnett	Medical Directo	Executive	Outside/Second	01/04/2024	2024/25,2025/26	Sessional GP.Not in partnership, not salaried, no enumeration receive	Crossley Street Practice
Ruth Burnett	Medical Directo	Executive	Loyalty Interest	01/04/2024	2024/25,2025/26	Community and primary care representative on RSET (Rapid Service E	NIHR
Jennifer Allen	Director of Peop	Executive	Loyalty Interest	01/04/2024	2024/25,2025/26	Husband is a partner at KPMG	KPMG
Jennifer Allen	Director of Peop	Executive	Loyalty Interest	01/04/2024	2024/25,2025/26	I volunteer regularly for Zarach a Leeds based charity.	Zarach
Jennifer Allen	Director of Peop	Executive	Loyalty Interest	01/05/2024	2024/25,2025/26	Husband is a Trustee for Age UK Leeds	Age UK Leeds
Jennifer Allen	Director of Peop	Executive	Outside/Second	01/04/2024	2024/25,2025/26	I am also the Director of Workforce for the Leeds GP Confederation	Leeds GP Confederation
Laura Smith	Director of Peop	Executive	Outside/Second	01/04/2024	2024/25,2025/26	I undertake some training & consultancy work on a self employed bas	Prospect Business Consulting and WellNorth Enterprises (also known as 360 Degree Sociey)
Laura Smith	Director of Peop	Executive	Outside/Second	01/04/2024	2024/25,2025/26	Within my LCH role, I provide DoW support to the Leeds GP Confeder	Leeds GP Confederation
Ruth Burnett	Medical Directo	Executive	Outside/Second	25/11/2024	2024/25,2025/26	Specialist reviewer bid paperwork for musculoskeletal and pain servic	Practice Plus Group
Lynne Mellor	Non Executive D	Executive	Outside/Second	18/09/2024	2024/25,2025/26	Business Consultancy specialising in Cyber and AI	The Human Digital Collaborative Ltd
Lynsey Ure	Executive Direct	Executive	Nil Declaration	18/11/2025	2025/26		
Helen Thomson	Non Executive D	Executive	Nil Declaration	15/08/2025	2025/26		
Ian John Lewis	Non Executive D	Executive	Nil Declaration	15/08/2025	2025/26		
Sara Munro	Interim Chief Ex	Non-Cont	Outside/Second	01/04/2025	2025/26	Trustee on the board of the WDT. This is a charitable trust and the rol	Workforce Development Trust
Sara Munro	Interim Chief Ex	Non-Cont	Outside/Second	01/04/2025	2025/26	substantive CEO of LYPFT NHS Trust	CEO of LYPFT
Alison Lowe	Non Executive D	Executive	Outside/Second	01/04/2025	2025/26	Director	Association Police and Crime Commissioners
Rachel Booth	Non Executive D	Executive	Outside/Second	01/10/2025	2025/26	Job title - General Counsel. Head of legal services for Bupa UK busine	Bupa
Andrea Osborne	Director of Finar	Executive	Nil Declaration	17/11/2025	2025/26		

Item 4ai

MINUTES OF THE TRUST BOARD MEETING HELD IN PUBLIC ON: 6 NOVEMBER 2025

Present:	Helen Thomson Deputy Lieutenant (DL)	Acting Trust Chair
	Dr Sara Munro	Interim Chief Executive
	Jenny Allen	Director of People (JA)
	Dr Ruth Burnett	Executive Medical Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Alison Lowe OBE (AL)	Non-Executive Director (Items 81- 97)
	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 86 -109)
	Laura Smith	Director of People (LS)
	Lynsey Ure	Executive Director of Nursing, Allied Health Professionals (AHPs), and Quality
Apologies:	Rachel Booth (RB)	Non-Executive Director
	Laura Smith	Director of People (LS)
In attendance:	Jonathan Hodgson	Internal Audit Manager, Audit Yorkshire
	Kathryn Merrick	Team Manager, Speech and Language Therapy (Item 85)
	Helen Robinson	Company Secretary (Items 102 -109)
	Nicky Sarginson	Specialist Speech and Language Therapist (Item 85)
Minutes:	Liz Thornton	Corporate Governance Officer
Observers:	Em Campbell	Health Equity Lead (Items 81-88)
	Clare Edwards	Associate Director for Corporate Governance Leeds and York Partnership NHS Foundation Trust
Members of the public	None in attendance	

Item 2025-26 (81)

Discussion points:

Welcome introduction, apologies, and preliminary business.

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

Apologies

Apologies for absence were received from the Non-Executive Director (RB) and Director of People (LS).

Item 2025-26 (82)

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 (83)

Discussion points:

Minutes of the last meetings, matters arising and action log

ai) Minutes of the meeting held on 4 September 2025

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

b) Action log

The eight actions on the log were reviewed.

2025-26 (66) - Winter Planning Board Assurance Statement The proposal to close this action was agreed. **Action closed.**

2025-26 (66) - Winter Planning Development of a Dynamic Dashboard: The Executive Director of Operations informed that Board that this would be released for testing within the next seven to ten days. **Action closed.**

2025-26 (66) - Winter Planning 2025-26: the Executive Director of Nursing and AHPs provided a verbal update on the 0-19 vaccination programme outcomes. **Action closed.**

2025-26 (67) - Updated Health Equity Strategy: covered by Item 88 in these minutes. **Action closed.**

2025-26 (67) - Health Equity Strategy the Acting Chief Executive to discuss the Trust's EQIA processes with the Associate Director of Strategy, Change, and Improvement: the Acting Chief Executive noted that this had been raised via alerts from both the Quality and Audit Committees and would be progressed through meetings of both these committees. **Action closed.**

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: this would be discussed at a Board Development session in January 2026. **Action closed.**

2025-26 (38i) and (38ii) - Duty of Candour: the Executive Director of Nursing and AHPs provided a verbal update on both actions. She provided assurance that the Trust was fully compliant with the Duty of Candour. In future assurance would be provided via triple A reports from the Quality, Assurance, and Information Group (QAIG). Risks around any delays in the process would be monitored by the Risk Management Group. **Actions closed.**

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

Item 2025-26 (84) - Taken out of agenda order

Discussion points:

Questions From Members Of The Public

None received.

Item 2025-26 (85)

Discussion points:

Patient Lived Experience: Children's Speech and Language Therapy

The parent of a child with selective mutism attended the meeting to speak about the support her son had received from the Trust's Children's Speech and Language Therapy (SLT) Team. She explained that selective mutism was an anxiety-based condition where an individual could speak comfortably in some situations but was prevented them speaking in others for example at school. She explained to the Board that her son had been referred to the Trust's SLT Team after starting school in Autumn 2023 when he had failed to speak at school. Following the referral her son was initially seen in Summer 2024. The Team had provided support, techniques and advice both to her and the school on strategies to help reduce her son's anxiety and encourage him to gain the confidence to speak. As part of this she worked in school one day per week as a volunteer and although not working one to one with her son she was able to be there for support and observe how the strategies were used and their impact. Over the last 12 months there had been a significant improvement in her son's anxiety, and he was now more confident to speak in the school environment. She praised the input from the Trust's SLT Team as key to driving forward the positive progress he had made.

The Board were interested to know whether her son suffered from episodes of anxiety at home.

Mum said that he did not display any signs of anxiety or mutism when out of school and as a family they were completely unaware of any problem with his ability to speak until the school had raised it a parent's evening during his first term in Reception. She explained that he interacted and played games with other children in his class and had friends but just did not want to speak.

The Board noted the positive comments she had made about the input from the Trust but was interested to know if there was anything that could have been done better.

She suggested that the Trust could do more to raise awareness of selective mutism in schools as early intervention was key to achieving a positive outcome.

The SLT Team Manager said that the Trust did offer support and training to schools which included a specific offer to buy into speech and language services.

Non-Executive Director (IL) asked how common selective mutism was in children.

The Board was informed that one child in 90 was diagnosed with the condition.

The Board thanked the mum and members of the SLT Team for attending the meeting to speak about her positive experience of the Trust's SLT service.

The Board agreed that, if possible, the SLT Service should consider more proactive involvement in schools to raise awareness of SLT conditions and the support and toolkits which were available to support school staff.

Item 2025-26 (86)

Discussion points:

Interim Chief Executive's report

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

Wider Societal Issues

The Trust continued to give a greater focus to supporting staff in the context of wider societal issues, racism, and discrimination. This had impacted on staff both directly and indirectly and on the people the Trust served across Leeds, many of whom were vulnerable.

She highlighted the work the Directors of People had been undertaking with colleagues from the staff networks, freedom to speak up guardian and leaders across the Trust to create safe space sessions

to listen and to learn. She emphasised that the Trust did not tolerate discrimination of any form and tackled it where it occurred. She informed the Board that NHS England (NHSE) had recently written to all organisations setting out their commitment to antiracism and antisemitism, with an ask of organisations to take clear action, and had indicated there would be further guidance, training and policy changes to follow that would lead to stronger action to prevent and respond to racism and discrimination.

The Board welcomed the commitment from NHSE and encouraged the Trust to review its policies in light of the ask of organisations to take clear action and suggested that this should include a review of the policy on withdrawing care in certain circumstances.

Operational and Medium-Term Planning

NHS Trusts were required to develop medium-term plans before the end of this year. The detailed guidance which set out the key priority areas for service delivery linked to manifesto commitments, the spending review and continuation of existing priorities had now been published. A draft submission would be shared with the Board at a meeting in early December with the aim of submitting the final version in January 2026.

National Neighbourhood Health Implementation Programme (NNHIP)

The Leeds application to be part of the NNHIP had been successful, along with West Yorkshire neighbours Wakefield, Bradford District and Craven. The programme was a large-scale test, learn and grow change programme. Department of Health and Social Care (DHSC) and NHSE partners would work with 43 local areas across the country to accelerate learning and implementation of neighbourhood health. The initial focus was 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. Leeds would 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.

Outcome: the Board

- Noted the report.

b) Provider Capability Assessments

A paper had been shared in advance of the meeting which summarised the process followed by the Trust regarding the provider capability self-assessment and included the agreed compliance ratings which had been agreed by the Trust Board. The Interim Chief Executive confirmed that the self-assessment had been submitted to NHSE on 22 October 2025.

Outcome: the Board

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

Item 2025-26 (87)

Discussion points:

Internal Audit – Audit Yorkshire

Jonathan Hodgson Internal Audit Manager, Audit Yorkshire joined the meeting to provide a verbal update on the Internal Audit work.

He informed the Board that delivery of the 2025/26 Internal Audit Plan was on track, and he thanked directors and staff in the Trust for their support. He said that the next meeting of the Trust's Audit Committee was scheduled for 9 December 2025 and he stressed the importance of ensuring that all the audits currently in draft were cleared for publication in advance of that meeting.

The Chair of the Audit Committee, Non-Executive Director (KR) echoed this, emphasing the need to ensure the plan remained on track.

The Internal Audit Manager said that work to develop the 2026/27 plan would begin soon with the aim of taking a draft to the Audit Committee in March 2026.

The Acting Trust Chair thanked the Internal Audit Manager for the update.

Item 2025-26 (88)

Discussion points:

Health Equity Five Year Tactical Plan

The Executive Medical Director presented the paper which proposed a new draft five-year tactical plan for health equity, to sit under the developing Trust wide five-year plan. The plan sought to continue the focus of moving from intent to action, by strengthening accountability and action for addressing inequity across the Trust.

The Board reviewed the current position and ambitions, the Health Equity 5-year tactical plan and the Health Equity Index.

Non-Executive Director (KR) raised concerns about the extension of the implementation timetable which would mean delivery would take ten years. He suggested that the Tactical Plan should be reviewed and re-submitted with a tighter delivery timetable.

Non-Executive Director (AL) also expressed disappointment with the pace of progress. She felt that the delay was in part due to the Trust's lack of financial investment in systems which would enable the delivery and interpretation of supporting data. The plan as currently presented did not provide assurance that the changes required would be delivered across the organisation within the timescales set out.

The Interim Chief Executive said that it was important to recognise that to drive this work forward at pace was a complex challenge and the Trust was in a stronger position than many other organisations but she acknowledged that currently the equity data was not mature enough to support the delivery of the ambitions in the plan.

She encouraged the Acting Trust Chair and committee chairs to take up the offer of a more in depth discussion with the Executive Medical Director and Health Equity Lead to identify which equity workstreams aligned with their committee areas of responsibility.

The Board agreed that this was a sensible approach and a report would be made back to the Board at a future meeting.

Action: Acting Trust Chair, Committee Chairs to meet with the Executive Medical Director and Health Equity Lead. A further Report to be made to a future meeting of the Trust Board.

Responsible Officer: Executive Medical Director.

Outcome: the Board

- Reviewed the 5-year plan and noted the risks to the scale and pace of delivery
- Noted and agreed the proposal for the Acting Trust Chair and committee chairs to discuss the areas of the plan associated with each committee's areas of responsibility.
- A further report would be made to a future meeting of the Trust Board.

Item 2025-26 (89)

Discussion points:

Trust Priorities – Mid-Year Update

The Executive Director of Finance and Resources presented the paper which provided a mid-year update on progress against the 2025-26 Wildly Important Goals (WIGs) as set out below:

- 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

Outcome: the Board

- Noted the progress made to date in 2025/26.

Item 2025-26 (90)

People Headlines and Strategy Update

The Director of People (JA) presented the paper which provided the Trust Board with information on key headlines linked to the LCH People Directorate portfolio. The report had been reviewed and discussed by the People Culture Committee prior to presentation to the Trust Board.

Headline areas covered in the report included:
• 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 and Culture Committee meeting on 23 September, one update had been made to the paper, on MARS, which confirmed staff proceeding to departure as 42.

The paper also provided an update on the progress made against the Trust's Workforce Strategy (2021-2026) outcome measures to date.

Non-Executive Director (LM) asked if there was any feedback from the staff who had attended the staff safety and support events.The Director of People (JA) said that a list of actions was being compiled and follow up actions were under discussion with the Executive Director of Operations and General Managers.

Outcome: the Board

- Noted the progress achieved in pursuit of the target measures set out in the current Workforce Strategy.

Item 2025-26 (91)

Discussion points

Quality Committee Chairs Assurance Report – 23 September 2025

Non-Executive Director (IL), Chair of the Committee presented the report and highlighted the issues in the Alert section:

Diabetes Development – Health Equity Data: limited progress had been made over the last five years in embedding automated equity reporting within diabetes projects. Further work was underway to strengthen data use and reporting.

Patient Story (March 2025) – Adult Safeguarding / Patient Experience: the Committee requested assurance that a clear process existed for managing complex patient experience cases and outcomes.

Clinical Patient Safety Training – Assurance Paper: a paper on clinical training had been requested to provide assurance on current arrangements and improvements. The paper would be reviewed through QAIG and Quality and Value Transformation and presented at the Quality Committee meeting in November.

Quality and Value – Equality Impact Assessment (EQIA): the Committee noted limited assurance regarding understanding and use of data in the EQIA processes to inform decision-making. Further work was required to embed robust data analysis across the organisation.

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

Outcome: the Board

- Noted the assurance provided.

Item 2025-26 (92)

Discussion points:

Infection Prevention and Control Annual Report 2024/25

The Executive Director of Nursing and AHPs presented the Annual Report for 2024/25. It informed the Board of the achievements within Infection Prevention and Control during 2024-25 and provided 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 also provided an overview of the collaborative work throughout the Leeds system, as part of the cooperation partnership agreement with Leeds City Council.
The Board agreed that in future the IPC Annual Report should be approved by the Quality Committee, but assurance would be fed up to Board each year via the Quality Committee assurance report.

Outcome: the Board

- Approved publication of the report.
- Agreed that in future the IPC Annual Report should be approved by the Quality Committee, but assurance would be fed up to Board each year via the Quality Committee assurance report.

Item 2025-26 (93)

Discussion points:
Safeguarding Annual Report 2024/25
The Executive Director of Nursing and AHPs presented the report which provided an overview of safeguarding activity, achievements, and ongoing challenges within the Trust over the past year. The Trust continued to prioritise the safety and wellbeing of all service users, ensuring robust systems were in place to identify, respond to, and prevent harm.

The Board agreed that in future the Safeguarding Annual Report should be approved by the Quality Committee, but assurance would be fed up to Board each year via the Quality Committee assurance report.

Outcome: the Board

- Approved publication of the report.
- Agreed that in future the Safeguarding Annual Report should be approved by the Quality Committee, but assurance would be fed up to Board each year via the Quality Committee assurance report.

Item 2025-26 (94)

Discussion points:
Business Committee Assurance Reports: 24 September 2025 and 29 October 2025
Associate Non-Executive Director (LM), Committee Chair presented reports and highlighted the issues in the Alert section of the reports:
Digital Letters: the Committee received assurance that the clinical risk was low. The Trust was now progressing with an SFTP transfer solution, with a 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 could feed into any future procurement from the Trust.

Estates Strategy and update: the Committee was unclear what risk the Trust was carrying in the absence of a strategy since the ending of the previous strategy in 2024. It was also unclear from the report what has been delivered from the strategy in 2019 and the refresh in 2022.

The Executive Director of Finance and Resources provided assurance that there was no ‘gap’ in the estates plan. A rolling contract was in place for 2025/26 in the form of a one year tactical plan. A further paper would be presented to the Business Committee in November to provide more assurance on delivery against the 2022-25 plan.

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

Outcome: the Board

- Noted the assurance provided and the matters highlighted.

Item 2025-26 (95)

Discussion points:
Audit Committee Assurance Report: 14 October 2025
Non-Executive Director (KR), Committee Chair, presented the report and highlighted the key issues in the Alert section:

Audit Plan 2025/26: the Committee Chair had been alerted to concerns related to the Trust's EQIA processes which would warrant further investigation and potentially lead to an in year adjustment to the Internal Audit Plan.PSIRF Internal Audit Report (limited assurance June 2025): weaknesses had been found in the application of PSIRF within Datix. The Executive Director of Nursing and AHPs attended the Committee meeting to provide an update on progress against recommendations. Eight out of 12 had been closed, work on the remaining four was in progress. The Committee asked for a further report in December 2025 which provided more assurance on the validation of competed recommendations and governance processes.

SIRO Report: the 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.

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 (96)

Discussion points:

Charitable Funds Assurance Report: 9 September 2025

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

Giving Voice Choir: the Committee had requested that an options paper be developed regarding whether the choir should continue to sit within the Speech and Language Therapy Service or with the charity.

Charitable Funds and Related Charities Annual Report and Accounts 2024/25: the Committee reviewed and approved the accounts which would be presented to the Audit Committee on 9 December following independent auditing, prior to final sign off.

Charitable Funds Officer: the Committee noted the work with the Finance Team to review performance against the trajectory set in the Three Year Plan.

Outcome: the Board

- Noted the assurance report and the matters highlighted.

Item 2025-26 (97)

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.

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 September 2025 with the same measures passing or failing their targets.

The Executive Director of Finance and Resources provided a brief update on the financial position. 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 remained on track to achieve its stretch target of £0.9m surplus by year end.

Achieving this target was essential for the Trust to deliver its share of the West Yorkshire (WY) system's additional improvement target. The financial position was 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 was a deficit of £2.38m. Planning assumptions continued to assume recurrent savings would be identified and therefore the Trust would be in a recurrent underlying breakeven position at the start of 2026/27.

Outcome: the Board

- Received and noted the update reports.

Item 2025-26 (98)

Discussion points:

National Operating Framework – Segmentation Update

- Sickness Rate Trajectories
- Waiting List Trajectories
- Wider Indicators

The Interim Chief Executive introduced the item. The Trust currently had a segmentation score of 4. The next segmentation and scoring was expected by the end of November 2025.

She invited the Executive Director of Operations to provide an update on the Trust's Waiting List Recovery Plan and the Director of People (LS) to provide an update on the Sickness Absence Improvement Project.

Waiting List Recovery Plan

The Executive Director of Operations led the Board through the paper which had been considered by the Business Committee on 29 October 2205. It presented trajectories for the four key services that most significantly affected the Trust's National Oversight Framework (NOF) score in the Access to Services Domain. These were Paediatric Neuro Disability (PND), Adult Speech and Language Therapy (SLT), Continence Urology Colorectal Service (CUCS) and Podiatry. Narrative was also provided for all other services with waits over 40 weeks.

The Board noted the paper and asked that future reports include data on 18 week waits.

Sickness Absence Improvement Project

The paper provided the Board with assurance regarding the implementation of the Sickness Absence Improvement Project, which had been established to address the Trust's current performance position in Segment 4 (low performing) in the NHS Oversight Framework 2025-26. A rate of 6.38% (Q4 2024-25), ranking 49th out of 61 comparable non-acute Trusts against a sector standard of 5.65%.

She explained that the project aimed to reduce sickness absence through a systematic improvement programme integrating policy clarification, accountability, capability development, and cultural change. The initiative operated on a quarterly PDCA (Plan-Do-Check-Act) cycle across four integrated workstreams, with clear governance, defined deliverables, and measurable outcomes. The paper outlined the project scope, governance structures, Q1 deliverables (due November 2025), key risks, and monitoring arrangements to provide confidence that the Trust was taking decisive action to move into Segment 3 in the first instance.

Outcome: the Board

- Received and noted the performance report.

Item 2025-26 (99)

Discussion points:

People and Culture Committee Chair's Assurance Report: 23 September 2025

Associate Non-Executive Director (LM), presented the report in the absence of the Committee Chair and highlighted the issues in the Alert section of the report:

National Operating Framework: the Committee had received a report on the work required to drive improvements in staff engagement and sickness absence figures, together with other aspects of the discussions. The deterioration in the scores for recommending the Trust as a place to work was concerning due to 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 People & Culture 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.

Staff Wellbeing: The Committee discussed 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 learnt about the planned listening events; however, concerns were raised 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 had responsibility for overseeing two risks:
Risk 3 Failure to comply with legislative and regulatory requirements: **Reasonable Assurance.**
Risk 6 Failure to effectively engage staff and leaders as well as to support their health and well-being in the current context: **Limited Assurance** – due to the deterioration in the scores for recommending the Trust as a place to work.

Outcome: The Board:

- Noted the assurance report and the matters highlighted.

Item 2025-26 (100)

Discussion points:

People Inclusion Improvement Plan 2025 – 2026(incorporating WRES / WDES and Pay Gap reporting)

The Director of People (JA) presented the report which provided the Trust Board with a strategic update on the current position and the actions the Trust would take to further advance equity, diversity, and inclusion (EDI). It evidenced the 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 supported people and the communities the Trust served.

The report had been previously considered by the People and Culture Committee.

The Acting Trust Chair confirmed that all non-executive directors had agreed an Equality, Diversity, and Inclusion objective for 2025/26.

Outcome: the Board

- Noted the current position in delivering against the NHS EDI Improvement Plan High Impact Actions.
- Ratified the Trust People Inclusion Improvement Plan 2025/26, confirming that its continued delivery provided assurance the Trust meets workforce obligations under the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract.

Item 2025-26 (101)

Discussion points:

a) Significant Risks Risk Assurance Report

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

She highlighted the following key points:

- Two risks on the Trust risk register that had a score of 15 or more (extreme).
- A total of 20 risks scoring 12 (very high).

The Board reviewed the report which summarised all risk movement, the risk profile, themes, and risk activity since the last risk register report was received by the Board in September 2025.

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.

b) Risks Management Policy and Procedure
The Executive Director of Nursing and AHPs informed the Board that the Risk Management Policy and Procedure was reviewed on a 3-yearly basis. The Policy had 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 was presented to the Board for approval.

Outcome: the Board
- Approved the Risk Management Policy and Procedure.

Item 2025-26 (102)

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.

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

Item 2025-26 (103)

Discussion points:
Board Service Visits Proposal
The Company Secretary presented the paper which proposed 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 introduced a new framework of learning and leadership visits, supported by the Corporate Governance Team, to run alongside the already existing Quality Walk process.

The Board welcomed the introduction of a new approach. It was suggested that 'Thank You' events should also be recorded as part of the new process.

Outcome: the Board
- Approved the proposal of introducing learning and leadership visits for the remainder of 2025/26.
- Agreed to review the process during Quarter 1 of 2026/27 once the first wave of visits had been mobilised.

Item 2025-26 (104)

Review Of Emergency Powers And Urgent Decisions Procedure (Chair and CEO actions and Committee urgent actions)
The Company Secretary informed the Board that the procedure for emergency powers and urgent decisions ('Chief Executive and Chair's actions') and Committee urgent matters was last reviewed in August 2019. She pointed out that whilst this is a procedure, rather than a policy, and did not require regular review, any amendments needed to be approved by the Trust Board.

One minor amendment was required correcting a reference number in the Standing Orders and this had been highlighted.

Outcome: the Board
- Approved the amendment made to the procedural document.

Item 2025-26(105)

Discussion points:
Any other business Blue Box Items and Close

The Executive Medical Director informed the Board that on Sunday 9 November the Leeds Remembrance parade would be taking place, and the Trust had been invited to take a place in the parade.

Board members were invited to meet at 10:00hrs at the Millennium Square outside the Leeds Museum to take part and march alongside members of the armed forces community.

The Acting Trust Chair closed the meeting at 12.30pm

Date and time of next meeting.
Thursday 5 February 2026 9.30am-12.30pm

2025-26 106	**Patient Safety (including patient safety incident investigations) update report – reviewed by Quality Committee September 2025**
2025-26 107	**Health and Safety Annual Plan – Six Monthly Update –reviewed by Business Committee on 24 September 2025**
2025-26 108	**Mortality Quarterly Report – Reviewed by the Quality Committee 23 September 2025**
2025-26 109	**Workplan – to note**

Trust Board Extraordinary Public Meeting held at 9.30am on 8 January 2026

Attendance

Present:	Helen Thomson Deputy Lieutenant (DL)	Acting Trust Chair
	Sara Munro	Interim Chief Executive
	Dr Ruth Burnett	Executive Medical Director
	Professor Ian Lewis (IL)	Acting Deputy Trust Chair, Non-Executive Director
	Alison Lowe (AL)	Non-Executive Director
	Lynne Mellor (LM)	Associate Non-Executive Director
	Andrea Osborne	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Khalil Rehman (KR)	Non-Executive Director
	Jenny Allen	Director of People (JA)
	Lynsey Ure	Executive Director of Nursing and Allied Health Professionals (AHPs)
Apologies:	Rachel Booth (RB)	Non-Executive Director
In attendance:	Helen Robinson	Company Secretary
Minutes:	Liz Thornton	Corporate Governance Officer (Virtual Link)
Observers:	None	

Item 2025-26 (110)

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 prior to papers being distributed to Board members.

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

Item 2025-26 (111)

Discussion points: Enhance Future Funding

The Executive Director of Operations presented the paper. She provided some background and context to the Enhance Programme and the business case presented for approval.

The programme was a partnership development by Leeds Community Healthcare NHS Trust (LCH) and Leeds Older People's Forum (LOPF) to release capacity in LCH services by investing in third sector capacity to work collaboratively with LCH services and provide personalised care and support to patients' physical and mental health and wider well-being,

aiding recovery, preventing deterioration and maintaining independence. The programme was now in its fourth year.

She explained that the 2025/26 financial year funding had reduced from £1m to £300k as the academic evaluation had indicated that there was significantly greater benefit to secondary and urgent care than to LCH. This included a 72.5% reduction in LOPF project management. Enhance had changed from a city-wide offer to being targeted at the five most deprived Neighbourhood Team areas and supporting development of Community Health Hubs, aligning with the Adult Business Unit's Best Place of Care Programme.

The business case presented to the Board for approval had previously been considered by the Senior Leadership Team (SLT), Business Committee and Quality Committee. Both Committees had supported the option recommended by SLT to fund the service for one further financial year - 2026-27. During this period, the intention would be to bring the discussion into the developing provider collaborative, recognising that the programme was central to neighbourhood health.

The Interim Chief Executive confirmed that she had raised the development of further funding beyond 2026/27 with colleagues in the GP Confederation and Leeds City Council.

Outcome: the Board approved

- funding the Enhance Programme for the 2026/27 financial year: £299,901
- bringing Enhance under the remit of Leeds' Joint Committee to consider, developing and funding beyond the 2026/27 financial year as a key component of the emerging Neighbourhood Model enabling prevention and reducing demand for healthcare services system-wide.

Item 2025-26 (112)

Discussion points: Emergency Preparedness, Resilience and Response- Core Standards Submission

The Executive Director of Operations presented the submission. The Trust had achieved a significant improvement in compliance, increasing from 27 fully compliant standards in 2023/24 to 50 in 2024/25. The NHSE Annual Assurance self-assessment had been submitted to the Integrated Care Board (ICB) on 31 October 2025.

The Trust now had zero non-compliant standards, with eight standards outstanding. These would form part of the Emergency Preparedness, Resilience and Response (EPRR) workplan for the coming year.

She added that discussions would begin about bringing together Leeds Community Healthcare NHS Trust and Leeds and York Partnership NHS Foundation Trust's EPRR functions by the end of March 2026

Outcome: the Board

- accepted assurance from the outcome of the NHSE EPRR Core Standard Assurance Audit 2025
- approved the standards.

Item 2025-26 (113)

Discussion points:

Any other business and Close

One matter was raised and was recorded as a private minute.

The meeting closed at 10.00am.

Date and time of next meeting
Thursday 5 February 2026 9.30am

AGENDA ITEM 2025-26 (4b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) action log: 5 February 2026

Key		Key colour code
Total actions on action log	1	
Actions on log **completed** since last Board meeting on 6 November 2025 with a **proposal to close**		
Actions due for completion by 5 February 2026 – for update at the meeting	1	
Actions not due for completion before 5 February 2026		
Actions outstanding at 5 February 2026**: not having met agreed timescales and/or requirements**		

Agenda Item Number	Action Agreed	Lead	Timescale/Deadline	Status
6 November 2025				
Item 2025-26 (88)	**Health Equity Five Year Tactical Plan:** Executive Medical Director/ Health Equity Lead to meet with Acting Trust Chair, Committee Chairs.	Executive Medical Director/ Health Equity Lead	Dates TBC post meeting	**Update on 5 February 2026**

Agenda item:	2025-26 (6)
Title of report:	Interim Chief Executive's Report
Meeting:	Trust Board meeting Held in Public
Date:	5 February 2026

Presented by:	Dr Sara Munro, Interim Chief Executive
Prepared by:	Dr Sara Munro, Interim Chief Executive

Purpose of the report:		
This report provides: An update to the Board on the Trust's activities since the last meeting and draws the Board's attention to any issues of significance or interest.	Approval	
	Discussion	
	Assurance	x

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives	x	**Acceptable assurance** General level of confidence in delivery of existing objectives		**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:
Updates are provided on activities relating to: • Our Services and Our People • Alignment with Leeds and York Partnership NHS Foundation Trust • System Update

Previously considered by:	N/A
Outcome of previous discussion/s:	N/A

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

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

and/or workforce)?			include this information?	

Recommendation(s)	The Board is recommended to: • note the update on key activities and issues from the Chief Executive.

List of Appendices:	None

Interim Chief Executive's Report

- **1 Executive Summary**

  The purpose of this report is to update and inform the Board on key activities and issues from the Chief Executive.

- **2 Our Services and Our People**

Service visits

It has been great to continue with service visits over the past two months and highlights from those are summarised as follows.

The ***Yeadon Integrated Neighbourhood Team*** let me observe their handover and team meeting and I was able to talk through with the senior nurses in the service what is working well and where we should focus our improvements. It was clear that the team works very flexibly with one another and partners – with a diverse mix of clinical needs on the caseload, which they were actively reviewing and prioritising – matching to team skills and roles. We discussed some of the more complex cases the teams deal with and future benefits that could come from greater partnership working. The team also felt there was still more to do to ensure that all partners understood what the service was there for, which should be helped as we get into more detailed planning of the neighbourhood health model.

The ***Therapy Team and Active recovery*** is a service that is discussed on a regular basis in Leeds system meetings given how central it is to supporting flow between hospital and community – and joining up health and social care provision. It was helpful to learn from the service lead the journey they have been on over the last 12-18 months to re-establish a core purpose and offer which gives them the platform now from which to focus on improving clinical effectiveness and productivity. I was given the privilege of accompanying active recovery on a home visit which was also attended by the care coordinator for reablement and witnessed first hand the need for adaptability and responsiveness to support people that have just been discharged. Again, colleagues were very open with me about what they have been able to improve and what some of the challenges are in supporting people with complex needs to remain at home for as long as possible.

Our ***Infection Prevention and Control team*** is a fantastic example of multi-agency cross partnership working – the passion and ambition of the team to improve and work across boundaries is limitless and they shared many examples of outstanding work, especially in support of some of our most high risk and vulnerable patient groups. They have lots of ideas on what more they could offer at a neighbourhood level – using data and intelligence to identify and help target the differential rates of infection at a neighbourhood level. They have also done an amazing job in the roll out of our staff flu vaccination programme this year – ensuring we achieved our 5% increase on last year's uptake.

The ***Medical and Dental engagement*** meeting invited me to their face-to-face meeting in December where we had open discussion about current experiences, what's working well and what could be improved for doctors and dentists in the Trust. We also discussed the importance of clinical engagement and clinical leadership – both now and when setting our strategic direction.

Service Update and Pressures

The Board is aware that resident doctors rejected the latest offer on terms and conditions from the government and went ahead with industrial action from the 17th to the 22 December 2025. This posed a significant risk of disruption for our services but due to excellent planning and cross departmental teamwork we did not have any impact on patient safety and core service delivery. The BMA is currently balloting members on future industrial action.

As anticipated demand on the health and care system increased over the winter period and in the past week we have seen significant pressure in our integrated neighbourhood teams. Services have also had to deal with a significant spike in staff sickness over the past couple of months. To maximise flow across the system and support those in greatest need we did for a week prioritise urgent referrals in the community.

Staff Engagement

We have received the initial results from the annual staff survey which are for internal use only until published in March 2026. The board can be assured that work is already underway on reviewing the data and working with teams and departments on areas for improvement and areas for shared learning.

Medium Term Planning

All Trusts and ICBs are required to submit 5-year strategic plans in February 2026. The trust board met in December to approve our draft submission to NHSE which was done on time. Since then, we have been given feedback on our draft submission and asked to submit additional information demonstrating board review and sign off. All chairs and CEOs are meeting with the regional team and ICB CEO/Chair to discuss the plans further.

Our meeting with the regional team was set up as a joint meeting for LCH and LYPFT and attended by me and the two trust chairs, along with regional NHSE and West Yorkshire ICB colleagues. We met on the 22nd of January to provide assurance that our final submission is on track, and we are clear what our priorities are and key risks we need to address. It was a positive meeting in which we discussed our known challenges such as reducing waiting times and reducing staff sickness rates. We also set out our future long-term plans which means our submissions next month will change as further develop our business case for organisational merger.

There is a separate paper to Board seeking comments on our final plan before submission which is due on the 12 February 2026.

➢ **3 Alignment with Leeds and York Partnership NHS Foundation Trust**

Both Trust Bboards formally agreed in November to develop a strategic outline case to explore the benefits and costs of merging our two organisations to create a new integrated provider of physical and mental health services. Since then, we have:

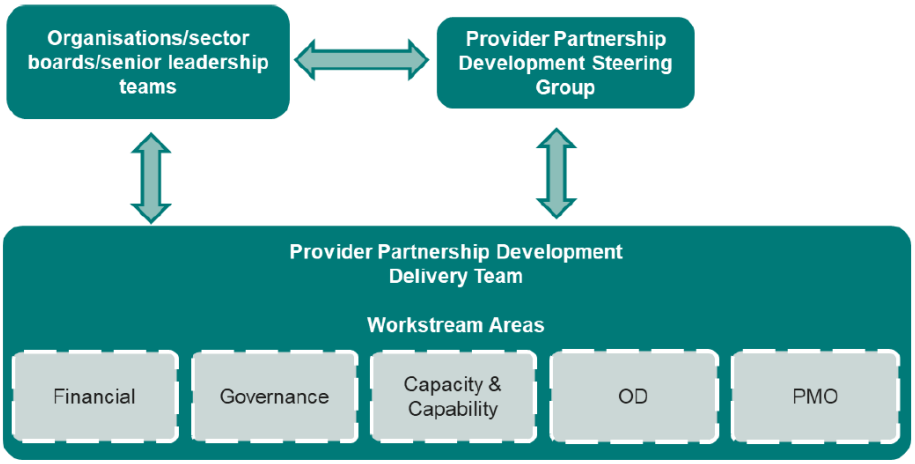
- Put in place the core leadership team to manage the transition between the organisations and NHSE.
- Secured the support of Deloitte to progress the strategic outline case (SOC) which was shared in draft prior to the board meeting and will be considered in private for approval prior to submission to the NHSE regional team in February.
- We held a joint Board meeting on 7 January 2026 which covered information and insights on the clinical service portfolio across both organisations and the project plan for development of the SOC and then full business case. Feedback from the session was positive and we are planning a further Board to Board in March 2026.

- Held several staff engagement sessions to brief colleagues across both Trusts on the proposals and seek initial feedback that will inform the detailed planning and future engagement.
- An initial meeting has been held to set up a working group called a 'Transition Committee' which will work on behalf of both boards to oversee the detailed transition plan. Further information included terms of reference for the transition committee will be shared with both boards on the proposed next steps.

➢ 4 System Update

Leeds Provider Partnership

Following the Leeds Place Review that concluded in 2025 we are continuing the work with statutory partners, primary care and the VCSE to improve the way we lead and manage health and care services across the city. We shared our proposals in a check and challenge session with the Integrated Care Board (ICB) leadership team in December 2025 and received positive and constructive feedback. There is further work to do on understanding, negotiating and agreeing the future relationship and level of delegation of ICB functions to the place-based provider partnership over the next 6-9 months. The ICB is keen to support place partnerships to be ready to operate in shadow form during 2026 and to formally delegate to a host place provider from April 2027 those functions agreed to be held at place on behalf of the ICB. The key strands of work in Leeds are captured in the following diagram:



West Yorkshire Integrated Care Board (ICB) Changes

Since the last Board meeting the West Yorkshire ICB has now concluded the first round of a voluntary redundancy scheme. This was mandated nationally to support future organisational change to the operating model of ICBs, which included a significant reduction in funding and headcount. Feedback is that there has been a high number of applications for redundancy in this phase and following the review and approvals process the ICB have finalised the proposed structures for the organisation which have gone out for formal consultation. Pending the outcomes of that, the appointments for senior roles in the ICB are scheduled to commence in April 2026. The aim is to conclude the redundancy process for all staff by October 2026.

There are some areas of function/activity which the ICB is asking for provider trusts to host on their behalf. As this is still in the early stages of negotiations we will update in the private Board on the latest position. We have also agreed commitment of funding for the MHLDA Collaborative team (hosted by LYPFT) for the next 12 months which will be discussed at the Committee in Common meeting later this month.

At the start of the New Year the Chief Executive for the West Yorkshire ICB, Rob Webster CBE, wrote to partners to inform us that he is standing down from his position this year. The timescales for this are to be confirmed once the new permanent Chair for the ICB has been appointed. Interviews for the Chair have now taken place, and we will update the Board once we have been informed of the outcome of the recruitment process.

5 Recommendations

The Board is recommended to:

- note the update on key activities and issues from the Chief Executive.

Dr Sara Munro
Interim Chief Executive
27 January 2026

Agenda item:	2025-26 (7Pi)
Title of report:	Medium Term Plan
Meeting:	Trust Board
Date:	5 February 2026

Presented by:	Andrea Osborne, Executive Director of Finance and Resources
Prepared by:	Dan Barnett, Associate Director of Strategy, Change, and Improvement

Purpose of the report:		
The development of the Trust's Medium Term Plan has been discussed at committees over the past month and the final versions are included for Board sign off ahead of submission to NHS England on 12th February 2026.	Approval	x
	Discussion	
	Assurance	

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives		**Acceptable assurance** General level of confidence in delivery of existing objectives	x	**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:

- Development of LCH's Medium Term Plan has been in collaboration with Board through the committees
- There are a few caveats in the plan where we are still waiting for information from NHSE and the ICB, but plans will be refreshed to accommodate these
- Included with this pack is the full 5 year narrative for LCH, key deliverables, and the Board assurance statements for sign off and approval

Previously considered by:	Trust Board 16th December 2025, Quality Committee 26th January 2026, Business Committee 28th January 2026
Outcome of previous discussion/s:	Agreement to proceed to developing final plans for approval and submission to NHS England

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?	Poorer access and outcomes in deprived neighbourhoods hence key focus for MTP on Neighbourhood Health and tackling inequalities
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	• The Board is recommended to approve LCH's Medium Term Plan submission to NHS England

List of Appendices:	Appendix 1 – Medium Term Plan 5 year Strategic Narrative Appendix 2 – Summary of the Wildly Important Goals 26/27 Appendix 3 – Summary of the key deliverables from the plan Appendix 4 – Board Assurance Statements

Medium Term Plan

1 Executive Summary

Leeds Community Healthcare NHS Trust (LCH) sets out our five-year Medium Term Plan (2026–2031) to strengthen community health services, reduce inequalities, and deliver the ambitions of the NHS Ten-Year Health Plan through a neighbourhood-based, digitally enabled, prevention-focused model of care.

At LCH we operate within a diverse and growing city where deprivation, rising multimorbidity, and increasing demand place sustained pressure on services. Our strategy responds by aligning fully with national, regional, and local priorities, including the Leeds Health and Wellbeing Strategy and the West Yorkshire Integrated Care Strategy. Central to the plan is the shift of care closer to home, improved digital capability, and a stronger focus on early intervention.

Our immediate priorities—framed as Wildly Important Goals—include implementing the Neighbourhood Health model, improving our performance against the NHS Oversight Framework, expanding our Quality and Value transformation programme, and preparing for organisational integration with Leeds and York Partnership NHS Foundation Trust (LYPFT). This integration aims to create a single, community-centred provider capable of delivering whole-person care and reducing fragmentation, alongside better value for money.

This plan acknowledges current challenges around waiting times, workforce pressures, and financial constraints but builds on strong foundations in quality governance, financial discipline, and innovative workforce practices. It outlines targeted investments in community capacity, digital infrastructure, and productivity improvements, alongside a commitment to equitable care, robust population health management, and meaningful engagement with service users and staff.

Overall, our plan positions LCH (and the new integrated organisation with LYPFT when it is created in 2027) to lead the delivery of proactive, integrated, neighbourhood-based care that improves outcomes for all Leeds residents and accelerates improvements for those experiencing the greatest disadvantage.

2 Overview and recommendations

As part of the Ten Year Health Plan – Fit for the Future, NHS Providers are required to develop 5 year Medium Term Plans. The development of LCH's Medium Term Plan has been undertaken in collaboration with the Board through the Business and Quality Committee meetings. The plan includes our forecasts for finance, activity, and workforce for the next 3 years, supplemented by a 5 year strategic narrative.

Submissions are due 12th February, and there are caveats in our plan in that:

- Capital bids are yet to be confirmed
- Quality aspects are due to be published in March 2026
- The ICB are yet to confirm arrangements for the transformation monies that will enable left shift and growth in community services.

As a result there will be a chance to refresh plans to accommodate these and other elements where we are still awaiting clarity and information.

Attached with this cover paper:

- Appendix 1 - 5 year strategic narrative
- Appendix 2 - Summary of the 26/27 Wildly Important Goals
- Appendix 3 - Summary of the key deliverables from the plan
- Appendix 4 - Board Assurance Statements

5 Recommendations

The Board is recommended to approve LCH's Medium Term Plan submission to NHS England

Dan Barnett
Associate Director of Strategy, Change, and Improvement
28.01.26

Leeds Community Healthcare NHS Trust

Medium Term Plan

Five Year Strategic Narrative - 2026-2031

Contents

1. Executive Summary

1.1 Executive Summary

Leeds Community Healthcare NHS Trust (LCH) sets out our five-year Medium Term Plan (2026–2031) to strengthen community health services, reduce inequity, and deliver the ambitions of the NHS Ten-Year Health Plan through a neighbourhood-based, digitally enabled, prevention-focused model of care.

At LCH we operate within a diverse and growing city where deprivation, rising multimorbidity, and increasing demand place sustained pressure on services. Our strategy responds by aligning fully with national, regional, and local priorities, including the Leeds Health and Wellbeing Strategy and the West Yorkshire Integrated Care Strategy. Central to the plan is the shift of care closer to home, improved digital capability, and a stronger focus on equitable, earlier intervention.

Our immediate priorities—framed as Wildly Important Goals—include implementing the Neighbourhood Health model, improving our performance against the NHS Oversight Framework, expanding our Quality and Value transformation programme, and preparing for organisational integration with Leeds and York Partnership NHS Foundation Trust (LYPFT). This integration aims to create a single, community-centred provider capable of delivering whole-person care to our diverse populations, and reducing fragmentation, alongside better value for money.

This plan acknowledges current challenges around waiting times, workforce pressures, and financial constraints but builds on strong foundations in quality governance, financial discipline, and innovative workforce practices. It outlines targeted investments in community capacity, digital infrastructure, and productivity improvements, alongside a commitment to equitable care, robust population health management, and meaningful engagement with people and staff.

Overall, our plan positions LCH (and the proposed integrated organisation with LYPFT) to lead the delivery of proactive, integrated, neighbourhood-based care that improves outcomes for all Leeds residents and accelerates improvements for those experiencing the greatest disadvantage.

1.2 Introduction and background

Leeds is a vibrant and diverse city of more than 840,000 people. It is characterised by both a relatively young population and a growing older population living longer with multiple conditions. The city's rich ethnic diversity is concentrated in its most deprived neighbourhoods, bringing significant social and cultural strengths while also requiring health and care services to be culturally competent, inclusive and accessible. Leeds benefits from a mature and collaborative Health and Care Partnership and Anchor Network, with a strong tradition of integrated, place-based working. Together we are united behind the Leeds Ambition: to create a healthy and caring city where the poorest improve their health the fastest.

Within this system, LCH was formed in 2011 to provide community healthcare services for the people of Leeds, delivering care in or close to people's homes. Our vision is to deliver the best possible care in every community.

We are a committed partner as part of the wider system and at place (Leeds) and recognise the importance of retaining the existing strong partnership relationships, values and behaviours we have all collectively worked together to create. As part of the new way of

working, we have across West Yorkshire agreed a set of partnership planning principles which we will all work to.

1.3 Links to national strategy

As a community provider our plan is heavily underpinned by the 10 Year Health Plan – Fit for the Future – and we are well placed to implement the three key shifts:

- Shift care from hospitals to the community
- Shift to digital first, data driven care
- Shift from treating illness to preventing it.

1.4 Links to regional strategy

We are a proactive partner in the West Yorkshire Community Collaborative. The West Yorkshire Integrated Care Strategy is to create 'a healthier more equitable West Yorkshire where everyone can thrive'. This will include strategic focus on improving population health, reducing inequalities, and supporting people with long term conditions through more personalised approaches.

1.5 Links to Place strategy

We collaborated on the development of the Leeds Health and Wellbeing Strategy 2023 to 2030, which has an overarching ambition that Leeds is a 'healthy and caring city for all ages, where people who are the poorest improve their health the fastest'. Within this broad ambition we are a key partner in delivering the Leeds Health and Care Partnership transformation priorities:

- Delivering better care closer to or at home through Home First
- Transformation of community mental health services
- Improving cardiovascular health
- Improve the lives of children with the most complex health needs.

All of this is underpinned by a Neighbourhood Health approach and Leeds is an early implementer through the National Neighbourhood Health Implementation Programme.

1.6 Quality Strategy

LCH's existing Quality Strategy has been factored into the development of this plan. We are aware that a new National Quality Board (NQB) Strategy will be published by March 2026 to guide local action on care quality. The LCH Quality Strategy will be reviewed against this when released. We are also aware that National Care Delivery Standards are expected in March 2026 to ensure consistent, high-quality care seven days a week – again the timescales don't align with the development of this plan but will be updated in future iterations.

1.7. Equity priorities

Our health equity priorities align with the national priorities for the National Health Inequalities Team and includes a commitment to improving Accessible Information Standards, promoting better health literacy in our services, improving interpretation and translation offers, and embedding health equity through our accountability and governance cycles.

1.8 Immediate improvement priorities

LCH's immediate improvement priorities have been signed off by our Board as part of the development of this plan, and they will be a focus for the next 12-18 months. In LCH we call these 'Wildly Important Goals' (WIGs). Prioritising the most impactful shared goals, in the context of a busy day-to-day agenda, ensures that resource and capacity can be directed appropriately for maximum delivery confidence.

1.8.1 Support the rollout of the Neighbourhood Health Model

As a community provider, LCH has a key role in supporting Leeds implement Neighbourhood Health, as part of the National Neighbourhood Health Implementation Programme. For LCH this will include restructuring services and leadership to better align with a neighbourhood health way of working; realigning service boundaries to shared geographic boundaries; identifying estate for Integrated Neighbourhood Health Hubs; supporting the development of multidisciplinary care teams that respond to population need and with a focus on health equity; and growing services that enable the left shift, such as Active Recovery and Urgent Community Response.

Whilst the details of the transformational left shift investments have yet to be agreed across the Leeds System and so are not entirely reflected in our activity and workforce plans, we anticipate being able to build on our existing work to redesign our community neighbourhood workforce and increase our use of inclusive digital solutions to further enable transformation of our services. This will better meet the needs of our population, enabling people to leave hospital sooner or avoid the need for admission or ED attendance.

LCH recently engaged with over 500 community members, through Healthwatch Leeds, to understand their views on how Neighbourhood Health should be implemented. We will ensure that these engagement principles will be central to the development of neighbourhood health models in Leeds.

1.8.2 Drive improvements in our National Oversight Framework position

LCH is currently positioned in segment 4 of the NHS Oversight Framework, which is not where we want to be in terms of what we offer to people and our workforce. Within this WIG, action plans, with clear improvement trajectories, are centred around how we will improve waiting lists, access to services, staff engagement, staff sickness, and our productivity and value for money. Additionally this focus has the potential to improve health equity as there is a higher proportion of people from deprived areas either waiting for services or missing appointments.

1.8.3 Transform our services through our quality and value programme

LCH is part-way through a highly successful cost improvement programme called ‘Quality and Value’, which balances the need for financial sustainability with quality, effectiveness, safety, and equity. To date the programme has ensured that the organisation is able to achieve financial balance recurrently, and provide a surplus to support other Trusts in the system with a deficit. The programme is underpinned by a bottom-up approach with staff, which supports them to design the ideas for more effective and efficient services. This WIG will continue to redesign services that haven’t yet been through the staff led methodology, and will leave a legacy of an embedded culture of continuous quality improvement.

1.8.4 Integrate LCH with Leeds and York Partnership NHS Foundation Trust (LYPFT)

In May 2025 a consultancy called thevaluecircle was commissioned by the Chief Executives within Leeds to complete an external, evidence-based strategic review of the provider

partnership across the Leeds health and care system. As part of this the Boards of LYPFT and LCH have formally approved the development of a strategic outline case for the integration of both organisations. It is the intent to have a strategic outline case submitted to NHS England by March 2026 and subject to approval, become an integrated care provider by March 2027. The first year of our five-year plan is centred around how we are preparing to become one integrated organisation, bringing the best of our different organisational cultures, approaches to the work we do and enabling greater efficiencies to be achieved in the medium-term.

2. Strategic Context

2.1 Context of the organisation:
LCH continues to deliver a wide range of 50+ community-based health service across Leeds and into areas of Yorkshire and Humberside. Stable operational performance is maintained across most of these service areas, underpinned by clear strategic goals.

Leeds Community Healthcare is currently in segment 4 in the NHS Oversight Framework (NOF). This has been driven by comparatively poor performance in relation to patients waiting more than 52 weeks for care, Children and Young People (CYP) accessing mental health care, relative costs, staff sickness and engagement. Significant work is underway to improve in these areas.

2.2 Current performance and key challenges:

2.2.1 Quality and safety
A well embedded approach to Equity and Quality Impact Assessments (EQIAs) ensures that all changes to clinical delivery are assessed and mitigated for their impact. Equity in quality and safety is included in the Patient Safety Incident Response Plan and incidents are analysed with demographic data to identify and address potential inequity in quality and safety. LCH has robust mechanisms for managing risk. Regular achievement of the 95% target for respondents reporting a “Very Good” or “Good” experience in Community Care (FFT). Strong monitoring and management of overdue patient safety incident investigations and improving patient safety training compliance to support this. Quality governance arrangements have been externally audited and confirmed as robust.

2.2.2 Finance
The 10 Year Health Plan presents an exciting opportunity for LCH to make a real difference to the Leeds System, with the availability of community growth funding. To date our ambition has been tempered by the lack of resources and most of the changes that have been possible have been limited in scope and unable to achieve the full impact on supporting system flow and acute capacity we know can be achieved. With the earmarked investment in community services in the first 3-years of the plan, LCH can begin to make sustainable, at scale changes to keep more people out of hospital. It should be noted however, a key risk to achieving our ambition is the Trust’s indicated CDEL allocation, this falls materially short of our operational capital requirements across both estates and digital and at this time it is difficult to see how we can achieve the large-scale strategic investment needed to achieve left shift.

LCH has a strong financial delivery track record having consistently met all its financial statutory requirements since it was established in 2011. This has been predicated on having realistic financial plans supported by robust in-year delivery oversight. This has meant that despite having challenging savings targets in recent years, LCH has been able to breakeven or deliver a surplus, our relentless focus on achieving savings recurrently through ‘Quality and Value’, underpinned by strong clinical and operational engagement means we anticipate exiting the financial year 2025/26 in an underlying break-even position, this represents a

significant improvement in our position post pandemic. LCH has a robust balance sheet and very strong cash position which in recent years has generated additional non-recurrent interest to support in-year pressures.

2.2.3 Workforce

In recent years, innovative approaches to recruitment, such as a Hyper-Local recruitment campaign have received national recognition in how LCH has been able to proactively manage recruitment and retention. Similarly proactive actions to bring down spend on agency and bank have been extremely successful. Ongoing and sustained improvement in appraisal rates and statutory and mandatory training compliance is another achievement.

Engagement scores in the NHS Staff Survey have dipped for the organisation, which can be expected during times of large-scale organisational change such as Quality and Value, but has impacted on LCH's overall NOF rating. A stretch target of 7.2 by 2027 has been set for staff engagement. Areas of focus from the NHS Employers "Dozen Do's" will be used to support leaders to achieve this. Indications from the most recent Staff Survey data is that we have stabilised our staff engagement and people promise scores.

Sickness absence rate has also been relatively high, again impacting on the NOF score. A sickness absence improvement project is progressing across 4 workstreams; guidance and process standardisation, Occupational Health review, Employee Assistance Programme promotion and organisational health diagnostics.

2.2.4 Operational performance

High demand for community nursing, urgent community response, and rehabilitation services continues to stretch capacity within LCH. For example:

- Waits for community services have historically been high but we have developed plans and trajectories where we expect to have no patients waiting more than 52 weeks by summer 2026
- Our performance in relation to Children and Young People (CYP) accessing mental health care we plan to have markedly improved by the end of 2026/27
- LCH is amongst the top providers delivering urgent community responses within 2 hours and has consistently met financial targets for a number of years
- Consistent achievement of waiting time targets for waits for NHS Talking Therapies
- Recently recovered performance and maintained high standards for our 6-week diagnostic waits
- Under performance in relation to consultant-led waiting times, but substantial work to recover this that is beginning to show improving trends
- Reporting on the equity of our waiting times. This is currently highlighting a variance in waiting times for those living in IMD1 vs those living in IMD2-10 and this is being actively managed via improvement in patient communications and support to those missing appointments. Early signs of improvement is already being seen, and this continues to be a focus in work to improve access and accessible information standards.

2.3 Population Health Needs

Despite its energy and assets, Leeds faces profound socioeconomic challenges. Around one in five[1] residents live in neighbourhoods ranked among the most deprived nationally, and this rises to one in four for children and young people. Deprivation, ethnicity, learning disability, and health inclusion continues to shape people's health outcomes, with those living within the most deprived neighbourhoods experiencing major illness a decade earlier than those in more affluent neighbourhoods and are three times more likely to die before the

[1] IMD 2025

age of 70. These inequalities are reflected in higher rates of preventable illness, stalling improvements in life expectancy, and greater barriers to accessing timely, high-quality care.

Mental ill health, long-term conditions and multimorbidity are impacting people living in Leeds, particularly among deprived neighbourhoods, contributing to rising pressure across urgent care, community services and social care. Anxiety and depression are increasingly common, particularly among younger people in deprived communities; nearly a third of children report feeling anxious every day, and one in five has a diagnosed mental health condition. Meanwhile, long-term conditions such as diabetes, cardiovascular disease and chronic respiratory illness are rising, often affecting the same individuals. The prevalence of major illness is projected to increase more than three times faster than the working-age population, with most of this growth concentrated in the most deprived neighbourhoods. These conditions do not occur in isolation: older people experience growing levels of frailty, dementia is more common in Leeds than elsewhere in West Yorkshire, and falls are increasing. Many people now live with multiple conditions at once, creating a level of complexity that places significant pressure on health and care services.

Environmental pressures further compound these health challenges. Air pollution contributes to a notable proportion of deaths in the city, and rising temperatures increases risks for vulnerable groups. Children also face ongoing issues such as obesity, poor dental health and the impacts of family stress and adversity, with nearly a fifth living in households affected by domestic violence, parental mental ill health or substance misuse. Inclusion health groups, such as Gypsy, Traveller, Roma, asylum seekers and refugees, experience considerably worse outcomes than the general population and face additional barriers to accessing care.

Looking ahead to 2030, Leeds will experience sustained growth in demand for health and care, particularly in mental health and long-term conditions. Earlier onset of multimorbidity in deprived communities will increase the proportion of life spent in poor health and intensify pressure on urgent and emergency care, community services and social care. At the same time, workforce shortages, financial constraints and the fragility of the third sector pose ongoing challenges. However, Leeds also benefits from strong assets: a committed system partnership, an engaged third sector, a digitally enabled population health management infrastructure, and strong community assets.

Key considerations for an organisation like LCH, and which is subsequently factored into this plan, and which take into account the population needs includes:

- Reducing health inequalities through targeted community interventions at a neighbourhood level
- Strengthening culturally competent, inclusive approaches to strengthening management of long-term conditions within neighbourhoods to ensure this meets the needs of our diverse communities
- Integrating physical and mental health care, particularly in relation to early interventions
- Prioritising early intervention for children and young people
- Expanding frailty, and rehabilitative offers for older adults.

3. Delivery approach with commissioners and partners

3.1 Approach with commissioners and partners

Leeds benefits from a mature and collaborative Health and Care Partnership, with a strong tradition of integrated, place-based working. Together we are united behind the Leeds Ambition: to create a healthy and caring city where the poorest improve their health the fastest.

A Partnership Leadership Team, made up of the Chief Executive Officers from the Leeds NHS Providers (including the ICB and primary care), Leeds City Council, and the third sector meet monthly to agree and oversee delivery of the transformation goals of the city, and the delivery enablers that underpin success. This includes:

3.1.1 Provider Partnership Review
A recent review of partnership arrangements in Leeds has led to the establishment of a Leeds Provider Partnership Transformation programme. In essence Health and Care organisations in Leeds have agreed to start working towards creating a Joint Committee with responsibility for pooled budgets which will enable true left shift to take place, better meeting the needs of communities and tackling inequalities by being more joined up and person centred. The integration of LCH with LYPFT will be one of the key workstreams from this review.

3.1.2 Neighbourhood focus that underpins everything
Services will be built around populations of around 50,000 people, using the 15 Leeds Local Care Partnerships boundaries as a common geography in the city. Population health intelligence from the Leeds Observatory will be used to target interventions where they will have the biggest impact. Health inequalities data will be used to focus on communities with the poorest outcomes. Virtual multi-disciplinary teams across health, social care, and the third sector will ensure shared care plans, caseload management, and embed rapid response to frailty and rehabilitation pathways. The integration of LCH with LYPFT will ensure better parity in terms of mental and physical health treatment, and combining work to address inequity for people at risk of worse physical and/or mental health outcomes, promoting earlier intervention and better prevention.

3.1.3 Digital and Data Transformation
Citywide digital and data work has made huge inroads into creating the Leeds Health Observatory which now enables the use of comprehensive data, statistics and reports from a number of sources, about health and wellbeing in Leeds. Future focus of the work will be to jointly scope interoperable digital systems to enable real time data sharing between providers. In addition to expansion of remote monitoring and other clinically appropriate interventions. This will be implemented whilst being mindful of digital literacy and access in the community, supported by the Leeds digital inclusion agency, 100% Digital.

3.1.4 Strategic Estates
A strategic estates group from across Leeds Health and Care ensures that strategic estates decisions are joined up and enable a Neighbourhood Health way of working. Current focus includes identifying suitable premises for the Integrated Neighbourhood Health Hubs in each of the 15 Local Care Partnership areas, which can be used for co-located, multidisciplinary care.

3.1.5 Strategic Finance
A strategic group of Finance Directors from across Health and Care in Leeds have responsibility for delivering a multi-year cost-improvement programme focused on productivity, digital optimisation, and reducing duplication. Resources are shifted in real time to help balance budgets at a system level. Plans are being developed to shift resources upstream into prevention and community-based care. There is also a focus on strengthening contract management and value-for-money oversight.

3.1.6 People and culture
Through the Leeds Health and Care Academy system-wide work within this area is focussed on making staff deployment more flexible through contracts and portability agreements between providers that help break down traditional organisational boundaries. This is

underpinned by citywide Organisational Development work to create a Team Leeds culture across providers.

3.1.7 Tackling Health Inequalities
A citywide Tackling Healthcare Inequalities oversight group is chaired by our Executive Medical Director, driving partnership approaches to equity. This includes the development and implementation of a citywide Health Equity Index.

3.2 Evidence base to support delivery outcomes
Our plan is entirely designed to mirror the ambitions of the Ten-Year Health Plan, which has been developed based on an extensive evidence base, including Lord Darzi's review of the NHS, and analysis of the changing demographics and population needs as outlined in section 2.3. For example:

- We will support the move away from annual, centrally driven planning to a 3-5 year place based approach. Within place we will be joined up with our partners to use existing resources to more responsively ad intelligently meet the needs of a growing and aging population
- We will return to pre-pandemic productivity levels, ensuring better value for money. Indeed, improved productivity in community services is shown to reduce long waits and improve health outcomes
- A digitally enabled future is a golden thread throughout the whole of our plan, as the evidence shows that this improves access and efficiency when risks of digital exclusion are also mitigated
- As a community provider one of our main priorities will be to realise left shift and implement neighbourhood care, as the evidence shows this proactive community based approach reduces non elective admissions.

4. Delivery areas

4.1 Quality and operational performance
Focus on Key Performance Indicators (KPIs) as per LCH's developing performance and accountability framework will enable focus on quality and operational performance. KPIs are allocated to the NHS Oversight Framework domains and therefore align well with the national areas of focus.

LCH is forecast to achieve national targets in relation to diagnostic tests, Mental Health Support Team coverage and reliable recovery and improvement for our patients receiving NHS Talking Therapies. Through uplifts for community growth allocations and/or left-shift funding, along with targeted productivity improvements, we will reduce waiting lists and manage demographic growth, and we expect to achieve the national community waiting list targets as well. The capacity our support to the system via our Urgent Community Response and Home Ward services meets local expectations.

LCH forecasts not achieving the national RTT targets for 18 week waits. This is due to long waits for neurodevelopmental assessments; a picture that is reflected nationally. Whilst service changes are being implemented and additional investment considered to improve the position we recognise that the service will require significant transformation to be clinically and financially sustainable.

As per national benchmarking LCH is shown to be more expensive than our peers. Our Quality and Value programme is already looking at how clinical services can be more productive, and next year the focus will be on the biggest outliers. As a small NHS Trust many of our corporate service are also an outlier compared to other Trusts. We have initiated a programme of transformation across each of our corporate serviced and this will

continue into 26/27, however beyond this we will need to look to the Trusts Integration Programme to secure further economies of scale and improved productivity.

At the writing of this plan we are aware that growth monies will be made available to enable left shift. Whilst full activity and workforce related modelling has not yet been possible, due to the timing, part of this plan development has included scoping a number of investment proposals that will support Neighbourhood Health in Leeds. We are looking at opportunities to utilise this funding as pump priming, aligning to the finance and contracting principles of provider partnerships, in a number of areas such as :

- Stroke – early supported discharge
- Community Gynaecology – expanded capacity
- Community Falls – left shift transfer of clinic, and 'dizzy' clinics
- Mental Health and Learning Disability and Autism (LDA) including, development LDA crisis accommodation as an alternative to acute hospital stay and diverting Children and young people in crisis from ED
- Strengthening our Urgent Community response by increasing places on the Home Frailty ward
- Roll out of our Active recovery reablement service with Adult Social Care across more neighbourhoods.

4.2 Adoption of core digital products

The adoption of core digital products will be facilitated through the evolution of functionality within Electronic Patient Record (EPR) systems deployed across our services and will be tailored to each of the clinical / professional groups. For example, the digital competency framework for Allied Professionals will see "products" such as transfers of care, medicines management, decision support tools and orders and results management being delivered by the core EPR product deployed within the Trust.

The adoption of the core digital products will be supported by the development of data standards with information capture at the point of care wherever practical. Important to the success of the adoption of core digital products is the continued investment in culture, training and the awareness of cyber risks.

With the adoption of digital services, clinicians will be able to demonstrate understanding of data management, information governance, data sharing and the ability to use and evaluate data to assist in clinical audit and the service impact for patients whilst using our EPR systems to support electronic transfers of care between services and care settings supporting efficiency, productivity, patient safety, equity, and better data quality for care and planning purposes.

With 100% of our clinical services already using an EPR solution, they are well placed to further increase their use of the core digital products.

5. Workforce

5.1 Strategic People Vision

LCH maintains a consistent golden thread in its strategic People vision: attracting, developing, and keeping the best people, in order to deliver outstanding care to our communities.

LCH's current Workforce Strategy (2021-26) sets out a strong vision with clear themes and deliverables to underpin this vision. It is currently being refreshed to ensure that its successor, the LCH Strategic People Framework, will support delivery of LCH's Medium

Term Plan objectives; together with the delivery of NHS 10 Year Plan requirements and the "three shifts".

The new LCH Strategic People Framework will focus on six themes: Leadership; People Services; Inclusion; Talent; Staff Experience and Organisation Design. These are the vehicles through which the Trust will deliver the skills and workforce required to transform for Neighbourhood Health, talent pipelines, productivity and a reduction in requirement on temporary or international labour. Underpinning themes of Inclusion and Staff Experience will cement LCH and its successor as a local employer of choice. Innovations like the LCH-developed Portability Framework, which enables employees to work across organisational boundaries in partner organisations by mutual agreement, will be key ingredients in the delivery of Neighbourhood Health and the Trust's continued partnership working agenda.

LCH has made good and consistent progress in the past 5 years on critical areas including effective workforce supply and deployment, improved representation and reduced disparity of experience amongst underrepresented groups. Continuous improvement occurs in the reported effectiveness of its leaders and the enhancement of employee health and wellbeing offers. The LCH Strategic People Framework builds on these strong foundations and takes them further with objectives including a focus on supporting leaders to work even more effectively across organisational boundaries; introduction of digital and AI tools to enhance the productivity and user experience of People Services; the provision of additional interventions to services requiring more support to improve inclusion and / or health and wellbeing; and a focus on better leveraging apprenticeships and other talent pipeline opportunities to sustain and retain our required workforce.

5.2 Integration with LYPFT

The Trust Integration Programme will enable LCH to further enhance its People outcomes. A dedicated People and Culture workstream will develop and implement a programme of work to bring the workforce of the two Trusts together, adopting a "best of both" approach and using inclusive, research-based staff engagement methodology. A combination of organisational development expertise and technical, emotionally intelligent HR expertise, working in collaboration with staff and leaders, will ensure that both the cultural codesign and procedural requirements of the new organisation are achieved in readiness for its Day 1.

5.3 Workforce Plan

The workforce numerical return was developed through triangulation with finance, activity and performance plans, using service-level trajectories, national planning assumptions and demand forecasts to model establishment, temporary staffing and productivity requirements. It reflects planned reductions in sickness absence and year-on-year bank and agency usage and incorporates the emerging workforce implications of the 10-Year Health Plan. Productivity improvements are built in to help offset activity growth, and uncertainty around left-shift and System Development Funding has been partially modelled. National policy requirements and system-level priorities have also been considered throughout plan development.

6. Finance

As noted earlier, LCH starts the five-year medium-term period with a strong financial position and an underlying breakeven position; this has been maintained throughout the plan.

Our income plans are aligned with all of our key commissioners. Uplifts for community growth allocations (x% of our WYICS contract income), are included within our plan and along with targeted productivity improvements we have planned for a proportion of this funding (x%) as investment to reduce waiting lists and manage demographic growth; the balance of funding is being held as transformation funding to achieve our collective system

commitment to “Left shift”. As referenced in section 4 the details of the transformational left shift investments have yet to be agreed across the Leeds System and so whilst indicative funding has been included within our financial plans we have not reflected this in the activity and workforce plans.

Our expenditure plans are based on recurrent budgets and so are grounded in operational reality underpinning economic assumptions are consistent with the national planning guidance. As the calculation of the cost uplift factor is weighted towards acute provider pay/non-pay expenditure ratios, by application we continue to incur additional cost pressures in excess national targets, across pay where our workforce reflects x% of our total weighted average costs compared to x% nationally and non-pay, where LCH’s estate composition is weighted towards LIFT buildings where uplifts are fixed at CPI rates. Our plans also recognise an additional cost pressure for drugs inflation which we anticipate being c x%.

In addition our revenue plans allow for some internal investments, predominantly within our digital teams where we recognise the need for enabling capacity through BI and clinical systems to support delivery of the required productivity and efficiency savings. In addition, we have recognised new depreciation charges alongside an historic shortfall on depreciation funding (£1.9m) which our plans assume will be funded from the national reserve.

Mitigation of local costs pressures and inflationary uplifts require delivery of savings targets of c x% over the life of the plan; these planned targets are less than in previous years as a result of the focus on recurrent savings thereby limiting legacy non-recurrent efficiencies. Nevertheless, our plans are stretching but deliverable. In 26/27 we enter year 3 of our 3-year ‘Quality and Value’ transformation programme, many areas have already been working on schemes to deliver the required 2026/27 savings, consistent with previous years we have used the productivity packs to target savings across corporate and support services. Oversight of the delivery of the savings programmes is the responsibility of the ‘Quality and Value Board’, executive SRO accountability sits within defined workstreams including service transformation, digital and corporate and business processes and LCH has a number of steering groups that report into the Board. These sign off each stage of a programme to ensure quality, equity and activity implications are considered before changes are made and then monitor these afterwards. LCH also has a robust approval process for recruitment which enables grip and control of all pay expenditure.

The proposed integration with LYPFT is expected to bring additional opportunities for rationalisation of our infrastructure, details of the benefits are being developed through the business case process and will inform development of detailed delivery plans as we progress through 26/27.

Our capital plans are based on both operational and strategic capital planning priorities. Our internal processes for prioritisation consider strategic fit and delivery confidence however our operational capital limit heavily restricts our ability to invest due to a number of non-nhs lease renewals. Whilst we have secured national capital through the Estates Safety Fund, beyond 26/27, our operational capital is insufficient to meet our operational priorities for both Estates and Digital.

In addition further access to national capital to support strategic developments for digitisation and refurbishment of our health centres will be critical to delivery against our transformation and productivity priorities as set out in section 7 below.

Our cash balances remain strong over the life of the plan, detailed year 1 phasing ensures that operating expenditure days remain high. As part of the planning process we have

stress tested our assumptions and are confident that our cash balances will be sufficient to maintain day to day operations over the next 3 years.

Operational and clinical leadership has been involved in all stages of the development of the details that underpin the high-level plans. This includes review of base budgets, identification of and prioritisation/mitigation of cost pressures, development of investment proposals, agreement of activity targets and delivery of bank and agency targets.

All investment decisions are scrutinised through our existing governance processes to ensure alignment with our strategic goals and value for money.

The financial plan is not without risk, but we will seek to mitigate the risks through maintaining our current approach of continuous capital planning, ensuring we are ready to access funding as it becomes available, improving our data quality and alignment of costs and activity through clinical engagement, and maintaining our robust financial systems and processes that traditionally have enabled us to develop contingency plans when needed.

LCH's five-year financial plan is realistic and demonstrates a sustainable position to underpin ours and wider System ambitions for operational delivery of the NHS 10 Year Plan. It has been developed in collaboration with a wide range of operational and clinical colleagues with oversight from the Trust Leadership Team, Quality and Business Committees and the Trust Board.

7. Transformation and Productivity

7.1 Approach to transformation

LCH's approach to transformation has been designed using learning from past large-scale organisational changes, which has included service reviews and the reset of services after the covid-19 pandemic. LCH's transformation methodology is a QI informed bottom-up approach that puts staff at the centre of change and improvement. It is a 180-day cycle that takes staff through data analysis, ideas generation and design, to implementation. The community voice is crucial to this, and recently LCH engaged with over 500 people, through Healthwatch Leeds, to understand how community services could be better delivered in future, and this is influencing our transformation plans.

A Business, Change, and Improvement Service (BCIS) combines business roles with project roles, quality improvement facilitators, and business analysts to create a multi-faceted team of change agents who can support the organisation's transformation priorities.

Following a review, a simplified project lifecycle is used to manage all transformation projects consistently and robustly. Director led groups will be established for each of our Wildly Important Goals, with oversight from the Senior Leadership Team to manage risks, issues, and interdependencies.

7.2 Transformation priorities over the next 12-18 months

LCH's transformation priorities are one and the same as the WIGs outlined in section 1.6, and in appendix 1.

For the next 12-18 months the focus will be as follows:

Transformation Priority	**Transformation projects included within**
Delivering Quality and Value – cost improvement that is	Service redesigns: • Administration Services

balanced with quality, equity, safety and effectiveness Director Leads: Executive Director of Finance and Resources, Executive Medical Director Governance Group: Quality and Value Board 	• Neighbourhood Teams • Self-management • Children's Fair Days Work • CYPMHS • Leadership in Business Units • Community stroke • Dietetics • Community Gynae, Homeless and Health Inclusion, TB • Chronic Pain, Multifunction rehab service Business development • Mobilise Short Term Community Beds • Prepare for Child Health Information and 0-19 Public Health Integrated nursing tenders • Embed Leeds Mental Wellbeing Service contractual changes • Ongoing implementation of West Yorkshire Community Dental transformation Trustwide enablers • Digital content creation for information hub
Implementing Neighbourhood Health  Director Leads: Executive Director of Operations, Executive Director of Nursing and AHPs Governance Group: TBC	• Active participation in National Neighbourhood Health Implementation Programme • Testing neighbourhood health hubs • Creating virtual multidisciplinary teams • Embed Enhance as BAU • Expansion of neighbourhood clinics model • Expansion of Active Recovery • MSK Pathway Review • 0-19 pilot in East Leeds • Multiple Long Term Conditions including mental health project Trust Wide Enablers • Access to national capital for digitisation and estate refurbishment
Improving NOF score 	Waiting list management • Implementation of digital allocation • Complete roll out of Therapy EPR unit • Strategy to reduce ND backlogs • Working with services to reduce inequalities in access through reducing missed appointments and waiting lists Staff engagement • Targeted action plans for improving staff engagement and sickness

Director Leads: Executive Director of Operations; Director of People Governance Group: Performance Panel	• Develop leadership and management capability • Active engagement with staff networks and trade unions Productivity • Establish productivity group • Data quality improvements to support better PLICS reporting and more robust monitoring • Focus on outlier areas (corporate and clinical services) Trust wide enablers • Embed principles for - Best Place of Care; Patient Initiated Follow Up; Opt in/out; missed appointments •
Integrating LCH and LYPFT  Director Lead: CEO Governance Group: Transition Committee	• Strategic outline case • Full Business Case • Due Diligence for acquisition • TUPE of staff • Shift of assets, contracts, responsibilities • Pathway development and integration • Centralisation of corporate functions

7.3 Productivity

A productivity group will be established to develop data and embed processes that allow effective monitoring and improvement of productivity across LCH. The initial focus will be clinical services and direct costs before developing into wider corporate productivity and activity value in 27/28. The work will mitigate any health equity risks from the beginning by having measures in place for early warning signs of unintended adverse consequences.

7.4 Transformation priorities beyond the next 12-18 months

Beyond the next 12-18 months, and subject to sign off of the Strategic Outline Case, from April 2027 LCH intends to have integrated with LYPFT to create a new health and care organisation. This planned alignment presents a major strategic opportunity. Alignment will enable the delivery of whole-person, community-based care from pre-conception to older age, and end of life care. It will provide access to the same workforce, information, data, records, physical resources and systems reducing the friction and fragmentation that we know our service users can experience due to a lack of integration. This also presents the opportunity to reduce inefficiencies through the duplication of governance and delivery structures, and increase the impact of our equity work.

Over the planning period we will be able to collectively address the shared challenges we individually today face, including reducing long waiting times for children and young people's

community mental health services, reducing admission rates for people with a learning disability and autistic people and optimise our ‘one workforce’ to reduce long waiting times for autism and ADHD assessments across the age range.

Specific transformation priorities will be formed as part of the development of the Full Business Case, and will include centralisation of corporate services for better productivity, and integrated pathway development that enables left shift and equitable approaches to earlier intervention and prevention.

7.5 Coordination of major transformation with partners to enable left shift

The NHS Medium Term plan requires systems to shift care closer to home, strengthen prevention and embed digital transformation, alongside improved access and productivity. Our strategic approach within Leeds is closely aligned with this and offers a credible route to delivery through its established partnership infrastructure, place-based transformation programmes and organisational plans.

Neighbourhood Health is the organising model through which Leeds will deliver both its local ambitions and national expectations. This model represents a shift from reactive, hospital-centric care to a proactive, integrated, community-based approach rooted in the strengths of local people and communities. By bringing together health, social care, public health and voluntary sector partners, Neighbourhood Health enables residents to receive the right care, in the right place, at the right time (often in their homes or within neighbourhood hubs). Multi-disciplinary teams work together around shared populations, supported by digital tools, shared care records, and robust population health management insight that allows earlier identification of risk and more personalised interventions.

As a partnership we will continue to meet the needs of our population by embedding prevention and early identification within our approach, tackling the wider determinants of health and targeting support where it is needed most. Using the Leeds Data Model and population segmentation, teams are able to focus on the groups at highest risk of poor outcomes, particularly within the most deprived neighbourhoods. Community power and partnership with the third sector will help ensure that culturally competent, asset-based approaches remain central to design and delivery. Providers will work collectively to deliver our shared goals, reducing preventable unplanned care and increasing early identification and intervention, thereby contributing to national expectations around improving productivity, stabilising urgent and emergency demand, strengthening primary care access and delivering care more sustainably.

As one of the wave one sites in the National Neighbourhood Health Implementation Programme, Leeds is helping to shape and test the national model for neighbourhood-level delivery. This includes developing scalable approaches to proactive care, new financial flows, joined-up workforce models, neighbourhood-based community diagnostic capacity, and integrated intermediate care. Over the coming years, organisations across the Leeds Health and Care Partnership will work together to embed these developments and ensure they benefit every neighbourhood.

8. Enablers

8.1 Key enablers

Key enablers for the plan, which have been briefly mentioned elsewhere in this document include digital, data, and estates. Whilst each have their own strategic plan, as set out below, our ambition is currently constrained by our capital allocations They are also workstreams within the proposed integration between LCH and LYPFT.

8.2 Digital

LCH has a Digital, Data and Technology Strategy that was approved at Trust Board in December 2024 and runs until March 2027, taking us to the point of integration with LYPFT. A three-year workplan has been developed to support this strategy and this has been reviewed in line with development of the 10-year plan to ensure we are meeting the requirements.

The strategy is designed to deliver the enablers which will support the transformation of clinical services through the adoption of software applications underpinned by a secure, capable underlying infrastructure. It is also crucial that it is inclusive and that our digital ambitions are equitable, not a barrier to healthcare for the most disadvantaged people.

8.2.1 100% EPR Coverage

We are supportive of implementing a single patient record across NHS. Through continued investment in both our own local EPR system and the regional shared care record "Yorkshire and Humber Care Record", partners in other organisations will benefit from the visibility of community care information provided by LCH to support ongoing clinical decision making in care settings beyond Leeds, similarly LCH staff will benefit from access to information delivered in for example secondary care services beyond Leeds. As the development of the Neighbourhood Health Care model continues, the ability to view patient information provided in different care settings becomes a fundamental requirement. As EPRs and associated systems mature, the levels of interoperability will increase allowing for a more seamless "data" experience, with more data being presented and shared between systems and this remains an objective within the LCH Digital Strategy.

We have considered our options for replacing our electronic patient record and have commenced an optimisation programme. Our planned integration with LYPFT creates an exciting opportunity for one EPR across the newly integrated organisation.

8.2.2 NHS App

LCH will continue to support patients accessing information about their care through the adoption of a digital letters solution. Providing patients with the functionality to access important correspondence about their care in a digital manner will not only support convenience, with information being accessible and choice but will support cost savings and contribute to a reduction in our carbon emissions with a reduction in printing and postage and delivery. As the adoption of this technology matures, LCH, through its digital strategy will be seeking to link this technology to the NHS App so the patient can benefit from a more seamless experience when accessing NHS services. As the NHS App increases its "reach" into community services, the Trust Digital Strategy will progressively transfer more functionality to it.

We are implementing an approach around digital communications to empower our patients to self-manage. Using our information hub as the front door for patients to access our services digitally, with a wealth of trusted information available at their fingertips, as well as being able to use accessibility tools making the information more inclusive. There will also be opportunities for patients to interact with services digitally, such as booking appointments, requesting medications and making contact with our services digitally, which will free up capacity on the telephone lines for people who are unable to access services digitally, or choose not to.

8.2.3 Digital Literacy and inclusion

We are collaborating with Leeds City Council's 100% Digital Team, who support our communities with access to digital, sign posting patients to local community hubs and free devices/data when required. We also appreciate we need to bring our workforce along in a similar way and have made a commitment to develop a sustainable training plan to ensure our workforce are fully competent, confident and capable in the use of digital technology in the

workplace. Ensuring that staff have the digital tools that they need to communicate effectively and efficiently with colleagues and patients.

8.2.4 Artificial Intelligence (AI) and Ambient Voice Technology (AVT)
The Trust Digital Strategy contains several schemes to pursue the adoption of both AI and AVT. The Anathem AVT product, a Mental Health Large Language Model is supporting a scoped designed to support tasks within the schools age CYPMHS team, and which will summarise the clinical assessment and subject to validation, be incorporated into the EPR. Acting as a test bed this solution could be expanded to ICAN services (pre-school Neurodiversity pathway) which would see the technology supporting clinicians delivering both pre-school and school age children. The trust has secured funding for the pilot and is currently preparing the governance assurances to launch the pilot.

8.2.5 Electronic Prescription Service (EPS) and Electronic Referral Service (ERS) API's
LCH has deployed this functionality where relevant and within the functionality limitations of the EPR system. Continued deployment of EPS will proceed with further services which prescribe. Current referral pathways have resulted in minimal use of ERS however as these are redesigned, opportunities for exploring further ERS will be taken.

8.2.6 Digital Infrastructure
Continued investment and development of the Trust digital infrastructure will support improved user experience, with a focus on delivering reliable connectivity to support the Neighbourhood models of healthcare with up-to-date connectivity (WIFI 6 802.11ax) which is well suited for the ranges of equipment used by LCH.

Continued investment in cyber defences remains the most important priority to protect patient data and preserve and maintain operational capability. Investments in scanning and patching software as well as penetration tests are vital planned schemes within the MTP timeframe.

8.3 Data
We will continue work to strengthen our Business Intelligence (BI) foundations. We will progress with moving the BI infrastructure to the cloud through 26/27 and 27/28 ensuring that the implementation is a good fit for future organisational plans. We will continue to engage with FDF flowing data as required nationally and will engage with national FDP initiatives to ensure that we are effectively exploiting the opportunities created by it. We will implement our Community Health Services Data Plan that monitors and improves the quality of our national data sets.

We will continue to increase engagement of clinical services with their costing data to drive improvements in cost and data quality, to support a productivity focus. 2026/27 will see the introduction a working group to support services in improving productivity with the aim of achieving the 2% year on year improvements. It will be data driven and data sets and reporting to support the process will be developed through 26/27 and 27/28. Initially this will focus on clinical services, but will widen in 2027/28 to corporate services. The group has the aim of embedding understanding and management of productivity in our performance frameworks.

We will support the organisation to deliver equitable care by implementing the regional Health Equity Index. This is a measure that can be used across the system to assess equity consistently. In 26/27 we will implement the measure in separate reporting on prioritised measure and characteristics. In 2027/28 we will look to embed use of the index across all of our reporting.

8.4 Estates

Development of the Medium Term Plan has aligned with the LCH refreshing its Strategic Estates Plan, which will set out the principles and framework for how we use our estate going forward, including strategic and operational drivers such as neighbourhood health, clinical service integration, increased use of digital and net zero carbon. Recently LCH has been on a journey of estate consolidation and rationalisation over the last 5 years, which has seen closure and ongoing disposal of 2 owned sites, as well as exiting of leased premises. This, along with efficiencies across our operational estates function, have already seen £1.4m of savings achieved over the last 2 years. The emerging Strategic Estates Plan will look at further opportunities to achieve cost savings, through improved utilisation of core and/or strategically located assets and where lease events are occurring across our non-owned estate.

The 2026-31 Strategic Estates Plan will continue to push for greater optimisation of our estate, from our own services, but also those of partners across the NHS, Local Authority and third sector, where there is a need for communities to be supported through a broader service offer. Our capital allocation moving forward is challenging, and will, as stands, not enable us to significantly invest in upgrading and transforming our estate. However, we know through our local knowledge that many of our buildings are situated in communities that experience some of the highest levels of health inequality in the city, and therefore we are committed to aligning use of these assets to support neighbourhood health, whether that be through use as Integrated Neighbourhood Health Hubs, or as part of a broader campus style approach to delivering neighbourhood health. The Leeds Strategic Estates Board is ensuring estates, as a key enabler, is central to the city's development of Neighbourhood Health (including contributing towards work of the National Neighbourhood Health Implementation Programme Pilot) and wider action on tackling health inequalities. Whilst recognising the retained accountability for our own estate, we are committed to delivering against the agreed estate principles of 'one public estate', data transparency, collaboration, and optimising the use of the Leeds pound.

9. Risks and Mitigations

A high level risk analysis has been undertaken in terms of the most strategic risks, and this has been triangulated with our Board Assurance Framework.

High level risk areas	**Mitigating actions**
Capital and financial constraints CDEL allocation insufficient to deliver estates, digital and Neighbourhood Health transformation; inflationary pressures; risk to left-shift investment	Prioritise capital to safety-critical and transformation-critical schemes. Strengthen system-level capital planning, and growth planning. Continue Quality & Value programme to release recurrent savings
Workforce capacity and wellbeing High sickness absence, lower engagement scores, recruitment challenges, and workforce transformation demands	Implement sickness improvement programme. Deliver refreshed Strategic People Framework. Strengthen leadership development and cross-organisational deployment
NHS Oversight Framework performance Current segment 4 position driven by long waits, CYP access, sickness, and cost metrics	Deliver targeted improvement trajectories. Enhance productivity through Quality & Value. Strengthen performance and accountability framework

Long waits and operational pressures High demand for community nursing, UCR, rehab; long waits for ND assessments; variation in waits by deprivation	Increase capacity through left-shift investment. Implement redesigned ND pathway. Use population health data to target support for IMD1 communities. Expand Active Recovery and UCR capacity
Integration with LYPFT Cultural alignment, governance, workforce harmonisation, and service continuity risks during integration	Dedicated Integration Programme with People and Culture workstream. Co-design organisational culture with staff. Clear governance roadmap and risk controls. Maintain service quality monitoring throughout transition.
Digital and data Limited capital for digital upgrades; interoperability challenges; digital literacy gaps; cyber security threats.	Prioritise EPR optimisation and core digital products. Strengthen data standards and IG training. Work with Leeds Digital Inclusion partners. Maintain investment in cyber security and resilience
Estates Limited capital may delay development of Neighbourhood Health Hubs; exposure to LIFT building cost inflation	Use Strategic Estates Group to identify shared solutions. Explore co-location and flexible use of existing estate. Review LIFT utilisation and renegotiate where possible
Rising demand and population health pressures Growth in multimorbidity, mental ill health, frailty, and complex needs, especially in deprived communities.	Expand frailty, rehab, and early intervention services. Strengthen neighbourhood MDTs. Use Leeds Observatory data to target interventions. Work with third sector partners to support high-need groups
Inequalities and access risks Risk of widening inequalities, especially digital exclusion and longer waits for IMD1 communities.	Embed EQIAs in all service changes. Targeted outreach and communication for deprived communities. Ensure digital alternatives remain available
System-wide dependencies Delivery of left shift and neighbourhood model depends on alignment across Leeds system partners.	Active participation in Provider Partnership and Joint Committee development. Shared planning principles and pooled budgets. Real-time resource shifting through Strategic Finance Group.

10. Monitoring and Reporting

Following a ‘Well-Led’ review in late 2024, LCH engaged Audit Yorkshire to review performance processes and frameworks in the organisation. Implementation of the recommendations has started and will extend into 2026/27. These span 3 areas: a new integrated performance report, a KPI library and a performance and accountability framework. These areas are interdependent and synergistic. They will streamline existing processes bringing together the operational performance processes and board level reporting and enabling a focus on data quality. Using SPC methodology these products will provide assurance to our Committees and Board by enabling reporting on what matters and ensuring that processes are in place to examine all areas requiring attention.

11. Supplementary Information

11.1 Service user engagement

As part of our preparation for delivering a neighbourhood health way of working in the community, in 2025 LCH commissioned Healthwatch Leeds to undertake a desktop review of existing intelligence about what people want from community-based services. In addition to talking to people's whose voices we hear less frequently. In total over 500 people were engaged with about the future of community services. This feedback has been factored into the development of this plan.

What people told us about Neighbourhood Health:

- GPs are still prized as a source of health support, even though they can be hard to access
- Most people we spoke to weren't regular users of community venues but would be open to using them for appointments
- Not everyone is interested in using online services, but many are. There's an unmet need for online services that let people keep the NHS up to date about their health
- People's motivation to take action that will protect their health is complex and varies by age, gender and more.

People's thoughts about Neighbourhood Health were often different depending on their circumstances. For example:

- People living in the greatest poverty tended to use fewer health services, despite being more likely to have a disability or long-term condition
- People who had difficulties getting out of the house were much less likely to be open to going to public spaces like libraries or community centres for health appointments
- Older people used the internet in smaller numbers compared with working-age people and were less interested in getting online
- Working-age people worry more than older people about how their lifestyle impacts their health, particularly when they're aged 46 to 55
- People from diverse communities were more likely than other communities to be unsure about whether they would be comfortable having health appointments in venues like libraries
- Unpaid carers were generally open to the idea of using community venues for health appointments.

Looking at all the feedback people have given us over the past several years. This has given us eight principles that any Neighbourhood Health service should follow. Good community services are:

- Shaped by the Three Cs: communication, compassion, coordination
- Timely
- Available to anyone who needs them
- Geared up for complexity
- Understanding of the role of the unpaid carer
- Sensitive to people's comfort with digital technology
- Understanding of how other public services contribute to health and wellbeing
- Compliant with the Accessible Information Standard
- Equity and Quality Impact Assessments
- Detailed modelling that supports pathway / service redesign.

Building on the recent engagement undertaken with Healthwatch Leeds, a structured and ongoing approach to service user engagement will be maintained to inform the future delivery of community services. The Healthwatch Engagement Action Plan will be overseen through LCH's Quality Assurance and Improvement Group (QAIG), providing a clear

governance route for coordinating engagement activity, tracking themes and ensuring actions are taken forward. A refreshed working group with defined membership and chair will be established to lead delivery, maintain regular dialogue with service users and representative organisations, and agree proportionate engagement methods as services evolve. Feedback received will be systematically reviewed, translated into service actions where appropriate, and reported through QAIG, with clear “you said, we did” feedback shared via agreed channels, including Healthwatch, to demonstrate how service user views have influenced decision-making and service development.

11.2 Staff Engagement

Between February 2024 and September 2025 a range of staff engagement activities have taken place within LCH with over 800 staff, again around the topic of the future of community health services. This has also been analysed in light of the Ten Year Health Plan and the three shifts, and has been used to develop this plan. In summary staff told us:

Hospital to community:

- The community service offer needs better visibility by showcasing what we do, ensuring there is parity across providers, underpinned by appropriate investment (that is sustainable and viable for the long term)
- Care should be developed around the person in an integrated, accessible, and holistic way – partnership working should be an enabler to this not a barrier
- Care can be fragmented and needs better integration and coordination across community sectors, particularly in areas of deprivation.

Analogue to digital:

- Digital innovations will play a critical role in the future but this shouldn’t come at the cost of compassionate, human care, and we need to get the basics right in terms of digital literacy, hardware and the things that we already have in place
- New digital offers should be co-produced with staff and service users
- Digital developments to prioritise include – single care record, apps for self management, remote consultation, AI automation.

Treatment to prevention:

- All care should be grounded in safety, prevention, and equity
- Prevention needs to be a long-term approach, underpinned by funding, and focussed on the wider determinants of health
- Prevention should start at a young age with early education and stronger mental health services in childhood.

11.3 Health Equity and EQIAs

Tackling health equity in all that we do is a strategic goal for the organisation in that this is a golden thread through all of our work as an NHS Trust, and not one off, siloed pieces of work. The lead for Health Equity is our Executive Medical Director, and the strategic plan is overseen by a cross-organisation leadership group, supported by our Health Equity Team.

To demonstrate our commitment to the Leeds ambition for helping the poorest improve their health the fastest, LCH has recently developed a 5 year tactical plan for addressing health inequalities, and which has been created in light of the NHS England Statement on Information for Health Inequalities for Boards and performance to increase transparency and accountability for addressing health inequalities. The plan includes a focus on:

- Strengthening governance and accountability for health equity
- Embedding health equity into all plans and strategies
- Expanding the capacity and capability of the organisation to take action on health equity

- Strengthening health equity data from collection to use in decision making
- Using the voice and influence of people
- Embedding equity into the heart of all decision making
- Working with people to reduce inequalities in access through reducing missed appointments and waiting lists
- Tackle known inequities faced by specific population groups
- Exploring prevention as a route to tackle inequity.

EQIAs are one mechanism for how we assess the impact of any changes we make to our services, in terms of equity and quality, but they are not the only way. Within LCH we have a well embedded EQIA process, as part of our change lifecycle, and EQIAs are started very early on in the change process and are constantly reviewed and kept up to date. The changes being brought about through our Medium Term Plan will be no exception.

12. Conclusion and summary

Leeds faces a complex and evolving health landscape, with clear challenges around deprivation, diversity and rising multimorbidity. But it also has significant strengths including a strong partnership, deep community roots, a clear shared ambition and a track record for innovation. By aligning fully with the NHS Medium Term Plan and delivering through our Neighbourhood Health model, we are in a strong position to move from reactive to proactive, from hospital-focussed to community-centred, and from fragmented to integrated care. This strategic direction, underpinned by the Leeds Ambition and delivered through Neighbourhood Health, will enable the city to move towards a more resilient, equitable and compassionate health and care system with improved outcomes for all and accelerates improvements for those who need it most.

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2026/2027

Our vision

We provide the best possible care to every community we serve.

Strategic goals

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

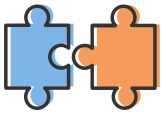
Wildly Important Goals (WIGS)

Support rollout of the **Neighbourhood Health Model** across the Leeds system including active participation in the National Neighbourhood Health Implementation Programme.

Drive improvements in our **National Oversight Framework** position through staff engage-ment, reducing waiting lists, minimising sickness absence, and boosting productivity.

Transform our services through Year 3 of the **Quality and Value programme** to deliver more effective, equitable, and financially balanced patient care and embed continuous quality improvement as standard practice through a QI-enabling plan.

Oversee and implement the **integration of LYPFT and LCH** to improve patient care delivery and optimise resources.



Outcome measures

Neighbourhood

Integrated neighbourhood/place based care

Increased use of population health data and digital tools

Leeds System NNHIP measures

Missed appointments

Patient facing activity

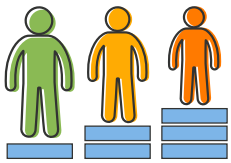
Contacts per WTE

Productivity

Workforce

Financial

Equity

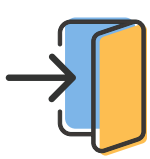


Productivity

Quality

Workforce

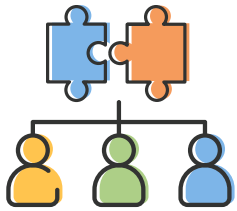
Access

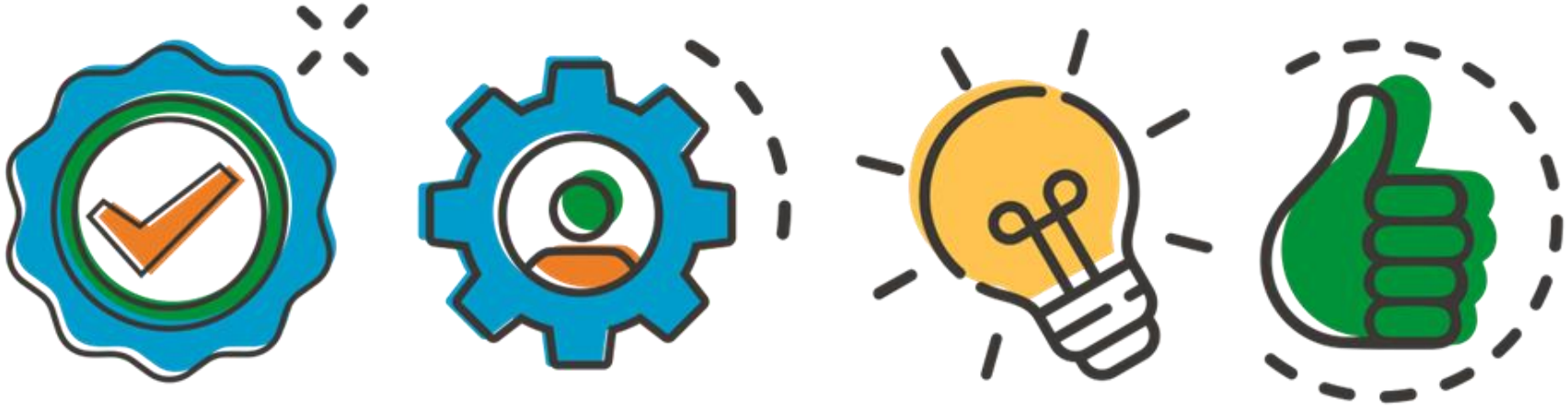


Option agreed

Project plan in place

Joint CEO





Medium Term Planning 2026/27 - 2028/29
High Level Key Deliverables Submission

Medium Term Plan – Key Deliverables Summary (1)

Finance & Productivity

- Balanced or Surplus Plan ✓ Balanced plan y.o.y
- Work towards dismantling of block contracts –impact of the exercise not yet implemented for MH & Community sector, work to improve data quality in place. Income plans are aligned to key commissioners
- Continue to identify and act on all opportunities for increasing productivity achieving 2% minimum each year- c3% efficiency plans , productivity metrics informing targets
- Capital Plans aligned with notified allocations – Plans reflect the notified allocation but significant challenge in that the current allocation falls short of our ambition

Performance

- Increase capacity to meet 3% growth in demand. Activity plans based on service trajectories assume +1.8% productivity , additional investment will create additional capacity overall growth
- RTT waiting time achieve national targets for % of patients waiting less than 18 weeks for Consultant led services 92% by 28/29- This is an ICB measure - as PND service contributes to the measure our plan currently does not assume compliance with national targets
- Actively manage long waits for community health services, reducing the proportion of waits over 18 weeks and developing a plan to eliminate all 52-week waits – This is an ICB measure – plan assumes will achieve compliance in year
- Community Waiting Times – By 26/27 at least 78% of community health service activity occurring within 18 weeks rising to at least 80% by 28/29 - This is an ICB measure , we expect to meet targets with growth funding
- There is a national target to achieve 0 children and young people waiting more than 104 weeks for mental health care by the end of 2026/27. Current projection show we will not achieve this target due to challenges with ND waiting times

Workforce

- Continue to reduce sickness absence (to 4.1%) Sickness absence above target, reduction plan aligned to NOF sector 3 benchmark in progress.
- Continue to reduce bank & agency usage (zero agency by 29/30, 7.5% year on year bank reduction) Plan is compliant with Bank & Agency Targets

❖Expect to be compliant with all non quantifiable metrics including :

- Implement the reformed Statutory/ Mandatory training framework
- Using NHS Staff Survey 25/26: Planned approach to Staff Survey action planning approved; results disseminated for services to commence work internally prior to lifting of external results embargo.
- Identify at least 3 areas where data shows the greatest staff dissatisfaction, alongside developing detailed action plans for in year resolution
- Calling out all forms of discrimination, and tackle sexual misconduct in line with Sexual Safety Charter
- Management and Leadership Framework – embed into recruitment and appraisal processes, includes all roles self assessing and undertaking 360 feedback
- Leadership and management offers – take part in national leadership programme offers, and College of Executive Clinical Leadership online modules

Medium Term Plan – Key Deliverables Summary (2)

Mental Health

- Expand coverage of mental health support teams in schools and colleges by 26/27 - 77% coverage of schools and pupils / learners reaching 100% by 2029 - Plan meets expectations
- Use ring-fenced funding to support the delivery of effective courses of treatment within NHS Talking Therapies - development of business case ongoing – Compliant with operational planning targets , currently scoping opportunity to go further using ringfenced funding
  - 26/27 - 51% reliable recovery rate and 69% reliable improvement rate
  - 28/29 - 53% reliable recovery rate and 71% reliable improvement rate
- Reduce longest waits for CYP community mental health services by improving productivity, and reducing local inequalities and unwarranted variation in access - Investment opportunities under review , without that funding no improvement in waiting times for these CYPs will be seen therefore a static waiting list size has been forecast
- Reform of SEND

Digital

- 95% of appointments after triage available via NHS app
- 28/29 greater use of digital to self-manage e.g. medicines
- Implementation of core national products e.g. ambient voice tech, NHS notify & AI

❖ Delivery of digital ambitions likely to be dependant upon receipt of additional capital

Quality

- Implement and embed PSIRF, modern service frameworks and national care delivery standards . Awaiting publication of key documents
- Use the new NQB quality strategy to guide local action to improve quality of care in highest priority areas Awaiting publication of key documents
- Demonstrate how we will reduce health inequalities in exercise of functions – Continuous area of focus supported by Trust key elements including EQIA process, inclusion of equity measures in strategies , plans and reporting
- Undertake local process and workflow engineering to support use of digital systems and remove duplicate paper based processes

Appendix Four – Board Assurance Statements

Ref	Updates since first submission	Category / Area For Assurance	Statement	Proposed final submission responses
1	No change	Foundational activities	The board has reviewed the outputs from the foundational work undertaken as part of phase one of planning. This includes reviewing demand and capacity analysis.	1. Embedded
2	Updated	Governance and leadership	The board can confirm strong clinical leadership has been involved in the development of plans.	1. Embedded
3	Updated		The board can confirm that plans reflect the consideration of population needs, underserved communities and inequalities when developing plans.	1. Embedded
4	Updated		Robust quality and equality impact assessments (QEIA) have been undertaken and reviewed by the board to inform the sign off of the organisation's plan.	2. Maturing
5	Updated		The board has played an active role in setting direction, reviewing drafts, and constructively challenging assumptions – rather than simply endorsing the final version of the plan.	1. Embedded
6	No change		The board is confident that there is a data-driven and clinically-led continuous improvement approach in place. The organisation has a systematic approach to building improvement capacity and capability.	2. Maturing
7	No change		The board confirms that the organisation has established structures to work effectively with commissioners and system partners, ensuring that system working is constructive and efficient.	1. Embedded [Full Assurance]
8	No change	Plan development	The board can confirm that the plan is evidence-based, robust and deliverable. The board is content that the phasing of the plan across three years is realistic.	1. Embedded
9	No change		The board can confirm that plans have been triangulated across finance, workforce and performance, ensuring each element of the plan reinforces the others, making the plan internally consistent.	1. Embedded
10	Updated	Productivity	The Board can confirm that the organisation has fully considered and incorporated productivity opportunities into plans, and that any phasing is credible and realistic. The board can provide justification where any identified opportunities cannot be fully delivered during this planning round, especially in the context of decisions to submit	2. Maturing

			non-compliant financial or performance plans or plans that do not deliver the 2% productity improvement.	
11	No change	Risk	The board can confirm that the organisation has a robust approach to risk management in place including the ability to demonstrate a comprehensive understanding of financial risk and an agreed approach to managing and mitigating risks in year.	1. Embedded
12	Updated	NHS standard contract & commissioning	The board can confirm that that the organisation has engaged with its ICB to ensure contract values used in planning submissions are agreed across (commissioner and provider) activity and financial plans.	1. Embedded
13	No change		The board can confirm that there is an effective process in place to manage the sign-off of contracts.	1. Embedded
14	No change		The board can confirm that there is a timetable in place to ensure that the board will be updated on the sign-off of contracts and any delays to signing contracts will be reviewed by the board.	1. Embedded
15	Updated	Workforce	The board can confirm the impact of the 10 Year Health Plan on the workforce has been considered in plans. This includes the impact of productivity gains and how staff are deployed including the three shifts - from hospital to community, from analogue to digital, from sickness to prevention.	2. Maturing
16	~~No change~~	~~Ambulance trusts only~~	~~The board, supported by the lead ambulance commissioner, can confirm that there is alignment of hospital handover trajectories in both ambulance and acute trust plans within their footprint.~~	~~N/A~~
17	New	Plan development	The board can confirm that the organisation has worked with its ICB to ensure their plans are fully aligned.	(new statement) 1. Embedded
18	New		The board can confirm plans have been developed in line with the ambition to move care from hospital to community and this shift is evident in plan returns and the integrated delivery plan.	(new statement) 2. Maturing
19	New		The board can confirm that the five year integrated delivery plan is fully aligned with the numerical returns.	(new statement) 1. Embedded

Agenda item:	2025-26 (8i)
Title of report:	People Headlines and Strategy Update
Meeting:	Trust Board Held in Public
Date:	5 February 2026

Presented by:	Laura Smith / Jenny Allen, Director of Workforce
Prepared by:	Laura Smith / Jenny Allen, Director of Workforce Ann Hobson, Transformation Lead

Purpose of the report:		
This paper is a standing item providing information on key headlines linked to the LCH People Directorate portfolio. It is reviewed and discussed at the People & Culture Committee prior to coming to Trust Board.	Approval	
	Discussion	
	Assurance	x

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives		**Acceptable assurance** General level of confidence in delivery of existing objectives	x	**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:

Headline Areas covered in this edition of the report include:

- People Strategic Plan progress
- Staff Survey
- Mutually agreed Resignation Scheme (MARS) Update
- NHS Action on Anti-Semitism, hatred and discrimination
- Leadership of Networks and Staff Side

The paper also provides an update on the progress made against LCH Workforce Strategy (2021-2026) outcome measures to date.

These headlines deliberately do not include the important topics of the **NOF Staff Sickness Absence Project**; the **NOF Staff Engagement Project** which are covered under the NOF item on this month's Board agenda.

The December People & Culture Committee additionally received a separate paper on **Staff Safety and Support**, from which a brief summary has been added to this Board paper

Previously considered by:	People and Culture Committee 11 December 2026
Outcome of previous discussion/s:	

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	x	Why not/what future plans are there to include this information?	Paper is workforce-focused. It includes EDI data and considerations

Recommendation(s)	It is recommended that the Board • Notes the Workforce Headlines presented in this report • Notes that in March 2026 a summary report from the LCH Workforce Strategy 2021-26; and a final draft of the new LCH People Strategic Plan will be presented to the People & Culture Committee • Notes the People & Culture Committee's support of the Trust's adoption of the IHRA definition of antisemitism and the actions to reaffirm and cement the Trust's stance against all forms of hatred and discrimination. • Notes the position and progress in relation to the target measures set out in the current LCH Workforce Strategy.

List of Appendices:	Appendix 1: 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:

- People Strategic Plan progress
- Staff Survey
- Mutually agreed Resignation Scheme (MARS) Update
- NHS Action on Anti-Semitism, hatred and discrimination
- Leadership of Networks and Staff Side
- Staff Safety and Support *(summary added for Trust Board version of this paper)*

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

These headlines deliberately do not include the important topics of the **NOF Staff Sickness Absence Project**; the **NOF Staff Engagement Project** which are covered under the NOF item on this month's Board agenda.

2. People & Culture Headlines

2.1 People Strategic Plan progress

At September's People & Culture Committee and the subsequent Trust Board meeting, an initial skeleton of LCH's new People Strategic Plan was shared.

The People Strategic Plan continues to be developed in parallel with LCH's Medium Term Plan, for which it will be an enabler. It will set out high level People intentions for LCH, to align with the NHS 10 Year Plan and its associated Workforce Plan.

It will align with local strategic intentions including recent Board decision-making associated with the Leeds Place Provider Review.

It is anticipated that LCH Strategic Plan will be concise and high level, with flexibility to respond to emerging priorities

It is proposed that March's People & Culture Committee receives a closedown summary from the 2021-2026 LCH Workforce Strategy for consideration, together with a final draft of the People Strategic Plan for their approval, which will incorporate the themes already approved by the Committee plus any additional that have since emerged.

2.2 Staff Survey

The 2025 NHS Staff Survey opened in early October and closed on Friday 28 November 2025. Response levels close to 55% mean that LCH can expect a valid and useful set of results.

Results were received by Trusts towards the end of December.

Whilst results are embargoed until March 2026, analysis of results and initial thinking about action planning began as soon as results are received and are in live discussion within the organisation.

2.3 Mutually Agreed Resignation Scheme (MARS)

The approved MARS scheme has now concluded, with 41 employees in total mutually agreeing their departures with the Trust. Agreements were formalised and signed by the end of October 2025.

The total cost of the departures falls within the financial envelope approved by the Trust Board.

The final day of LCH service for the majority of MARS leavers was 12 January 2026. A very small number have formally mutually agreed a final day of service of 31 March 2026.

The Nominations & Remuneration Committee received a formal report on the MARS scheme in its December meeting.

2.4 NHS Action on Anti-Semitism, hatred and discrimination

In response to NHS England's letter dated 16 October 2025 requesting action on racism including antisemitism, it was recommended that the Trust adopts the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and reaffirmed its stance against all forms of hatred and discrimination.

In short, the IHRA definition of antisemitism is as follows; whilst the link in the paragraph above provides examples:

"Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities."

With support from the People & Culture Committee, communication of the adoption of this definition has now occurred, and work will be initiated to review uniform and workwear guidance to ensure alignment with NHS best practice and ensure to ensure completion of updated national EDI training once released.

These actions help to demonstrate the Trust's commitment to equality, inclusion, and patient safety, while mitigating reputational and compliance risks.

2.5 Leadership of Networks & Staff Side

Staff Side's current chair stepped down in January 2026 in order to concentrate on a new substantive role following her success in securing a promotion at LCH.

Expressions of interest have been sought for a replacement. A number of suggestions are under consideration to ensure that the LCH maintains its longstanding history of constructive and effective formal partnership with Trade Union colleagues.

Staff Networks continue to experience some changes in leadership:

- The acting chair of the Pride Network recently stepped down to concentrate on clinical duties. Strong leadership and presence remains in the Network amongst its other officers, one of whom is presenting the Staff Network spotlight item in December's People & Culture Committee
- The leadership positions of the Disability & Long Term Conditions Network remain unfilled at present and a number of options are being explored .
- The leadership tenure of the REN chair and vice chair will come to an end by the end of June 2026 and work has commenced to identify successors.

2.6 Staff Safety & Support

As the Board is aware, a rise in racist incidents in the UK during Q2 created concern across the Trust and some instances of racist behaviour towards staff, by patients and/or carers, were reported.

The informal reporting of staff feeling vulnerable has reduced since October; and the number of Datix incidents reported remain relatively consistent. Some positive reports have been received about action taken in response to concerns.

The Trust has implemented a range of engagement and actions focused on the safety and support of staff. These are ongoing and have included direct engagement with staff across a number of Open Space sessions, with additional targeted sessions taking place with staff in particular services and locations across the city.

To ensure embedding and ongoing monitoring of the actions; they have been adopted into the Trust's overarching Inclusion Action Plan, which includes actions on all of the High Impact Actions associated with ED&I.

3. Workforce Strategy Delivery Progress – December 2025

The dashboard at ***Appendix 1*** 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.

A notable exception to this is the Sickness Absence target where as the Committee is aware, sickness absence is currently at NOF Segment 4 levels, albeit with clear plans in place for improvement.

The majority of targets remain on track and RAG-rated green or blue; with most targets now either achieved or superseded. Of particular note is the recent achievement of the 14.5% representation target for global majority representation in the Trust's workforce.

4. Conclusion

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

5. Recommendations:

It is recommended that the Board

- Notes the Workforce Headlines presented in this report
- Notes that in March 2026 a summary report from the LCH Workforce Strategy 2021-26; and a final draft of the new LCH People Strategic Plan will be presented to the People & Culture Committee
- Notes the People & Culture Committee's support of the Trust's adoption of the IHRA definition of antisemitism and the actions to reaffirm and cement the Trust's stance against all forms of hatred and discrimination.
- Notes the position and progress in relation to the target measures set out in the current LCH Workforce Strategy.

Laura Smith / Jenny Allen; and Ann Hobson

Director of People; and Transformation Lead

3 December 2025 / updated 28 January 2026

Appendix 1: 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% Update Dec 2025 Master Vendor Agreement: Work continues with the NOECPC towards moving to a master vendor model as part of the Yorkshire & Humber Community & Mental Health Cluster, thus controlling agency costs more effectively. DataHub: We are building a manager's dashboard for bank and agency data, including fill rates across teams and professions. This greater visibility of temporary staff usage will support more effective management of costs.	**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 Update Dec 2025 3rd Year Students Recruitment: The Temporary Staff Bank team have launched a dedicated recruitment initiative aimed at bringing 3rd-year student nurses into Band 3 Healthcare Assistant roles. This campaign has focused on giving student nurses structured, flexible opportunities within our Adult Neighbourhood Teams and Wound Clinics, supported by a full induction and clinical skills training programme. As a result, we have successfully strengthened the pipeline of new bank	**Completed**		Hybrid Working is fully embedded, supporting and informing the design and delivery of LCH approaches to Estates, Sustainability and Digital	**Completed**

	workers, expanding the capacity available to services while offering students valuable community nursing experience.				
	Recruitment Service offer is clearly specified, with associated KPIs regularly monitored and achieved Update Dec 2025 Service catalogue and description in place. Recruitment dashboard has been created and published, allowing better visibility of recruitment data. KPIs for the team have now been identified and are reported against in monthly service reviews.	**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 – Superseded as Quarterly Pulse survey does not ask those questions now and only reportable annually from the Staff Survey results. Update Dec 2025 We have run Two 'Leading yourself and your team through change' sessions (23 people) since Sept, with further one planned for Feb and a waiting list. The Staff Survey closed on 28 November, and we're looking forward to seeing the results before Christmas. Once received, we will work closely with teams that show the greatest need, using insights from the survey alongside other People data to provide targeted support where it matters most.	**Superseded**	**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 Update Dec 2025 Our People Operations team has worked hard to improve the accuracy and completeness of data within ESR, boosting performance to just short of the 14.5% target Key actions include: Fixing a critical configuration issue in the recruitment system that previously impacted ethnicity data. Proactive engagement with staff who haven't declared their ethnicity in ESR (excluding those who selected 'prefer not to say') With this process in place, we expect performance levels to stabilise	**On target**
	New managers have attended an LCH Leadership Essentials module, or provided evidence of recent equivalent training with a previous employer LEAD Programme Update Dec 2025 Mary Seacole Programme We are excited to announce a new partnership with LYPFT, BDCT, and SYPFT to deliver the Mary Seacole Programme in-house. This 18-month contract means we can use our allocated places as targeted interventions.	**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 Update Dec 2025 Bespoke work continues to be undertaken such as Interviewing support and techniques with the REN group	**In progress**

	Our first joint cohort is scheduled for February 2026, supported by three newly trained facilitators: Aarti Vyas-Brannick, Richard Worklock, and Hannah Beal. Leadership Apprenticeships Planning is underway for new Leadership Apprenticeship cohorts at Levels 3, 5, and 6. We will host staff drop-in sessions in December, with new cohorts expected to launch mid-2026. Competency Framework We have started engaging managers on the first draft of our Management Competency Framework, while keeping a close eye on developments around the emerging national framework to ensure alignment. Our priority for the last quarter of 25/26, is to develop manager training around key HR modules, starting with sickness absence management, a critical area linked to the National Oversight Framework.				
	Executive Team performance in Committee and Board settings reviewed by external audit partner, informing Well Led action planning and individual development plans	**Completed**		Staff Survey results evidence reduction of at least 50% in the gap in discrimination experience of disabled and BAME respondents, with aspirations towards complete closure of the gap. Whilst the overall trend for BME staff has shown a narrowing of the disparity gap, for staff with a disability, the disparity gap remains (Based on WRES and WDES staff survey results 2019-2024)	**Improving**
	LCH talent management programme cohorts are at least representative of the diversity of the LCH workforce, with underrepresented groups specifically targeted for opportunities to develop their career. Focus for 2025/26 - targeting existing development offers	**Completed**		100% of new starters and middle managers have been offered training in LCH's approach to Inclusion via the LCH Leadership Essentials course. Now focused on LEAD programme, and Skills Boosters, targeted to services going through organisational change; and 25/26 focus additionally on where areas of need are identified and New Manager Induction Update Dec 2025 Staff Networks & Allyship We have launched the first iteration of our Allyship Campaign, and we will continue to evaluate and improve as we progress.	**Superseded**

				Staff have been invited to help shape inclusion at LCH. On 16 December, we're bringing colleagues together for an open conversation about inclusion and belonging. Our focus is to build an EDI Forum that truly represents and amplifies staff voices, and we'll report back to PCC on the outcomes.	
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. Update Dec 2025 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. Update Dec 2025 Sickness absence is at NOF segment 4 levels, with a focused project in place to improve the position. Based on detailed forecasting, whilst some progress has been made on S/A/D absence, the overall 5% target is unlikely to be achievable as the annual average sickness rate for 2025. The EAP contract has been renewed for a further year, which provides a range of health and wellbeing support staff can access, including up to 6 x counselling sessions. On-going promotion of this staff benefit continues.	**Unlikely to achieve target by 31 March 2026**		The GP Confederation has a full suite of pay, terms & conditions protocols	**On track**
	Long term sickness absence rates return to target levels of <3.5%, with a stretch target of 3% Update Dec 2025 The Sickness Absence Improvement Project (NoF) continues under four workstreams: policy/process, Occupational Health, EAP, and organisational health. Qualitative and quantitative data from the NOF Sickness Absence project is now enabling more specific identification and analysis of factors affecting the episodes and frequency of absence in individual teams. Managers are being supported with tailored sickness absence training and additional support on complex cases.	**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. Update Dec 2025 We are preparing a bid to the NHS Charities Together Transformation Grant to support *Healthy Teams, Healthy Care* a coordinated wellbeing programme that brings our existing wellbeing roles into a single, supported	**In progress**		LCH staff join ICP and ICS colleagues in undertaking collaborative and system leadership training opportunities	**Completed**

	Advocate network (previously known as Health and Wellbeing Champions and Mental Health First Aiders). If successful, it will strengthen early intervention, improve staff support, and embed wellbeing more clearly into Business Unit and Trust-level governance CrISSP continues to be fairly busy with themes around untoward deaths, adult and child safeguarding impact, work related stressors and individual issues including related to racial discrimination in current climate. New CrISSP debriefer training this week, recruited via REN to ensure diversity and representation.				
	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 Update Dec 2025 Service catalogues and descriptions in place for all teams (People Systems, Service Analysis, Temporary Staffing Bank, Data, and People Partnering). KPIs for all People Services teams have now been identified and are reported against in monthly service reviews.	**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**			

Updates for Dec 2025 shown in purple font

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	**Report to:**	Trust Board 5 February 2026
Date of Meeting:	25 November 2025	**Date of next meeting:**	27 January 2026

Introduction

Quorate meeting with a full agenda and good debate on key topics in relation to Quality Assurance in LCH. The Committee felt that for some agenda items (the Quality Strategy and Quality of Care NOF report), position statements had been submitted but lacked enough clarity to provide assurance about progress, and has therefore requested information on actions/achievement to be brought back in future updates.

Alert	Action
1. Clinical Essential Skills Recording and Reporting - An update paper was received, summarising that although there was no single system for recording clinical skills training, local systems were in place. Training compliance and risk now being monitored through Business Unit reports to QAIG and escalated to Quality Committee via QAIG AAAs. Limited assurance agreed by the Non-Execs.	Update on the action plan for moving towards one system being brought to January Quality Committee. Testing methods to be included in the update. Risk to be reviewed. Recommend as a subject for future Internal Audit.
2. QAIG key issues for escalation – low compliance rates noted for servicing and asset management of medical devices.	Business Units had been asked to prioritise equipment and check compliance rates and asset registers. Action plan on medical devices to be presented to January Quality Committee
3. Report of perceived breach of regulations at Wetherby YOI in relation to management of controlled drugs	Awaiting formal inspection report (HMIP/CQC) but work ongoing to review practice and ensure safety.
4. In 2025 to date, there have been four similar cases reviewed under SUDIC processes. One case was known to LCH. The remaining cases are not known to LCH	All 4 cases discussed for trends and themes at SUDIC meeting and Safeguarding Sub Committee. The LCH case has had a rapid review and will go through the PSIRF framework including duty of candour.

Advise

- National Oversight Framework – 52 week waits. Committee received an update on the 9 remaining services with waits over 40 weeks. Pleasing progress noted, and assurance provided that issues were being addressed. 18 week trajectories to be shared with Committee in January.
- National Oversight Framework – Quality of Care report (following 'partially confirmed' self-assessment). Paper provided a summary of the current position but lacked e*vidence of* action. Will be a standing agenda item going forwards in order to track progress.

Committee Escalation and Assurance Report

- Quality Strategy – Committee received an update on the priorities for 2024-27. Next update to include what had been achieved.
- Enhance Business Case – the Committee supported TLT and Business Committee's view that £300k funding should be provided to retain the elements of the service which would enable future scaling up if funding from elsewhere was secured.
- Performance Brief – areas of concern noted in CAS alerts and overdue Patient Safety Incident Investigations – both being monitored via QAIG.
- Clinical Governance Report – importance of the quality walks was discussed, alongside the new Board members service visits framework. Suggestion that the Clinical Governance report is now received by QAIG instead of Quality Committee.
- Quarterly Mortality Report: Committee reassured that actions from the internal audit had been evidenced and closed. Further work to be done with the ICAN team on the number of child deaths yet to be reviewed.
- Transition to the new Performance Framework: Signing off the KPIs – the list was approved, but some clarity requested around reporting by exception.

Assurance

- Children, young people and families strategy – update received, with progress evident. Next update to include information on 0-19 tender, giving every child the best start in life; and the upcoming SEND inspection.
- Engagement Strategy – Committee approved the approach of having a refreshed set of engagement principles linked to the CQC questions.
- Patient Group Directions/NICE guidance compliance update/ Clinical audit update – all received and noted.

Risks Discussed and New Risks Identified

- The Risk Register report was presented, showing movement in clinical and operational risks scoring 8 and above. The Trust continues to have two extreme risks scored 15 and above. Updates regarding the new risk on the closure of 18 Leeds City Council run children's centres would be provided as the emerged.

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**

Committee Escalation and Assurance 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 to preventable harm, poor patient outcomes, and a diminished patient experience.	16 (extreme)	Reasonable	• Clinical Essential skills recording – limited assurance received • Medical device compliance – limited assurance received • Quality of Care report – lacked assurance on actions being taken • Quality Strategy report – lacked information on achievements to date
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
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

Committee Escalation and Assurance Report

Author:	Helen Robinson/Ian Lewis
Role:	Company Secretary/Committee Chair
Date:	5/12/2025

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	**Report to:**	Trust Board 5 February 2026
Date of Meeting:	27 January 2026	**Date of next meeting:**	24 March 2026

Introduction	
Issues with quoracy due to sickness and other commitments but managed to be quorate for key decision items with some rearranging of the agenda. Another full agenda, and good debate on actions from previous meetings. The Committee agreed that more assurance was received overall, but again requested information on actions/achievement to be brought back in future updates.	
Alert	**Action**
• HMYOI Wetherby Inspection by HM Chief Inspector of Prisons and Care Quality Commission – Regulation 12 medicines management breach. Findings being reviewed by LCH. Processes were deemed safe and in line with our policies, action plan to be developed.	Recommendations to be taken to Quality Assurance and Improvements Group and escalated to Quality Committee.
• Dental radiation incidents – 2 Significant Accidental or Unintended Exposures (SAUE) had been submitted to the CQC. Initial investigations completed and rapid reviews scheduled, no evidence of patient harm to date.	Completion of rapid reviews.
• Update on Metrics (Patient Safety Incidents) – An update on Metrics was received; issues had been flagged with data extraction from Datix and manual correction required so committee expressed concerns on level of assurance. Incorrect information was presented to committee but was verbally corrected.	Further update to be provided at March meeting on both the correction of data and the outcome of the investigation into BI extraction failure.
• Medical Devices Position Statement – only limited assurance on overall position, given the scale of missing data and the extent of work required.	An exception report would be taken to the March meeting, with a full update to be provided in May when the majority of actions were due to be completed.

Committee Escalation and Assurance Report

• Update on Clinical Training Systems – Committee received a report with an update on the progress to record and report on the clinical essential skills of staffs. The level of assurance remained limited with no material improvement despite the action plan.	A progress update to be provided to the Committee in May, and an internal audit into the area was suggested.

Advise

- Quality live issues – 4 additional PSIIs initiated, discussion around the capacity of trained staff to complete PSII investigations and the risk of a backlog. Options for additional investigators currently being explored.
- National Oversight Framework – waiting list update – An update on waiting list was provided and reported that the longest waits had continued to reduce, focus shifting to 18+ week waits.
- Internal Audit Plan - received an update on the development of the Internal Audit Programme for 2026–27. It was proposed that effectiveness of the organisation's wellbeing offer be reviewed in response to rising sickness levels. It was also suggested that further scrutiny of controlled drugs governance should be included in the audit programme.
- Quality Account – the first draft was presented. It was acknowledged that the document was at a very early stage and it was agreed that an updated draft would be brought for review. Consideration being given to having a page-turn for this document.
- Medium term plan – Committee discussed the limited reference to children's services, and acknowledged that this reflected the national focus. More detail was anticipated through local implementation. Committee agreed for the plan to be submitted to Board, but further quality-focussed scrutiny would be required through implementation.

Assurance

- SUDIC Service Spotlight – well received presentation on the process around Sudden and Unexpected Deaths in Childhood and the strong inter-agency work involved.
- Ratified the new Patient Group Directions (PGD) approval process via QAIG rather than Quality Committee.
- Performance Brief and Domain Reports – A report providing an overview of performance across LCH NHS Trust was presented. It was agreed to take acceptable assurance, although it was agreed further assurance around risks associated with delayed PSII actions and duty of candour compliance should be provided through the narrative in the report.
- Safe Staffing Report – Committee received a report covering the last six months (from July 2025 till December 2025) relating to non-acute accommodation services. Report focused on Hannah House and Wharfedale. Provided reasonable assurance overall.
- Quality and Value – including EQIA Update – Committee was provided with an update on Trust's EQIA process. It was agreed it provided reasonable assurance regarding progress on EQIA implementation and governance.

Committee Escalation and Assurance Report

- Quarterly mortality report – received and noted. Support for reintroduction of the Learning from Death Review Group.
- Progress update on measuring effectiveness – An update on progress was received. Committee suggested a joint effectiveness workshop with LYPFT.

Risks Discussed and New Risks Identified

Brief verbal update on the risk management deep dive and review of static risks. Three categories of findings emerged from the review: Risks where actions taken had had an impact but that had changed over time, requiring rewriting, Risks that had been so broad originally that they actually encompassed multiple sub-risks that needed logging individually, and risks involving partners where the actions within control of the Trust had been completed. Risk owners were tasked with reviewing and rewriting static risks accordingly.

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 to preventable harm, poor patient outcomes, and a diminished patient experience.	16 (extreme)	Reasonable	• Medical devices – limited assurance received • Clinical training systems – limited assurance received
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.	12 (high)	Reasonable	• National Oversight Framework – limited assurance
Risk 3 Failure to comply with legislative and regulatory requirements.	12 (high)	Reasonable	• Medical devices – limited assurance received

Committee Escalation and Assurance Report

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.			
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.	12 (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:	Helen Robinson/Ian Lewis
Role:	Company Secretary/Committee Chair
Date:	04/02/2026

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 5 February 2026
Date of Meeting:	26 November 2025	**Date of next meeting:**	28 January 2026

Introduction

Quorate meeting. The Committee sought assurance with very good discussions across al key agenda items including Trust priorities. The Committee thanked two committee members for their contributions to LCH given their departure – Dawn Greaves for her contribution to Digital Transformation and Ranjit for her secretarial support. The Committee welcomed two observers, Clare Granger, Interim HoS for Community Dental and Leanne Parker, Clinical Fellow. The Committee received a deep dive update on Q&V with Fair Day's work. It discussed and noted the work to date on the Neighbourhood model, MTP and Digital Printing. The Committee discussed 3 business cases including Weight Management and welcomed the Mind Mate Support Service update.

Alert	Action
• Strategic Estates Update – A summary of improvements was provided. Progress on refreshing the strategy for 2026-2031 was shared, and a draft would be brought to Committee in February 2026. Assurance was not provided on risk analysis and mitigation. The Chair was concerned Estates risks had not been captured. The Committee noted work has now just commenced to log risks for Estates.	Risks to be logged and assessed against LCH plans.

Advise

- Neighbourhood Model update – the Committee heard that by 31 March 2026 the footprint would need to be established, the priorities and scope of services defined, and leadership and accountability arrangements agreed. The Partnership Leadership Team had agreed to be held accountable for all five priority areas. It was emphasised that the Quality and Value Programme work had taken ABU in the neighbourhood model direction anyway, but that careful management would be required for the other Business Units that had been through Q&V to follow suit. Further information on the National Neighbourhood Implementation Programme (NNHIP) would be welcomed at future meetings.
- Medium Term Plan update – Committee noted that the first draft submission of a two-year operational performance and activity plan was due on 17 December 2025. The capital allocations risk was noted, with a focus on collaboration at Place and system level being essential due to lower than expected allocations. It was noted that the 5 year plan would be difficult to draft until the Strategic Outline Case (SOC) was finalised. A risk around the amount of change and uncertainty at system level was noted.
- Strategic Estates Update – Although the previous strategy had ended in 2024/25, work continued on the plans. Progress on refreshing the strategy for 2026-2031 was shared, and a draft would be brought to Committee in February 2026. The Chair was concerned Estates risks had not been captured, and work had commenced to rectify this.

Committee Escalation and Assurance Report

- Digital Letters – The SFTP transfer solution was working well to date with 11 services live at the time of the meeting. It was agreed that SFTP would continue to be implemented with remaining Synertec letters migrated to HCC Hybrid SFTP, and then to progress with the development and testing of Phase 2 Data Driven Appointment Letters. Legal advice now received and considered. Lessons learnt were discussed, starting with procurement processes for digital projects.
- Enhance business case – Committee supported the Senior Leadership Team's recommendation to continue to fund Enhance for 2026/27 at a cost of £299,901.
- Wide Area Network & Telephony Re-Procurement Update – procurement to wait until the SOC is finalised with a view to run as a single procurement for both LYPFT and LCH.
- NHS Shared Business Services (NHS SBS) – LCH to continue with the current financial system provider while an upgrade is completed in 2026/27. This may give an opportunity for a joint solution with LYPFT.
- Performance Brief – while improvements in reference costs were noted, the sickness absence rate had increased and this would be discussed further at the People & Culture Committee in December 2025.
- Finance dashboard – Capital plans projected to underspend by £0.8m due to slippage on asset disposals. Options being considered to avoid underutilising in-year capital funds in a way that still provides value-for-money for the organisation.

Assurance

- Quality & Value Programme – Break-even financial position noted, consistent with planned trajectory. As at the end of October, the Trust had identified £10.578m of its £14m savings target for 2025/26, with a full year effect of £11.797m. Committee received a presentation on A Fair Day's Work by the Children's Business Unit, including the successes and the challenges. The positive impact on staff was noted.
- Finance Reports (monthly dashboard and quarterly update) – strong performance continued to be noted against financial plan, with a year-to-date surplus of £0.762m and full year forecast of £0.9m, reflecting the Trust's contribution to the WYICS stretch target. Recurrent CIP forecast had improved to £10.578m although achievement of the full recurrent target remains likely. Updates received on national/system financial positions and the medium-term planning process.
- Transition to the New Performance Framework – KPIs agreed, although the Committee chair requested digital KPIs be included in those that report through Business Committee.
- Waiting List Recovery Plan –The Committee received an update on reducing the waiting lists for our patients, and received assurance that risks continued to be managed.
- Service Spotlight – presentation received from MindMate Support, and their collaborative approach was commended by the Committee.

Committee Escalation and Assurance Report

- NHS Annual EPRR Core Standards Self-Assessment submission – a significant improvement in compliance was noted, with no non-compliant standards in the latest submission.

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	Noted that the current instability at both Place and system level could have an impact on the Trust.
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	12 (high)	Reasonable	

Committee Escalation and Assurance Report

able to operate, leading to patient harm, reputational damage, and financial loss.			
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	Limited regarding the contractual position in relation to digital letters but reasonable overall.

Author:	Helen Robinson/Lynne Mellor
Role:	Company Secretary/Committee Chair
Date:	8 December 2025

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 5 February 2026
Date of Meeting:	28 January 2026	**Date of next meeting:**	25 February 2026

Introduction

Quorate meeting. The Committee sought assurance with very good discussions across all key agenda items including the submission of the Medium-Term Plan and Board Assurance Statements. The Committee welcomed Em Campbell as observer for EDI, Jonathan Hodgson, Internal Audit Manager Audit Yorkshire to present the draft Internal Audit Plan for 2026/27 and the ABU Therapy team representatives. The Committee discussed and noted the work to date on the Sustainability plans, Neighbourhood Health Model and Leeds Provider Review.

Alert	

Advise

- Neighbourhood Model Update (Key Priority) – the Committee heard that by 31 March 2026 the footprint would be established, the priorities and scope of services defined, and leadership and accountability arrangements agreed. This would bring together services across the NHS, social care, and community organisations. Aligning the 13 Neighbourhood Teams in Leeds with the Primary Care Networks (PCN) on a postcode basis was almost complete. A Matron for Pro-Active Care would be assigned to each PCN.
- NHS Provider Partnership Review (Key Priority) – the Committee noted progress on work to develop the scope of the different workstreams, vision, and mandate of the partnership. The plan was for the boards to approve a joint committee which would operate in shadow form from October 2026. Work was continuing on the integration of Leeds Community Healthcare Trust (LCH) and Leeds and York Partnership NHS Foundation Trust (LYPFT). This would include formal approval of the Strategic Outline Case (SOC) in February 2026.
- Medium Term Plan – the Committee discussed further development of the Trust's ~~Medium Term~~Medium-Term Plan and suggested some amendments to the Board Assurance Statements. Committee was happy for the Trust Board to sign off final versions ahead of submission to NHS England on 12 February 2026.
- National Oversight Framework Waiting list update (key priority) – the Committee received an update on waiting list improvement plans across key services. Progress against trajectories was included for Paediatric Neurodisability (PND), Adult Speech and Language Therapy (SLT), Podiatry and Continence, Urology and Colorectal Services (CUCS). Narrative was also provided on all other services with 18+ week waits. The Committee welcomed the improvements on waiting lists with significant improvements for some services, and noted the focus needed on the 18+week waits particularly PND.
- Sustainability Quarterly Update - the Head of Facilities Management and Safety presented the report as the Environmental and Sustainability Manager had now left the Trust. Partnership work was underway with ~~LYPFT~~LYPFT, and this would be formalised via a service level agreement (SLA) with a plan for to

Committee Escalation and Assurance Report

fund 50% of two posts in LYPFT in the short term. Long term succession planning for this work would be considered when there was more clarity on the integration with LYPFT. The Committee discussed the loss of two key individuals in the sustainability team, and the potential risk this posed. The Committee also noted the need for ~~received assurance that the risk of losing focus on the work programme was not significant.~~a wider focussed review on succession planning for other functions/disciplines, one to be considered by the People and Culture Committee.

- HEARTT options paper – the Committee approved an option to cease the current project and commence closure activities based on assurance that increased capacity in the Business Intelligence Team had led to improved analytical capability and that more comprehensive data was available within the Trust.
- Procurement Strategy – the Head of Procurement at LYPFT provided an update on the on progress against the Trust's Procurement and Logistics Strategic Plan and the Trust's plan to strengthen the procurement service provision, by moving to a fully outsourced Procurement service provided by LYFFT from 1 February 2026.
- Draft Internal Audit Annual Operational Plan 2026/27 - the Committee reviewed and commented on 2026/27 Draft Internal Audit Operational Plan and made suggestions about the scope of some of the planned audits, for example a need to hold a procurement review particularly in the stages prior to contract award~~—~~. Comments to be assimilated and a final draft to be taken to SLT prior to March Audit Committee.
- Research and Development Finance - the Committee welcomed the Report and the opportunities it presents for the Trust and approved the resource proposals to support delivery of the 5-year plan.
- Digital and Data Strategy Internal Audit report – Committee noted the limited assurance opinion~~—~~. An action plan was in place and some recommendations already implemented~~—~~. Attain had reviewed internal project management methodology and made recommendations to strengthen the approach~~—~~. A follow up report was requested.
- New Integrated Performance Report (IPR) – The Committee welcomed the new format of the report of the IPR which was much clearer and made the data more transparent. The Committee ~~was still awaiting the~~noted the development of digital KPIs is planned to be included for IPR reports through the Business Committee.

Assurance

- Quality and Value Programme – The Committee noted the update from the Quality and Value Board which included a summary of the progress of Month 9 2025/26 from a programme and the financial perspective. The Committee received acceptable assurance around progress on the delivery of the programme and its positive impact on staff.
- Finance Reports (monthly dashboard and quarterly update) – Overall performance remained on track, with the organisation continuing to deliver against its key financial targets. The I&E position remained stable, with a year-to-date surplus of £0.829m and a full-year outturn surplus of £0.900m, while cash balances continued to be strong at £2.8m above plan. Updates were received on the local and national/system financial positions.
- Service Spotlight – presentation received from the Adult Business Unit on work to reduce waiting times and improve productivity for Neighbourhood Therapy. The work to was commended by the Committee as an excellent example of how services could be transformed which should be shared across the Trust.

Committee Escalation and Assurance Report

Risks Discussed and New Risks Identified
• The Committee discussed risks as the agenda progressed and 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.	12 (high)	Reasonable	
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.	12 (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 (extreme)	Reasonable	Robust discussion held on the ~~Medium Term~~Medium-Term Plan
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	

Committee Escalation and Assurance Report

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.	8 (high)	Reasonable	

Author:	Liz Thornton/Helen Robinson/Lynne Mellor
Role:	Corporate Governance
Date:	4 February 2026

Committee Escalation and Assurance Report

Name of Committee:	Audit Committee	**Report to:**	Trust Board 5 February 2026
Date of Meeting:	9 December 2025	**Date of next meeting:**	10 March 2026

Introduction

Quorate meeting with a full agenda and good debate on key topics – good challenging conversations, particularly in relation to the update on the DSPT Toolkit.

Alert	Action
• DSPT 2024-2025 Action Plan & DSPT 2025-2026. The Committee received an update on the Trust's current position and progress regarding the Data Security and Protection Toolkit (DSPT) for 2024–2025 and 2025–2026. The Trust's submission was initially rated "Standards Not Met," later amended to "Approaching Standards" following NHS England (NHSE) approval of the DSPT Improvement Plan. • The Committee asked for more assurance that that the same standards which applied to the Trust regarding Windows 11 and urgent patches relating to the NHS smart card infrastructure had been implemented by the Trust's service delivery partners.	**A plan which prioritised the risks for each contractor or supplier to be shared with the Committee via email as soon as finalised.**

Advise

- Internal Audit Progress Report - One limited opinion Internal Audit Report was received and reviewed by the Committee – Digital and Data Strategy. . It was noted that the management responses to the recommendations were strong, and some work had already been completed. The Business Committee would consider the report in detail at its meeting on 28 January 2026 but it was agreed that the implementation of the Digital and Data Strategy had wider implications and could have a significant impact on the quality of care provided by the Trust.
- PSIRF Internal Audit Report (limited assurance June 2025) – weaknesses found in the application of PSIRF within Datix. Committee received an update on progress against recommendations, with 8 out of 12 closed, and work on the remaining 4 in progress. The Chair of the Quality Committee reported on the assurance received by the Quality Committee on the progress to develop strengthened governance processes. The Committee noted the update but requested a further report in March 2026 withmore assurance on the validation of competed recommendations and governance processes.

External Audit – continuing delay to the National Audit Office issuing the audit completion certificates was noted. Planning work for the 2025/26 external audit would begin shortly.

Assurance

Committee Escalation and Assurance Report

- Internal Audit – follow up of overdue recommendations - An update on the number of open recommendations showed a continuing improvement, with additional executive management oversight leading to fewer being overdue. Work to improve reporting would continue into 2026.
- Internal Audit Progress Report - Four significant opinion internal audit reports were reviewed: eRostering, Well Led, Financial Sustainability and Medicines Management.
- Charitable Funds Annual Report and Accounts 2024/25 - The Committee recommended that the final Charitable Funds annual report and accounts be presented to the Charitable Funds Committee on 16 December 2025 for formal adoption ahead of ratification by the Trustees on 8 January 2026.
- Counter Fraud Progress Report – quarterly update report received including an update on Failure to Prevent.
- Financial Controls- Quarterly Update - The Committee received information on: 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, working capital and budget setting.
- Risk Management Annual Report – Committee noted considerable progress on strengthening the Trust's risk management processes over the last year, including the establishment of the Risk Management Group, a risk amnesty, updated policy and procedure and improved training offer.

Risks Discussed and New Risks Identified

- N/A

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	**Risk score (current)**	**Overall level of assurance provided that the strategic risk is being managed (or not)**	**Additional comments**
Risk 5 Failure to maintain business continuity: If the Trust is unable to maintain business continuity in the event of significant disruption, then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.	12 (high)	Reasonable	N/A

Author:	Liz Thornton/Khalil Rehman

Committee Escalation and Assurance Report

Role:	Corporate Governance Officer
Date:	16/12/2025

Committee Escalation and Assurance Report

Name of Committee:	Charitable Funds Committee	**Report to:**	Trust Board 5th February 2026
Date of Meeting:	16/12/2025	**Date of next meeting:**	19th March 2026
Chair:	Alison Lowe	**Parent Committee:**	Trust Board

Introduction

This report identifies the key issues for the Board from the Charitable Funds Committee held on 16th December 2025. Quorate meeting with good debate on key topics.

Alert	Action
No alerts	

Advise

- Workforce wellbeing grant from NHS Charities Together – application drafted for a Transformation Grant of £150,000. Some concerns from the exec team regarding duplication of existing wellbeing offers, and committee discussion held around any recruitment implications and longer term sustainability. Further information requested before approving whether the application was to be submitted and on what basis.
- The final LCH Charitable Funds and Related Charities Annual Report and Accounts 2024/25 were reviewed and approved. As they had been reviewed by the Audit Committee they would now be recommended for Trustee sign off on 8 January 2026.

Assurance

- The Committee received fundraising updates in relation to events in the next 12 months including the Race Across Leeds. Spend for promotional materials to be agreed by directors.
- CPR-athon – over 120 people trained with lots of community engagement and interest in the charity raised.
- Yorkshire 3 Peaks Walk – completed by 7 walkers and £1423 raised in total.
- Delivering Joy – c.200 gift bags received from Dunelm for the campaign, distributed to Recovery Hubs, Hannah House (patients and siblings), Homeless Health and Inclusion Team, and TB Service. Plans for remaining gifts agreed.
- Finance report covering April –October 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:	18 December 2025

Agenda item:	2025-26 (13i)
Title of report:	Integrated Performance Report
Meeting:	Trust Board Held in Public
Date:	5 February 2026

Presented by:	Andrea Osborne, Director of Finance
Prepared by:	Victoria Douglas-McTurk, Head of BI and Performance, Adam Glass, Performance Manager

Purpose of the report:		
This report aims to provide an overview of performance across Leeds Community Healthcare NHS Trust. Performance is measured across six domains that align to the NHS Oversight Framework.	Approval	
	Discussion	
	Assurance	x

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives		**Acceptable assurance** General level of confidence in delivery of existing objectives	x	**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:

- Overall LCH performance is improving. Our NOF forecasting shows a possible move out of segment 4 in Q3 reports. This is a tentative forecast that may change as more national data is published.
- We are seeing consistent improvements in relation to our non-reportable waiting times and indications are that we would meet the national 78% target for 18 week waits in the not-too-distant future. This is alongside positive movements in relation to the equity of our waiting list processes.
- We are meeting our statutory and mandatory training target for the first time in over 2 years. Our UCR performance remains excellent reflecting the ongoing work and focus to ensure that we see those patients that need the most urgent response from us. And good work has been done to recover the number of in date Medicine Code Assurance Checks.
- The trust still has work to do to recover sickness rates which have spiked beyond seasonal expectations this month. Appraisals have also dropped over the same period.
- Waits for children needing a neurodevelopmental (ND) assessment continue to cause low performance in relation to our 52 week waits (pre-school) and ND waits (CAMHS). However, the issue is understood, and

work is underway to improve both. This is a nationwide issue due to the increased demand for ND assessments.

- There has been a recent spike in the number of overdue PSII actions. This has been at a higher than usual level since July but is now showing early signs of recovery. Overdue actions are held on the Trust risk register.

Previously considered by:	Senior Leadership Team, Quality Committee, Business Committee
Outcome of previous discussion/s:	

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

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	Equity of our consultant led waiting times is improving
	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:	



Integrated Performance Report

NHS
Leeds Community Healthcare
NHS Trust

January 2026

Reporting on: December 2025 and Q3 2025/26



Executive Summary

NHS Leeds Community Healthcare NHS Trust

Summary

Overall LCH performance is improving. Our NOF forecasting shows a possible move out of segment 4 in Q3 reports. This is a tentative forecast that may change as more national data is published.

We are seeing consistent improvements in relation to our non-reportable waiting times and indications are that we would meet the national 78% target for 18 week waits in the not-too-distant future. This is alongside positive movements in relation to the equity of our waiting list processes.

We are meeting our statutory and mandatory training target for the first time in over 2 years. Our UCR performance remains excellent reflecting the ongoing work and focus to ensure that we see those patients that need the most urgent response from us. And good work has been done to recover the number of in date Medicine Code Assurance Checks.

The trust still has work to do to recover sickness rates which have spiked beyond seasonal expectations this month. Appraisals have also dropped over the same period.

Waits for children needing a neurodevelopmental (ND) assessment continue to cause low performance in relation to our 52 week waits (pre-school) and ND waits (CAMHS). However, the issue is understood, and work is underway to improve both. This is a nationwide issue due to the increased demand for ND assessments.

There has been a recent spike in the number of overdue PSII actions. This has been at a higher than usual level since July but is now showing early signs of recovery. Overdue actions are held on the Trust risk register.

Summary Performance

Data Quality : **Medium Assurance**

Performance: **Improving**

Top 5 Highlights

KPI	Target	Actual	Performance	Assurance
Number of teams who have completed Medicines Code Assurance Check 1st April 2019 versus total number of expected returns	100% by year end	100%		
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 18 week standard	TBC	1	↘	
% Patients waiting under 18 weeks (non reportable)	>=95%	71%	H	F
Community health services two-hour urgent response standard	>=70%	87%	H	?
Statutory and Mandatory Training Compliance	>=90%	90%	H	F

Top 5 Concerns

KPI	Target	Actual	Performance	Assurance
Number of overdue PSII actions	No Target	18		
Number of patients waiting more than 52 Weeks (Consultant-Led)	0	1165	H	F
Percentage of Children over 5 currently waiting more than 18 weeks for a Neurodevelopmental Assessment		98%	H	
Total sickness absence rate (Monthly) (%)	<=6.5%	8%	H	?
AfC Staff Appraisal Rate	>=90%	81%	L	F

Introduction

This report aims to provide an overview of performance across Leeds Community Healthcare NHS Trust.

Performance is measured across six domains that align to the NHS Oversight Framework:

- Access to Services
- Finance & Productivity
- Effectiveness and Experience
- Improving Health and Reducing Inequality
- Patient Safety
- People & Workforce

The KPIs examined in each domain are reviewed and approved by the Board annually and managed via a change control process.

This report is underpinned by the Making Data Count methodology. Statistical process control charts are used to highlight the organisational KPIs relevant for inclusion. Criteria for inclusion are any KPI:

- demonstrating special cause variation
- breaching national standards
- with a low data quality rating
- meeting its target after an extended period of under performance

For more details on the Making Data Count methodology, please see appendix 1.

January 2026 is the first month in which we have presented our IPR in this format. It is one of 3 products that are in the process of being implemented following a review by Audit Yorkshire. It accompanies a Trust KPI list and new Performance and Accountability Framework. The implementation plan for these stretches into 2026/27. This report will be evolving alongside that process.

NHS Oversight Framework (NOF) Performance

Detailed narrative on the measures that contribute to the NOF is provided in the appropriate domain report. This page provides a summary and overview of performance

NHS Leeds Community Healthcare NHS Trust

Summary

- **LCH's overall segment score will potentially improve to 3 in Q3.**
- This is a tentative forecast that may change as more national data is published. As more data is made available, we will be more confident of the forecast.
- This is due to improvements in CYP access to MH services and waiting times as per the Access LCH trajectories (further info on the latter is available in the Access domain reporting).

		Q2				Q3 (forecast)				Q4 (forecast)			
Domain	**Metric**	Value	Score	Rank	Segment	Value	Score	Rank	Segment	Value	Score	Rank	Segment
Overall		-	**2.71**	49 of 61	4	-	**2.62**	43 of 61	3	-	**2.52**	41 of 61	3
Access to Services	Percentage of patients waiting over 52 weeks	7.82%	3.32	32 of 41	3	6.94%	3.26	31 of 41	3	2.91%	3.03	30 of 41	3
	Annual change in the number of CYP accessing MH services	-6.98%	3.65	45 of 49	4	3.83%	2.65	29 of 49	3	7.76%	2.07	18 of 49	2
Finance & Productivity	Combined Finance		1		1		1		1		1		1
	Planned surplus/deficit	0	1	15 of 61	1	0	1	15 of 61	1	0	1	15 of 61	1
	Variance year-to date to financial plan	0	1	26 of 61	1	0	1	26 of 61	1	0	1	26 of 61	1
	Relative difference in costs	117.58	3.7	54 of 61	4	117.58	3.7	54 of 61	4	117.58	3.7	54 of 61	4
Effectiveness and Experience	Urgent Community Response 2-hour performance	88.99%	1.83	18 of 38	2	88.71%	2.13	18 of 38	2	88.71%	2.13	18 of 38	2
Patient Safety	NHS Staff Survey - Raising concerns sub-score	7.05	1.4	9 of 61	1	7.05	1.4	9 of 61	1	7.05	1.4	9 of 61	1
People & Workforce	NHS Staff Survey - Engagement theme sub-score	6.95	3.25	46 of 61	3	6.95	3.25	46 of 61	3	6.95	3.25	46 of 61	3
	Sickness Absence Rate	5.80%	3.51	46 of 61	4	5.99%	3.56	44 of 61	4	5.99%	3.56	44 of 61	4

NHS Oversight Framework (NOF) Performance

Leeds Community Healthcare NHS Trust

Summary

CYP Access to MH Services

- We are now flowing indirect contacts for CAMHS into the MHDS. This has increased contacts and improved the score. In coming months, these contacts will also be included for Infant Mental Health and LMWS.
- As this measure will not form part of the NOF in 2026/27 focus the working group has shifted its focus to the draft measures for next year namely:
    - NHS TT – Completed courses or treatment and reliable recovery
    - Urgent referrals to Crisis Services with first face to face contact within 24 hours
    - People accessing MH services with a paired outcome score
    - CYP MH related waits that are over 104 weeks
    - Initially work will focus on aligning local reporting on these measures with national reporting

Relative difference in costs

- From Q2 onwards the score is based on the Trusts 24/25 National Cost Collection , despite an improvement in the Trusts NCC index this was not sufficient to change segmentation; this is an annual data collection improvements will not be achieved for some time
- A continued programme of work to improve data quality and productivity is underway. To date the NTs, ICAN and CAMHS have been engaged. These have identified changes to data processing that are likely to improve relative costs.
- A workshop with LMWS is planned for 28th Jan. Reviews with all other services will be planned to deliver improvements to the 2025/26 return.
- Initial draft dashboards visualising PLICs data are now ready for discussion with stakeholders. Once 2024/25 data is approved, we will release it there.
- Dashboards will be further developed to make our 2025/26 return available before it is submitted and productivity metrics to track internal performance will form part of the new IPR process.

NHS Staff Survey – Engagement Theme

- Work ongoing to identify individual service scores for targeted support to improve staff engagement and response rates
- Intention plans to be completed by leaders of services (once they have analysed their results accessible by a new dashboard end Jan/early Feb) to include action on staff engagement, sickness/wellbeing and inclusion

Sickness Absence

- Long term sick absence case views have been completed
- Sick Absence Manager Training produced and ready to pilot in January
- Occupational Health Training ready to roll out, starting in February
- Organisational Health work is in early stages, with initial pilot currently underway in Police Custody services
- Organisational and Business Unit sick absence targets created and supporting dashboards built

Safe Domain Summary

Accountable Exec: Lynsey Yeomans

NHS Leeds Community Healthcare NHS Trust

Summary

There were seven Patient Safety Incident Investigations (PSII) which concluded in December 2025. Five were completed as part of one deaths exception report as all incidents had similar known themes of learning. This learning was cross referenced against existing improvement plans/action plans with two additional actions identified. One PSII was for an MRSA Bacteraemia case and one for a patient fall with no causal or contributory learning identified and therefore neither attributable to LCH care. All have been through the internal Patient Safety Incident Investigation process and approved by the Executive Director of Nursing and Allied Health Professionals. Actions have been agreed based on the learning and recommendations from the investigation and uploaded to the Incident Reporting System for completion and upload of assurance that the action has been met. Full details of the learning from these incidents will be included in the six-monthly Patient Safety report.

There are 18 overdue PSII actions which remain a risk until recommendations and actions have been implemented and embedded. Three are pending closure as the requirement of the action has been completed. Overdue actions are held on the Trust Risk Register under risk ID 1359.

There were six incidents which met the requirement for Statutory Duty of Candour. Five were compliant with one from November for Adult Business Unit recorded as a breach to the internally set timescales for completion.

Domain Summary Performance

Data Quality : **Medium Assurance**

Performance: **Off Track**

KPI	Target	Actual	Performance	Assurance
Compliance in Level 1 and 2 Patient Safety Training	TBC	88%	H	F
Number of Patient Safety Incident Investigations (PSII)	No Target	7		
Number of overdue PSII actions	No Target	18		
Number of teams who have completed Medicines Code Assurance Check 1st April 2019 versus total number of expected returns	100% by year end	100%		
Compliance with statutory Duty of Candour	TBC	100%		?
Attributed MRSA Bacteraemia - infection rate**	0	0		
Clostridium Difficule - infection rate**	3	0		
Never Event Incidence**	0	0		
CAS Alerts Outstanding**	0	1		
Data Quality Maturity Index (DQMI) - CSDS dataset score**	TBC	91%	H	
Data Quality Maturity Index (DQMI) - IAPT dataset score**	>=95%	98%	H	P
Data Quality Maturity Index (DQMI) - MHSDS dataset score**	>=95%	88%	H	F

Compliance In Level 1 and 2 Patient Safety Training

Domain: Patient Safety | Accountable Exec: Lynsey Yeomans | Author: Shelia Sorby

Target: 95% | Actual: 88% | SPC Variation: H | SPC Assurance: F | Data Quality: **Medium Assurance**

What is the trend we see?

Currently, patient safety training compliance for level 1 & 2 is 88%, which is below organisation target of 95%. It shows a gradual improvement and sustained improvement in the last 6 months.

What is being done about it?

Improvement work is targeted to close the gap in areas that are not meeting the target threshold. Working with teams who are at the lower end of the training target and any areas where we have concern about compliance.

When do we expect to see improvement

We expect to see ongoing improvement with the achievement of 95% within 3 months. We are looking at how to ensure people can do their training within work time while support operational demand

What are the risks to delivery?

The risk is that we will not meet the 95% due to increased demands on services. Also risk that there is limited engagement and follow up meaning the targets are reduced. This will be mitigated but monitoring through QAIG and Performance Panel.

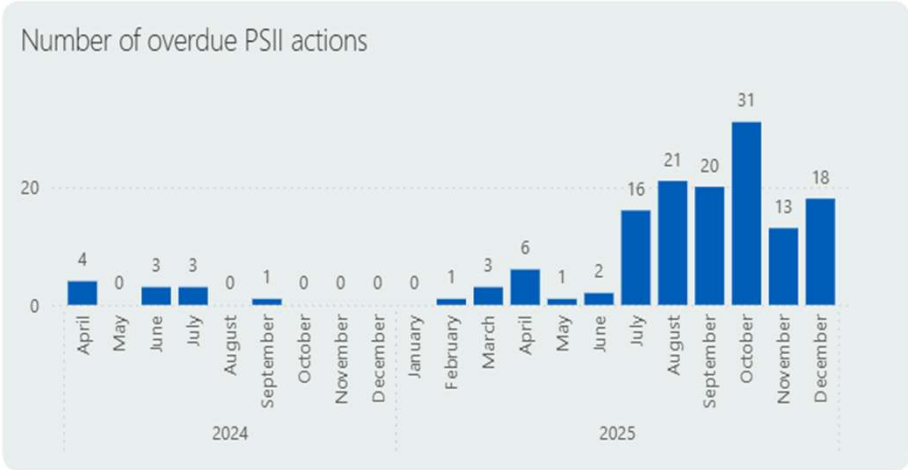
Number of overdue PSII Actions

Domain: Patient Safety | Accountable Exec: Lynsey Yeomans | Author: Sarah Yeomans

Target: No Target | Actual: 18 | Data Quality: **High Assurance**

What is the trend we see?

There are 18 overdue PSII actions in the incident reporting system, three of the actions are due to be closed imminently as the action required has been completed. Of the 15 remaining overdue actions five are for the Adult Business Unit, four each for Children and Corporate Business Units and two for Specialist Business Unit. Some of these actions are significantly past the due date and were due for completion in March (1), May (1), June (1), August (1), three due in October (3), November (2) and December (6).



What is being done about it?

Overdue PSII actions continue to be escalated in the monthly business unit reports this will continue to be monitored and highlighted, and the process for agreeing an extension continues to be reinforced within the Business Units and within Clinical Governance . This is an ongoing risk which is held on the trust Risk Register ID 1359 (score 9, possible, moderate harm) as incomplete PSII actions remain a risk to patient safety until implemented and embedded. Discussion remains ongoing in relation to a formalised process to consider individual actions and the level of risk associated to each.

When do we expect to see improvement

The discussion will be followed up at the Quality and Assurance Group Meeting to explore next steps and management of this risk.

What are the risks to delivery?

There is a risk that if Patient Safety Incident Investigation actions are not implemented and embedded within timescale this may lead to further patient harm because the actions are as a result of investigations into incidents that have already caused or contributed to moderate or above patient harm.

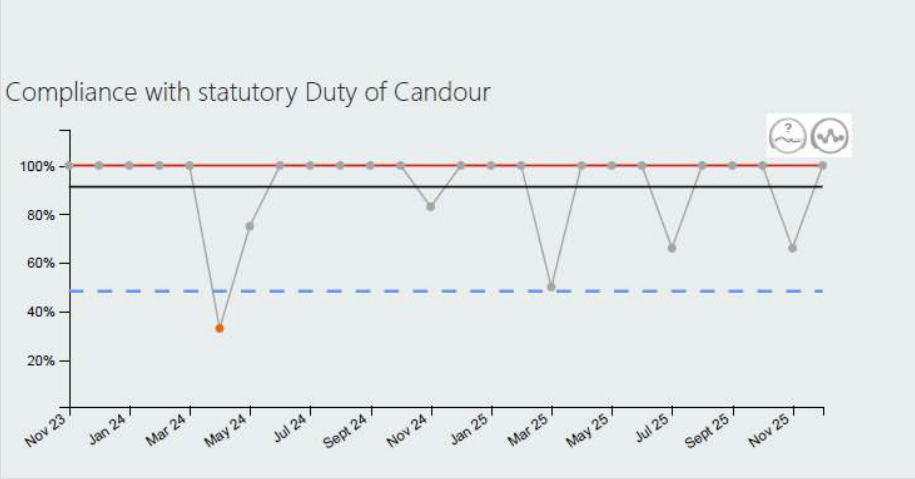
Compliance with Statutory Duty of Candour

Domain: Patient Safety | Accountable Exec: Lynsey Yeomans | Author: Sarah Yeomans

Target: 100% | Actual: 100% | SPC Variation: | SPC Assurance: | Data Quality: **Medium Assurance**

What is the trend we see?

The data shows common cause variation with no significant changes throughout 2025 however compliance with Statutory Duty of Candour internally set deadlines is inconsistent in meeting the target of 100%. For November and December there were six incidents which met the criteria for statutory duty of candour. Three of these were compliant with the internally set deadlines for completion and two were completed after the due date however attempts had been made to complete within the timescale and were completed as soon as reasonably practicable so were assessed as compliant. The remaining Statutory Duty of Candour was reported as a breach in November as there was a delay in the letter being updated by the author and returned to the Patient Safety Team to be sent. The actual 100% figure is aligned with December's data.



What is being done about it?

Verbal information is provided at Rapid Review Meeting and written information including the Duty of Candour One Minute Guide continue to be provided to those leading Duty of Candour conversations which includes timescales for completion. The Patient Safety Team continue to follow up at regular intervals to ensure that incidents are on track to meet expected timescales or where the timescale is not met all steps have been taken to complete as soon as reasonably practicable. Due to capacity within the workstream this has been challenging but recruitment is underway which should support a robust follow up/escalation process for Statutory Duty of Candour completion. Training has recently been rolled out to Incident Handlers across the trust with regular sessions now ongoing including a section on Statutory Duty of Candour.

When do we expect to see improvement

Improvement is expected within the next quarter.

CAS Alerts Outstanding

Leeds Community Healthcare NHS Trust

Domain: Patient Safety | Accountable Exec: Lynsey Yeomans | Author: Delphine Arinze

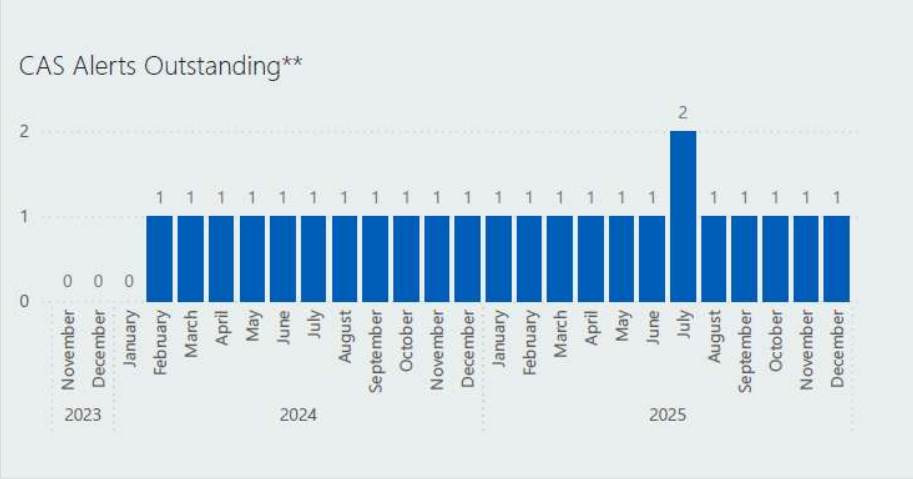
Target: 1 | Actual: 2 | Data Quality: **Medium Assurance**

What is the trend we see?

There are no new CAS alerts but one Enduring Standard CAS alert. Stayed at 1 for 2yrs until July 2025.

1) Overdue: NatPSA/2023/010/MHRA Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: LCH is required to meet 5 of 7 actions; of these, 3 have been completed. The remaining 2
   a) 10,000 pending risk assessment, is down to 7,000
   b) the actions present challenges across all city-wide organisations and are being addressed at ICB level.

2)Enduring: NHS/PSA/W/2018/009: Risk of harm from inappropriate placement of pulse oximeter ear and finger probes. Staff are actively acquiring sufficient Sats probes and providing training, supported by the display of the "how to use" poster across all clinical areas. Reassurance is being provided by staff, currently awaiting assurance.



What is being done about it?

*1).*A city-wide working group was established and continues to liaise with the ICB to seek resource provision.

2)Reminders have been consistently sent to colleagues to support staff in keeping this issue at the forefront, and an audit will follow for assurance purposes.

When do we expect to see improvement

1) This action process is ongoing, and completion would depend on resources provision .

2) It is expected that compliance will be achieved by April 2026.

What are the risks to delivery?

1) There is a risk of death from entrapment or falls.

2) There is a risk of harm from the inappropriate placement of pulse oximeter probes, which may result in inaccurate readings and inappropriate treatment, potentially leading to patient death.

Number of Teams who have an in-date Medicines Code Assurance Check (completed in the last 24 months)

NHS Leeds Community Healthcare NHS Trust

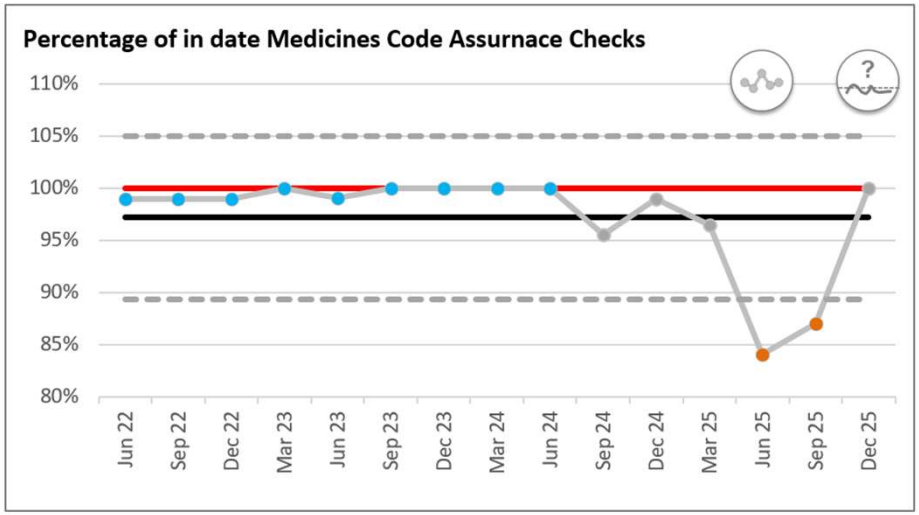
Domain: Patient Safety | Accountable Exec: Ruth Burnett | Author: Carolyn Nelson

Target: 100% | Actual: 100% | SPC Variation: | SPC Assurance: | Data Quality: High Assurance

What is the trend we see?

In July 2025 we spotted a problem with the number teams who had an out-of-date Medicines Code Assurance Check (MCAC).

Twenty-one of the 116 teams who handle medicines are overdue a MCAC; the service offer of three teams has changed with medicines handling activities now being delivered. This was a special cause concern.



What is being done about it?

A programme of visits by the Medicines Optimisation Team commenced in July 2025 to complete the overdue and missing MCACs with the Services and Teams affected. Visits continued during Q2 and Q3.

Where standards were not being met, action plans were agreed ; follow up visits to check implementation will be undertaken in Q1 2026/27.

A full programme of visits will be undertaken throughout 2026/27 to ensure the target continues to be met and staff are supported to follow legislation and best practice in handling medicines.

What are the risks to delivery?

There is a risk that if staff do not follow legislation or best practice, the Trust may fail to meet CQC standards for the regulated activity of treatment of disease, disorder or injury.

When do we expect to see improvement

The December 2025 data shows an improvement, with 100% of teams who handle medicines completing a MCAC within the last 2 years.

Data Quality Maturity Index (DQMI) - MHDS Dataset Score

Leeds Community Healthcare NHS Trust

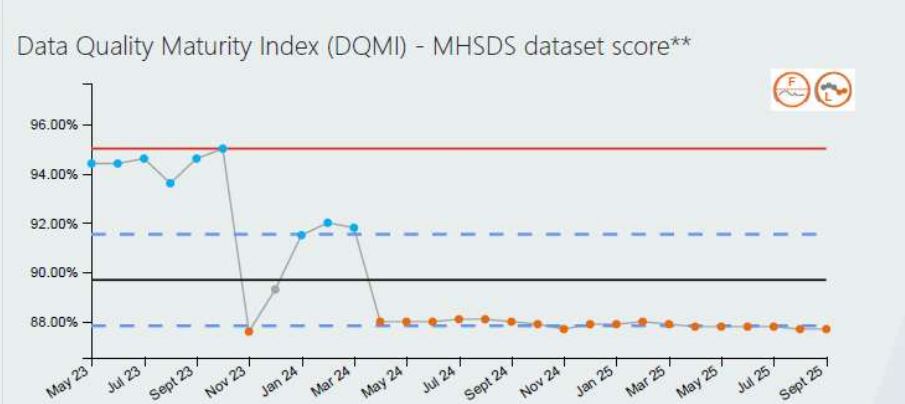
Domain: Patient Safety | Accountable Exec: Andrea Osborne | Author: Victoria Douglas-McTurk

Target: 95% | Actual: 88% | SPC Variation: | SPC Assurance: | Data Quality: High Assurance

What is the trend we see?

Our DQMI score in relation to our national Mental Health Data Set (MHDS) has been at a significantly low level since May 2024. This is mostly due to low levels of completion of the following fields: Referral or closure reason, service or team type referred to and primary reason for referral.

We are performing comparably well to other trusts. Our current (September 2025) score is 87.7%. This is against a national average of only 41.6%.



What is being done about it?

Errors in processing by NHS England are suspected. Contact has been made to try to rectify these, and we are awaiting a reply. These may have an impact on some nationally reported data. The BI team are identifying the exact issue and potential impact. If appropriate a risk will be logged.

The warehousing team are examining the fields with low scores and determining what actions could be taken to rectify it.

When do we expect to see improvement

An update will be provided in the next IPR. It is possible that there may be some improvements by that time if quick fixes are available for our low scoring fields. But it is more likely that this will take longer, perhaps 6 months to a year.

What are the risks to delivery?

A slow response from NHS England in relation to rectifying data processing issues. This will be escalated if a timely response is not received.

Caring Domain Summary

Accountable Exec: Lynsey Yeomans

Leeds Community Healthcare NHS Trust

Friends and Family Test (FFT) performance remains strong overall, with a current positive response rate of 94%, although this is below the agreed target of greater than 96%. This indicates that the majority of patients continue to report a positive experience of care.

Analysis shows that no agreed targets have been met across IMD 1 and IMD 2–10 categories for consultant-led 18-week and 52-week pathways, and for non-consultant-led 18-week pathways. This demonstrates variation in patient experience across pathways and deprivation groupings, highlighting the need for continued focus on understanding and addressing the drivers of experience and access.

During the reporting period, 12 complaints were received. Themes from complaints and FFT qualitative feedback are reviewed through established governance arrangements to inform learning and service improvement within the Caring domain.

Sub Domain Summary Performance

Data Quality : **Medium Assurance**

Performance: **Unchanging**

KPI	Target	Actual	Performance	Assurance
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	>=95%	94%		
Total Number of Formal Complaints Received	No Target	12		

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

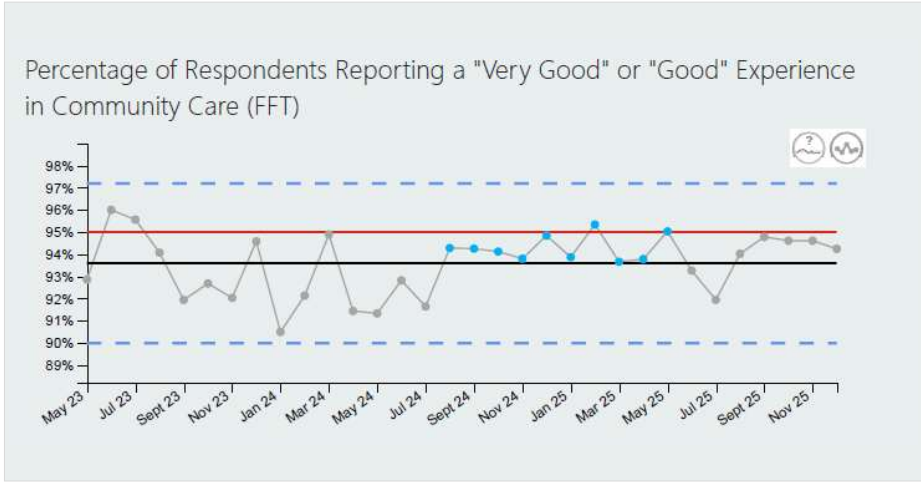
NHS Leeds Community Healthcare NHS Trust

Domain: Caring | Accountable Exec: Lyndsey Yeomans | Author: Hayley Barker

Target: 95% | Actual: 94% | SPC Variation: | SPC Assurance: | Data Quality: High Assurance

What is the trend we see?

There is currently no significant change within the data. The data continues to remain within the upper and lower control limits and within normal variation.



What is being done about it?

We will continue to review and identify areas and services where very good and good has dropped below the expected target over the coming months.
The Patient Engagement Manager outlined a proposal which has been approved by Quality Committee. The paper outlined a change to standardise our FFTs and move towards bespoke surveys for service specific feedback. This will support service improvement plans for engagement and involvement and reduce the current risks to delivery identified.

When do we expect to see improvement

We will provide an update on next steps and time frames once agreed.

What are the risks to delivery?

The current process of FFT has variations in use across services, with both standardised and bespoke FFTs currently in use which creates a risk of non-compliance in some formats that are being used.
There is a further potential risk of non-compliance from services where they are not using a Trust Wide FFT, which could deviate from a pre agreed Trust standard for consideration of equity, introducing both a compliance risk with the guidance and our equity commitments. It also poses challenges with a potential risk in obtaining comparable and reliable data from FFT for Trust-wide analysis and service improvement reducing the visibility of system-wide themes and learning.

Effective Domain Summary

Accountable Exec: Ruth Burnett

NHS Leeds Community Healthcare NHS Trust

Summary

Audits

Audit numbers continue to rise, with 146 audits registered for 2025–26 (an increase of 17). As services add audits throughout the year, the total continues to expand, impacting comparative quarterly reporting. There is an increased risk that not all audits will be completed as only 32% (47 audits) have been completed at the start of Q4. National audit compliance is improving:

- LCHT is registered for all 8 relevant national audits.
- Full data are submitted to 5; partial data to 2; no data to SSNAP due to national system constraints rather than Trust performance.

Compliance with audit completion is monitored and escalated through Business Unit reports and QAIG. The introduction of a new rolling audit programme for 2026—with clearer prioritisation and improved transparency via MS Teams folders—aims to strengthen compliance and reporting.

Performance improvement is not expected until Q1 2026–27 for the current audit cycle. Full impact of the changes to the audit programme will likely not be visible until the end of the next audit cycle but will be monitored and escalated through QAIG.

NICE Guidance

16 NICE Guidance are currently open and are within the two-year timescale to implementation set out in the PL326 Policy for the Dissemination, Implementation and Monitoring of NICE Guidance. Overdue Guidance are: **NG197 Shared Decision Making; NG212 Mental Wellbeing at Work.**

NG197: progress is being made towards compliance through the launch of the About Me template in SystmOne, and incorporating shared decision-making into clinical training quality assurance.

NG212: progress is dependent on the introduction of Staff Health and Wellbeing advocates, renewal of the Employee Assistance Programme contract, and the closure of the West Yorkshire Mental Health Hub. Actions for the Peoples Directorate to support achieving compliance are to update on advocate role once introduced; introduce annual audit to monitor compliance (NICE Quality Standard 147).

Domain Summary Performance

Data Quality : **Medium Assurance** Performance: **Off Track**

KPI	Target	Actual	Performance	Assurance
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 18 week standard	TBC	1.00	↘	
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 52 week standard	TBC	1.13	~	
Difference in access to services for patients living in IMD1 vs IMD2-10 - DM01 Services	TBC	0.58	~	
Difference in access to services for patients living in IMD1 vs IMD2-10 - Non-Consultant 18 week standard	TBC	1.22	↗	
Number of NICE guidelines with full compliance versus number of guidelines published in the year prior to last financial year applicable to LCH	100% by year end	94%		
Number of NICE guidelines with full compliance versus number of guidelines published last financial year applicable to LCH	No Target	88%		
NCAPOP audits: number started year to date versus number applicable to LCH	100% by year end	88%		
Priority 2 audits: number completed year to date versus number expected to be completed in 2021/22	100% by year end	33%		
Total number of audits completed in quarter	No Target	38		

Overall, there is good assurance for compliance with NICE Guidance as the majority are on track, with those overdue having defined actions which are underway.

Health Equity

An apparently sustained improvement in equitable access for Consultant led 18 week standard is seen, with the difference in access to services for patients living in IMD1 vs IMD 2-10 falling to 1 for the first time in the Consultant led 18 week standard. Early signs of improvement are noted in the other waiting list standards and this continues to be a focus of the Access LCH work, with the About Me template now live.

In Quarter 4, the Access policy review will be completed, opt-in principles rolled-out and thematic analysis available on the admin phone calls with people in IMD1 who have missed appointments, supplemented by a new missed appointment record on SystmOne. These will provide further learning on which interventions are successful in addressing this inequity, to support further roll-out.

Priority 2 Audits: Number Completed Year to Date Versus Number Expected to be Completed in 2025/26

Leeds Community Healthcare NHS Trust

Domain: Effective | Accountable Exec: Ruth Burnett | Author: Ann Henderson

Target: 100% | Actual: 33% | Data Quality: Low assurance

What is the trend we see?

There continues to be an upward trend in the number of audits being registered by services in Q3. Although the number of completed audits has also increased (47 in Q3), there remains a clear gap in the number of status updates being submitted to the Clinical Effectiveness Team (CET) -only 30 received. This means that while audit activity is rising, the incomplete reporting prevents full assurance that all registered and completed audits are being captured accurately. This is a similar trend that has been seen in previous years, with audit completion or update on audit status being difficult to ascertain by CET from services. There is an improved picture for compliance with national audits relevant to LCH, with LCH registered for all relevant national audits. There is full data submission to 5 out of the 8 relevant audits, partial for 2 (NACR, NOA), with no submission to 1 (SSANP).

What is being done about it?

A new audit programme for 2026-27 is in development and due to be rolled out to Business Units and services in Q4. The programme will help to ensure audit activity is directly linked to national priorities, NICE quality standards, and internal policy requirements, provide clearer expectations or service and focus resources on priority audits. The audit programme will be introduced in a stepped approach, allowing services time to embed the new audits while increasing transparency through use of MS Teams channels, As the programme is introduced, services will also be able to raise risks where audits cannot be completed. This will strengthen organisational oversight by improving understanding of where barriers exist and ensuring that risks to delivery are identified early and responded to appropriately.
For SSNAP and NACR services continue to engage with auditors regarding data set upload functionality. The Tier 3 Weight Management service is working with Clinical Systems to achieve full data set submission.

When do we expect to see improvement

We will see improvement throughout 2026-27 as the new audit programme is introduced. However, it may not be until the following year until the programme is more embedded that we begin to realise the full benefits of the programme. Services may see an early improvement due to the reduction in email traffic and completion of documents on MS Teams.
Improvement in submission to national audits for SSNAP is dependent on auditors, and no timeframe has been made available from them. This is a similar picture for NACR, where there is partial submission. Full data submission for the NOA is expected by end of Q1 2026-27.

Data quality has been assessed as low assurance for clinical audit as the KPI does not reliably answer the question about audit progress. Results may be incomplete as services are not consistent in updating status, and there can be a lag in reporting depending on when services update CET. Reporting should improve with the move to the new audit process and would improve with further digitising of the process.

What are the risks to delivery?

- Service capacity to be able to adjust to the change.
- Capacity within the Clinical Effectiveness Team to deliver the new audit programme for Q1. However, the programme will not require all audits to be registered at the beginning as in previous years, so can be added to as required.
- Move to using MS Teams channel may present challenges to some services who are not used to using this platform.
- There is minimal risk with National Audit compliance as issues with data submission lie mainly with auditors. LCH have action plans in place to address partial submission to the NOA.

Number of NICE Guidelines with Full Compliance Versus Number Published last Financial Year

Leeds Community Healthcare NHS Trust

Domain: Effective | Accountable Exec: Ruth Burnett | Author: Ann Henderson

Target: No Target | Actual: 88% | Data Quality: High Assurance

What is the trend we see?

Two Guidance are currently out of the two-year timescale to implementation set out in the PL326 Policy for the Dissemination, Implementation and Monitoring of NICE Guidance. These are NG197 Shared Decision Making and NG212 Mental Wellbeing at Work.

One guidance that could have become overdue within the next reporting period (NG51 Suspected sepsis: recognition, diagnosis and early management) has been updated and replaced by NICE's guidelines on suspected sepsis in people aged 16 or over (NG253), suspected sepsis in under 16s (NG254) and suspected sepsis in pregnant or recently pregnant people (NG255). All these guidance are currently being reviewed for compliance by relevant services, co-ordinated by IPC.

What is being done about it?

Actions to achieve full concordance with NICE guidance have been escalated to Business Unit Clinical and Quality Leads.

It was proposed to Quality Committee that both NG 197 and NG212 were closed as partially concordant, but this was not agreed to.

NG197: outstanding actions to achieve concordance are interlinked with the launch of the About Me template, completion of consent within EPR, and incorporating shared decision-making into clinical training quality assurance.

NG212: progress is dependent on the introduction of Staff Health and Wellbeing advocates, renewal of the Employee Assistance Programme contract, and the closure of the West Yorkshire Mental Health Hub. Actions for the Peoples Directorate to support achieving compliance are to update on advocate role once introduced; introduce annual audit to monitor compliance (NICE Quality Standard 147).

When do we expect to see improvement

Improvement for NG 197 will be as the actions above are embedded in practice. Compliance with the About Me template and consent is measured through the record keeping audit as well as bespoke reporting to be completed for the About Me template. Training is being completed in Q4, improvement may not be seen until Q2. Improvement for NG 212 is dependent on completion of the above actions and progress measurable once roles are established, decision about linked services are made and annual audit begins. Review of compliance with both guidance will be completed by Clinical Effectiveness and Compliance Manager and Head of Clinical Governance.

What are the risks to delivery?

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

Risk of reputational harm is assessed as low as action plans are in place to achieve full concordance.

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

Leeds Community Healthcare NHS Trust

Domain: Effective | Accountable Exec: Ruth Burnett | Author: Em Campbell

Target: 1.0 | Actual: 1.13 | SPC Variation: | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

The likelihood of patients in our most deprived areas (IMD1) waiting longer in these services has returned to within process limits, potentially indicating a levelling out of the previous increase, although it remains above target which was being achieved in the last financial year.

What is being done about it?

Longer waiting times for people in IMD1 are part of monthly Access LCH meetings, identifying which individual services are contributing to this aggregated position. Further work is being undertaken to understand the causes and solutions to the difference between services. Previous trustwide analysis identified that this was due to higher rates of cancellation and non-attendance by people in IMD1 rather than a difference in rates of invitations to appointments. This is being checked with more recent data. A range of improvement projects are being delivered to reduce missed appointments in IMD1 across the trust and services with longer waiting times for people in IMD1are being prioritised for additional support to embed these.

When do we expect to see improvement

The About Me template to record reasonable adjustments and other needs eg carers is now live, with associated improvements to the delivery of those adjustments expected to align with use of the template for all new referrals in Q4. A longer trajectory is expected for existing caseloads, but this will not adversely impact waiting times.

In Quarter 4, the Access policy review will be completed, opt-in principles rolled-out and thematic analysis available on the admin phone calls with people in IMD1 who have missed appointments, supplemented by a new missed appointment record on SystmOne. These will provide further learning on which interventions are successful in addressing this inequity, to support further roll-out.

What are the risks to delivery?

Limited capacity to make multiple contact attempts and have conversations with people living in deprivation to identify support they need to attend appointments.

Signposting to sources of support, particularly to address financial barriers to attending, may not be sufficient or timely enough to enable someone to attend an appointment in the near future.

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

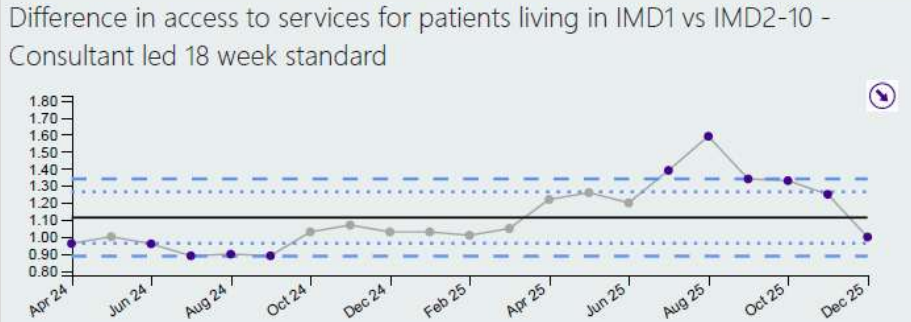
NHS Leeds Community Healthcare NHS Trust

Domain: Effective | Accountable Exec: Ruth Burnett | Author: Em Campbell

Target: 1.0 | Actual: 1 | SPC Variation: | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

The difference in odds ratio for consultant-led 18-week standard waits has reduced to 1, identifying patients in our most deprived areas (IMD1) are not waiting longer in these services than the rest of the population.



What is being done about it?

This will continue to be monitored to ensure this equitable position continues. Work will be undertaken to identify what is in place that has enabled this change, with learning shared with other services where patients in IMD1 are more likely to wait longer than the rest of the population.

What are the risks to delivery?

It is not yet known which actions have had the greatest contribution to this improvement, so ongoing work will be required to understand how to maintain it.

When do we expect to see improvement

Continued positive position expected.

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

Leeds Community Healthcare NHS Trust

Domain: Effective | Accountable Exec: Ruth Burnett | Author: Em Campbell

Target: 1.0 | Actual: 1.22 | SPC Variation:  | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

The steep upwards trend in likelihood of patients in our most deprived areas (IMD1) waiting longer in these services has levelled out, though still remains outside standard variation.

What is being done about it?

Longer waiting times for people in IMD1 are part of monthly Access LCH meetings, identifying which individual services are contributing to this aggregated trustwide position. The greatest difference has been identified as 2 weeks and further work is being undertaken to understand the causes and solutions to this. Previous trustwide analysis identified that this was due to higher rates of cancellation and non-attendance by people in IMD1 rather than a difference in rates of invitations to appointments. This is being checked with more recent data. A range of improvement projects are being delivered to reduce missed appointments in IMD1 across the trust and services with longer waiting times for people in IMD1 are being prioritised for additional support to embed these.

When do we expect to see improvement

The About Me template to record reasonable adjustments and other needs eg carers is now live, with associated improvements to the delivery of those adjustments expected to align with use of the template for all new referrals in Q4. A longer trajectory is expected for existing caseloads, but this will not adversely impact waiting times.

In Quarter 4, the Access policy review will be completed, opt-in principles rolled-out and thematic analysis available on the admin phone calls with people in IMD1 who have missed appointments, supplemented by a new missed appointment record on SystmOne. These will provide further learning on which interventions are successful in addressing this inequity, to support further roll-out.

What are the risks to delivery?

Limited capacity to make multiple contact attempts and have conversations with people living in deprivation to identify support they need to attend appointments.

Signposting to sources of support, particularly to address financial barriers to attending, may not be sufficient or timely enough to enable someone to attend an appointment in the near future.

Responsive Domain Summary

Accountable Exec: Sam Prince

NHS Leeds Community Healthcare NHS Trust

Summary

Although some patients continue to experience long waits to access treatment in a small number of services, further improvements have been delivered during this period. Significant recent reductions have been achieved in the longest waits within PND and CYMPHS. Services have also made strong progress in reducing the number of patients waiting more than 40 weeks for care to start, notably across Podiatry, Adult SLT, Dental and CUCS.

The total number of people waiting for care remains broadly static, with a total of 25,691 people waiting for care to start at the end of December 2025, compared to 27,933 at the start of the financial year. However, the total number of patients waiting more than 52 weeks continues to decrease, falling to 1,647 at the end of December 2025, from 3,430 at the end of August 2025.

The Trust's focus is now shifting towards achieving the nationally set target of 78% of patients waiting less than 18 weeks. The Trust is currently at 72.6%, equating to a gap of 1,339 patients to meet the 78% target. To support delivery against this ambition, 6-weekly forecasts are now in place across all services with waits over 18 weeks, providing increased grip on trajectories, capacity planning, and targeted recovery actions. Services are also producing longer-term plans to reduce their waits down to 18 weeks.

Further improvement have been seen in the Trust's performance against the Urgent Community Response Standard, with performance sitting at 87%.
Our Children's Audiology Service were slightly below the target for 99% of patients seen within 6-weeks, achieving 98% in December 2025. This was due to a single patient who required a specific appointment time and day, which unfortunately placed their appointment just beyond the six-week timeframe.

Domain Summary Performance

Data Quality : Medium Assurance

Performance: Off Track

KPI	Target	Actual	Performance	Assurance
% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	>=95%	38%		F
% Patients waiting under 18 weeks (non reportable)	>=95%	71%	H	F
Available virtual ward capacity per 100k head of population	TBC	8		
Community health services two-hour urgent response standard	>=70%	87%	H	?
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	No Target	61%	L	
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	>=95%	99%		P
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	>=75%	88%		P
LMWS – Access Target; Local Measure (including PCMH)	24456 by year end	2111		
NOF - Annual change in the number of children and young people accessing NHS-funded MH services	No Target	0		
Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care		2		
Number of Patients Accessing CAMHS	No Target	1147		
Number of patients waiting more than 52 Weeks (Consultant-Led)	0	1165	H	F
Percentage of Children over 5 currently waiting more than 18 weeks for a Neurodevelopmental Assessment		98%	H	
Percentage of patient contacts where an ethnicity code is present in the record	>=95%	98%	H	P
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	>=92%	25%	L	F
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	>=99%	98%		?
Zero tolerance RTT waits over 65 weeks for incomplete pathways	0	997	H	F
Zero tolerance RTT waits over 78 weeks for incomplete pathways	0	801	H	F

Consultant-led RTT Waiting Times – 18- and 52-week Standards

Domain: Responsive | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: 92% and 0 | Actual: 24% and 1227 | SPC Variation: H L | SPC Assurance: F | Data Quality: High Assurance

What is the trend we see?

The primary influence of this trend continues to be for children awaiting Autism Assessment within our Paediatric Neuro Disability Clinics. However, due to the waiting list initiatives progress against the 52-week waiting list for this cohort is now improving at pace.

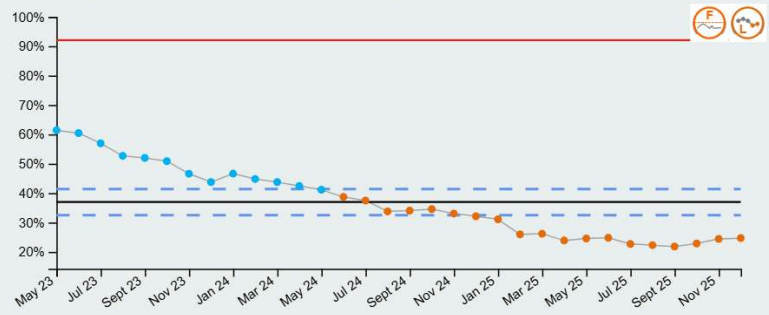
What is being done about it?

Actions to reduce PND waiting times include validation of the waiting list to confirm ongoing need, secondary triage by ICAN clinicians against updated preschool diagnostic autism assessment criteria, and the use of four locum Paediatricians to deliver assessments for those meeting the revised criteria. A targeted review of 457 patients on the complex medical waiting list is underway, alongside a broader capacity and demand review. Further weekend clinics and additional locum capacity are also being explored.

When do we expect to see improvement

While the waiting list is reducing, progress is slower than anticipated and original trajectories are now unlikely to be met. It is expected that a small number of young people will remain waiting over 52 weeks beyond March 2026. The service is therefore developing a business case for recurrent staffing to support sustainable improvement and delivery of the 18-week target.

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



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

What are the risks to delivery?

A key risk is the expiry of temporary locum contracts before the 52-week waiting list has been fully reduced, with no substantive replacements currently in place.

Non-consultant led 18 week waits

Domain: Responsive | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: 95% | Actual: 71% | SPC Variation: | SPC Assurance: | Data Quality: **Medium Assurance**

What is the trend we see?

The statistically significant rate of improvement has slowed through December for non-reportable 18 week waits. However, this started to improve again in early January and is expected to continue into 2026. Performance against the 18-week standard, however, remains significantly below the target of 95%, although is moving towards the 78% target set out in the Medium Term Planning Framework. We continue to see overall reductions in the number of people waiting more than 52 weeks, now standing as can be seen in the table.

52+ week waits	Oct 25	Jan 25
CAMHS	743	595
Adult SLT	88	27
CUCS	30	4
Diabetes Services	2	2
MSK	2	4
Podiatry	28	3
Dental	367	124
PND	1269	928

What is being done about it?

Trajectories are being used and monitored. CYMPHS ADHD pathway, Dental, Podiatry, Adult SLT and CUCS have all made significant progress in reducing their longest waits. Access LCH has moved focus from the longest waits to looking at 18 weeks and services across the Trust are developing plans to ensure the 18-week target can be met. The majority of our non-consultant led longest waits now sit in CAMHS in the ND pathway and long-term plans for this pathway are in development.

When do we expect to see improvement

Despite a potential slowdown in the coming weeks, the overall 18-week position is still anticipated to improve as services continue to address and reduce their longest waits. Several areas, including Podiatry and CUCS, have demonstrated substantial progress in eliminating their longest-waiting patients and will now transition their focus toward reducing shorter waits. There are 976 patients currently recorded within Tier 3 Weight Management who are not actively waiting but are pending transfer and will be removed from the waiting list. This adjustment will significantly improve the Trust's reported position and is expected to bring overall performance close to the 78% target.

What are the risks to delivery?

A range of non-recurrent initiatives are currently being implemented across services to manage waiting lists. However, as longer-term plans are still in development, there is a risk that these approaches may not align, creating a potential gap in provision and leading to further growth in waiting lists.

CAMHS Eating Disorder

Domain: Responsive | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: 95% | Actual: 38% | SPC Variation: | SPC Assurance: | Data Quality: **Medium Assurance**

What is the trend we see?

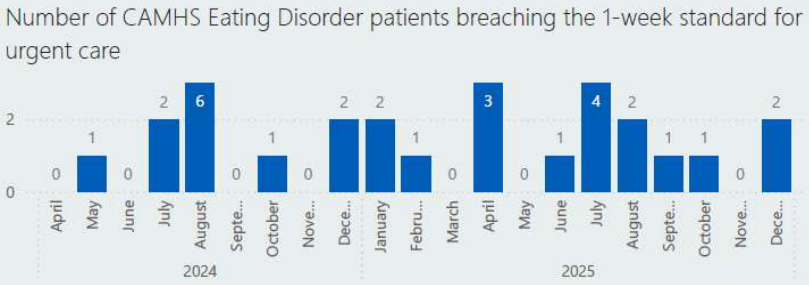
Performance against both the urgent and routine targets continues to be below target, and this is being driven by demand that outstrips capacity. The service has several gaps in roles that are sufficiently qualified to offer initial assessment appointments.

Performance against the routine standard is at 38% and some way off the 95% target. This is due to staffing challenges and slower than anticipated recruitment into the team.

The increasing complexity of cases has resulted in young people requiring more frequent and prolonged periods of intervention, as reflected in the BI data. This is placing additional pressure on available capacity. Referral volumes also remain consistently high, further contributing to the demand on the service.

What is being done about it?

The ICB has recently provided additional funding to increase capacity for assessment appointments. Enhancing the availability of more experienced clinicians will strengthen both the service's ability to assess new patients and its capability to manage the increasing risk and complexity within the caseload. Recruitment has been successful for 1 WTE Band 7 and 1 WTE Band 3 posts, with the remaining vacancies currently out to advert and interviews scheduled.



When do we expect to see improvement

If recruitment is successful, the service aims to have the post recruited to by Q4 this year however start dates will be in Q1 of the next financial year for those still outstanding

What are the risks to delivery?

- Any potential further delays to recruitment may continue to cause delays, breaches and demand outstripping capacity.
- Delays in accessing assessment and treatment which could result in further deterioration.
- However, physical health monitoring is held by primary care so this is managed, and families can contact the service for support and guidance if needed.

CAMHS Neurodevelopmental Assessment

Domain: Responsive | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: | Actual: 98% | SPC Variation: | SPC Assurance: N/A | Data Quality: **Medium Assurance**

What is the trend we see?

Due to limited capacity the service prioritises waits based on clinical need. This means the long routine waits continue to grow whilst capacity continues to outstrip demand.

What is being done about it?

A business case for the Neurodevelopmental service within CAMHS is scheduled for consideration at the February Business Committee, with a focus on securing substantive increases in staffing.

What are the risks to delivery?

- Without additional capacity the caseload will most likely continue to grow and there will be further breaches of 18 week waits.

When do we expect to see improvement

Subject to business case approval it would be following the recruitment of additional substantive staff for the team.

LMWS NHS Talking Therapies Waiting Times

Leeds Community Healthcare NHS Trust

Domain: Responsive | Accountable Exec: Sam Prince | Author: Samantha Steede

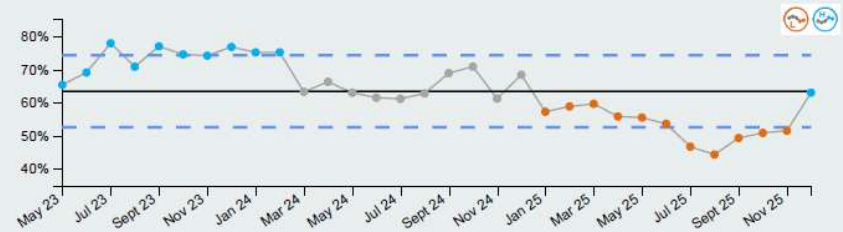
Target: | Actual: 63% | SPC Variation: L H | SPC Assurance: N/A | Data Quality: Low Assurance

What is the trend we see?

This indicator is reported as a Data Quality and Performance Concern.

Current data extracts suggest improvement, but a timeliness issue within the service has been found. This means the most recent month (Dec 25) shows improvement, but when the data for Dec-25 is refreshed, this month will show a lower figure. The pattern is that this figure reverts to a lower percentage value once additional data is added. A similar pattern has been observed in the Access indicator for the same service.

There are gradual improvements from Sep 25 to Nov 25, with four consecutive points showing improvement. A fifth point would represent statistically significant improvement.



What is being done about it?

Productivity improvements are leading to better performance. A comprehensive productivity action plan is being implemented, supported by a working group focused on maximising clinical capacity, optimising clinical and non-clinical activity, increasing newly qualified caseloads, strengthening engagement processes, and exploring digital solutions to improve efficiency. The capacity to offer digital therapy via Xyla has been increased recently.

In terms of Data Quality, the service will be meeting with the BI team to develop an improvement plan. Reporting on the timeliness of service recording of records will be monitored, and an update on progress given to this Board

When do we expect to see improvement

Some small term gains are expected during Q4, but ten newly qualified CBT practitioners begin building their caseloads from April 2026. Longer-term sustainability from September 2026 onward will depend on confirmation of ICB funding aligned to the workforce model and embedded productivity improvements.

Improvement on timeliness of recording should be expected during Q4, but fully recovery may require actions to continue into Q1 of the next Financial Year.

What are the risks to delivery?

There are longer term risks relating to funding and service capacity to meet demand, which rely on ICB decision-making.

Risks to the improvement of timely recording include limited engagement from staff in changing long-standing practices and habits.

Well-Led Domain Summary

Accountable Exec: Laura Smith and Jenny Allen

NHS Leeds Community Healthcare NHS Trust

Summary

Overall performance within the People domain continues to demonstrate sustained improvements in compliance and data quality. Sickness absence, however, remains a significant challenge. In response to National Oversight Framework expectations, a joint programme of work between the People Directorate and Operations is being delivered, including targeted analysis of high-absence areas, enhanced support for managers and the forthcoming refreshed Wellbeing at Work Toolkit. These proactive actions and preventative measures, combined with expected seasonal down trends, should see absence levels improve in March/April.

Overall sickness absence remains above the organisational target and continues to trend upwards, with the latest position at **8.2% against a target of 6.5%**. While this remains a sustained area of concern, short-term sickness absence is in line with expectations for this time of year and reflects established historical seasonal patterns. The key focus is on long-term sickness absence, which is impacting a number of specific service areas. Deep-dive reviews have been agreed with services showing the highest levels of absence to ensure tailored actions are in place.

Appraisal compliance remains below target at **81% against 90%,** however overall performance is still stronger than at any point in the past two years. Although there has been a recent dip, it remains within the SPC control limits.

Statutory and Mandatory Training compliance continues to perform well, remaining above the Trust target at **90.3%** following the introduction of the new stat mand dashboard, which is supporting managers to maintain compliance through more accessible row level data.

The percentage of staff identifying as BME has improved to **15% against a 14% target**, reflecting improved ESR data quality and proactive engagement with staff to complete declarations. Some fluctuation is expected over time as workforce changes occur.

Domain Summary Performance

Data Quality : **Medium Assurance** Performance: **On Track**

KPI	Target	Actual	Performance	Assurance
The overall percentage of staff who have identified as BME (including exec. board members)	14%	15%	H	?
Staff Turnover	<=14.5%	9%	L	P
'RIDDOR' incidents reported to Health and Safety Executive	No Target	0		
Total sickness absence rate (Monthly) (%)	<=6.5%	8%	H	?
AfC Staff Appraisal Rate	>=90%	81%	L	F
Starters / leavers net movement	>=0 in favour of starters	12		?
Reduce the number of staff leaving the organisation within 12 months	<=20.0%	13%		?
Statutory and Mandatory Training Compliance	>=90%	90%	H	F
Total agency cap (£k)	No Target	267		

Workforce Total Sickness Absence rate (Monthly) (%)

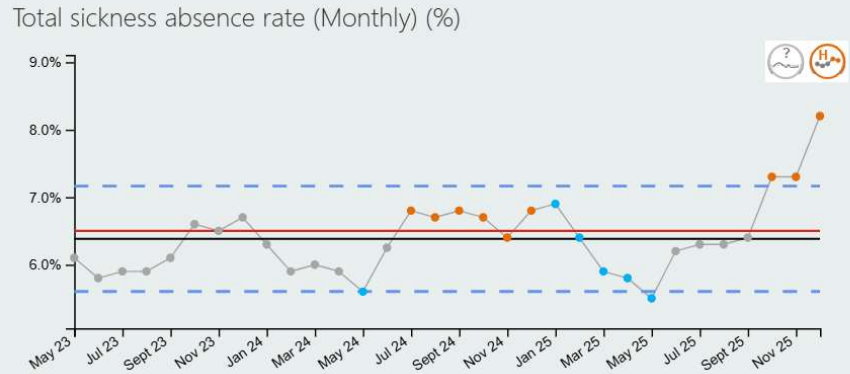
Leeds Community Healthcare NHS Trust

Domain: Well-Led | Accountable Exec: Laura Smith and Jenny Allen | Author: Leanne Harrison

Target: 6.5% | Actual: 8.2% | SPC Variation: H | SPC Assurance: ? | Data Quality: High Assurance

What is the trend we see?

The data indicates a continued rise in overall sickness absence rates. While short-term sickness absence is in line with expected seasonal patterns, overall absence remains above the organisational target, indicating a sustained area of concern.



What is being done about it?

Qualitative and quantitative data from the NOF Sickness Absence project is now enabling more specific identification and analysis of factors affecting the episodes and frequency of absence in individual teams. Teams targeted for this analysis are those where evidence suggests sickness absence may be unduly high, with particular focus on long-term sickness absence. Current priority areas include services within the Neighbourhood Teams, 0–19, Dental Services, LSH and Police Custody.

Actions to support managers include sickness absence training and additional support on complex long-term cases, alongside focused deep-dive reviews agreed with services experiencing the highest levels of absence.

As part of the NOF response, a joint programme of work between the People Directorate and Operations is progressing through multiple workstreams that aim to support managers and positively impact staff wellbeing at work. The updated Wellbeing at Work Toolkit is expected to be launched to services within the next few weeks, alongside enhanced intranet resources.

When do we expect to see improvement

Based on trends from previous years, and supported by proactive interventions and preventative measures, we anticipate a reduction in both long-term and short-term sickness rates in the spring. This outlook is further strengthened by the continued focus and involvement of People Partnering and the People Directorate.

What are the risks to delivery?

Reduced capacity. There is likely to be an impact upon waiting lists and service's ability to meet service level agreements.

Increased pressure on remaining staff. There is the potential for further stress and burnout within the workforce, which is also likely to impact on morale.

Increased operational costs. Overtime rates and temporary staff maybe required in order to provide essential cover.

AfC Staff Appraisal Rate

Domain: Well-Led | Accountable Exec: Laura Smith and Jenny Allen | Author: Rich Cooper

Target: 90% | Actual: 81% | SPC Variation: | SPC Assurance: | Data Quality: **Medium Assurance**

What is the trend we see?

Appraisal compliance improved significantly following focused efforts across Business Units, reaching a peak in July 2025. Although the second half of 2025 showed a gradual decline, overall compliance remains higher than at any point in the last two years, indicating that the underlying improvements are still holding.

What is being done about it?

Business Units continue to receive specific appraisal targets through their performance panels, with ongoing monitoring at the BU level. The recent decline in compliance will be formally addressed at upcoming performance panels, ensuring accountability and targeted action.

When do we expect to see improvement

Continued improvement is anticipated throughout 2026, supported by ongoing monitoring, clearer expectations, and local performance panel oversight.

What are the risks to delivery?

These factors could slow or disrupt progress:

1. **Competing operational priorities**. Workload pressures, particularly the recent organisational focus on sickness absence may divert attention away from appraisal completion.
2. **Inconsistent local ownership**. Different teams place varying levels of emphasis on compliance, leading to uneven performance and slower overall improvement.
3. **Limited managerial capacity**. Managers with large spans of control may struggle to complete appraisals on time without additional support or clearer prioritisation.

Statutory and Mandatory Training Compliance

Leeds Community Healthcare NHS Trust

Domain: Well-Led | Accountable Exec: Laura Smith and Jenny Allen | Author: Tom Breckin

Target: 90% | Actual: 90% | SPC Variation: H | SPC Assurance: F | Data Quality: **Medium Assurance**

What is the trend we see?

The compliance figure has continued to increase since June 2024. It is currently on 90.3% and therefore continuing to remain above Trust target figure of 90%, which it hit in October last year.

What is being done about it

A new statutory and mandatory training dashboard was released at the start of November, in order to support services with maintaining this high level of compliance. This dashboard provides row level data and can be easily accessed by managers. Since the introduction of the dashboard, compliance figures have remained over target level.

When do we expect to see improvement

The expectation is that compliance figure will continue to trend slightly above the 90% Trust target level.

What are the risks to delivery?

Service pressure: High clinical demand, vacancies and sickness absence reduce staff availability to attend or complete training.
Insufficient Protected Learning Time. Different teams place varying levels of emphasis on compliance, meaning some staff have less time to complete.
Limited managerial capacity. Managers with high numbers of staff or with high demand may have less time to manage compliance and follow up on expired or expiring training with their teams.

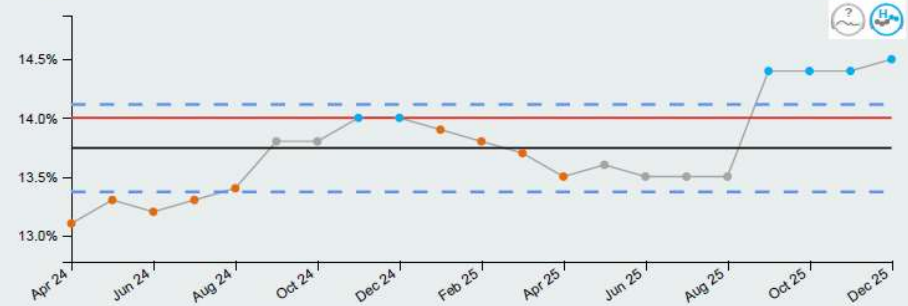
The overall percentage of staff who identified as BME (including exec. Board members)

Domain: Well-Led | Accountable Exec: Laura Smith and Jenny Allen | Author: Rich Cooper

Target: 14% | Actual: 15% | SPC Variation: | SPC Assurance: | Data Quality: **Medium Assurance**

What is the trend we see?

Performance continues to improve, reflecting the actions taken by the People Directorate to strengthen data quality within ESR. A key issue with ethnicity data in the Recruitment system has now been resolved, and a proactive approach to contacting staff who have not declared their ethnicity has further supported this improvement. These steps are now translating into sustained positive movement in the metric.



What is being done about it?

Work will continue to focus on monitoring ethnicity declarations in ESR and directly engaging with staff who have not yet provided this information. As we move into 2026, ongoing monitoring may be required, and there may be a need to review the current target of 14% to ensure it remains appropriate.

When do we expect to see improvement

Performance levels are expected to stabilise. However, this metric is sensitive to workforce changes, particularly new starters and leavers, so some fluctuation should still be anticipated.

What are the risks to delivery?

A significant number of leavers, or the decommissioning of a service, could negatively impact the metric and reduce performance levels.

Finance Domain Summary

Accountable Exec: Andrea Osborne

NHS Leeds Community Healthcare NHS Trust

Income & Expenditure: As at the end of December 2025, the Trust reported a year-to-date (YTD) surplus of £0.829m, compared to its break-even plan. The Trust remains on track to achieve its stretch target of £0.9m surplus by year end. The current financial position is being supported by one-off measures, such as releasing historic accruals no longer required and utilising budget underspends. After accounting for the full-year impact of savings already delivered, the forecast underlying position at Month 9 is a £1.7m deficit. Planning assumptions expect further recurrent savings to be identified, enabling the Trust to achieve a recurrent underlying breakeven position at the start of 2026/27.

Cash: The Trust's cash position remains strong, with a year-to-date closing balance of £46.8m, higher than the planned figure by £2.8m. The cash operating days, which is to pay short-term liabilities, is 76 days. Compliance with the Better Payment Practice Code (BPPC), our requirement to pay suppliers within 30 days or by the due date, is above target at 97.5% by both number and value of invoices.

Capital Expenditure: At the end of December 2025, the Trust has reported a spend of £2.3m on owned assets and £1.79m on ROU assets. The underspend against plan as at Month 9 is related to lower than planned lease remeasurements (£1.0m) and finalisation of two property leases (£2.5m). The Trusts capital limits in future years remains challenging, as a result a number of operational capital schemes have been approved to bring forward from future years to offset the underspend.

Quality & Value Programme: Identified CIP has increased marginally (£140k) during December, bringing the forecast total to £11.1m, a full-year effect of £12.25m. (c88% of target). Year to date, the Trust is delivering the plan in full, comprising £8.3m of recurrent savings, with the remaining savings delivered through non-recurrent measures. Work continues to achieve the target although it is likely to delivery will now be in 26/27.

Temporary Staffing: Year-to-date performance is underspend of £0.479m, with temporary staffing expenditure representing 4.3% of gross staff costs. This is 0.3% favourable to plan. Following a review of agency invoice coding the position has been corrected and now reports a forecast underspend of £0.642m. Most temporary staffing spend continues to support winter pressures and waiting list initiatives. Costs associated with waiting list initiatives are not expected to continue beyond the 2025/26 financial year.

Domain Summary Performance

Data Quality : High Assurance Performance: On track

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	-	(829)	**(829)**	-	(900)	**(900)**
3,600	Underlying (Surplus)/Deficit	-	1,149	**1,149**		1,723	**1,723**
50,908	Closing Cash Balance	43,976	46,832	**(2,856)**	43,426	49,387	**(5,961)**
(7,628)	Capital Expenditure (CDEL)	7,358	4,018	**(3,340)**	9,711	9,323	**(388)**
	Quality & Value Programme						
9,130	Recurrent Savings	10,501	8,341	**2,160**	14,000	11,101	**2,899**
6,648	Non Recurrent Savings	-	2,160	**(2,160)**	-	2,899	**(2,899)**
15,778	**Total Savings**	**10,501**	**10,501**	**-**	**14,000**	**14,000**	**-**
	Temporary Staffing						
2,408	Agency	1,803	1,267	**(536)**	2,861	1,985	**(876)**
5,334	Bank	4,039	4,096	**57**	5,419	5,653	**234**
7,742	**Total Temporary Staffing**	**5,842**	**5,363**	**(479)**	**8,280**	**7,638**	**(642)**
168,716	**Total Gross staff Costs**	**126,029**	**123,398**	**(2,631)**	**168,953**	**165,698**	**(3,255)**
4.6%	**Temp Staffing Costs as a % of gross staff costs**	**4.6%**	**4.3%**	**(0.3%)**	**4.9%**	**4.6%**	**(0.3%)**

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

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

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

Agenda item:	2025-26 (14i)
Title of report:	National Operating Framework Sickness Improvement Project
Meeting:	Trust Board Meeting Held In Public
Date:	5 February 2026

Presented by:	Jenny Allen / Laura Smith – Director of People
Prepared by:	Hannah Stankler – People Projects Manager

Purpose of the report:		
This report provides: Provides the Board with an update on the use of target setting across the organisation and business unit level in relation to improving Sickness Absence rates for NOF standards	Approval	
	Discussion	
	Assurance	x

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives		**Acceptable assurance** General level of confidence in delivery of existing objectives		**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:
• Sickness absence continues to rise, with a December spike to 8.2%, driven by an early flu season and increased stress-related absence • Trust remains in NOF Segment 4, performing above the sector benchmark and requiring sustained improvement to progress to Segment 3 • New target-setting framework developed, balancing Trust-wide ambition with realistic business-unit-level accountability

Previously considered by:	People and Culture Committee – December 2025
Outcome of previous discussion/s:	

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			What does it tell us?	

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

Recommendation(s)	• Note the progress made within the NOF Sick Absence Improvement Project workstreams. • Support the proposed approach to sickness absence target setting for 25/26 and the development of business unit level targets. • Note the targeted actions being taken in response to the recent spike in sickness absence, including the focused deep-dives with identified services.

List of Appendices:	

NOF Sickness Absence Improvement Project Update

1 Executive Summary

This paper provides an overall update on the Trust's NOF Sickness Absence Improvement project. It summarises the Trust's progress since the plan was last presented to the Board and to the People and Culture Committee in December, highlighting developments across the four workstreams; policy and process, occupational health, employee assistance, and organisational health. The update outlines the actions taken to strengthen the consistency and effectiveness of sickness absence management, including proactive long-term case review, enhanced guidance and training for managers, and targeted wellbeing and support interventions.

As part of the wider NOF programme update, the paper also sets out the proposed approach to sickness absence target-setting for 2025/26. It outlines the rationale for the revised methodology, which combines an evidence-based Trust-wide target with differentiated business-unit expectations to support both ambition and fairness. This approach takes account of the continued rise in sickness absence, early seasonal pressures, and the requirement to set realistic improvement trajectories aligned to movement from NOF Segment 4 towards Segment 3.

The Board is asked to consider progress to date across the NOF project elements included in this paper, review the target-setting methodology and underlying analysis, and confirm the direction of travel for the next phase of implementation.

2 Project Update

2.1 Progress Against the Sickness Absence Improvement Plan Overview

The Trust continues to implement the Sickness Absence Improvement Plan agreed by the Board, with work progressing across all four workstreams: policy and process, occupational health, employee assistance, and organisational health. The primary focus remains on strengthening consistency of practice, improving managerial confidence, and enabling earlier and more effective intervention in both short- and long-term absence.

Policy, Process and Managerial Capability

- Updated guidance, training materials and supporting tools have been developed to provide clearer expectations and improve the consistency with which sickness absence processes are applied.
- Pilot training sessions with high-absence services are scheduled to commence in January, with wider rollout planned thereafter.
- Sickness review panels and deep-dive sessions have been completed across all services. These have highlighted variation in the quality, timeliness and

escalation of management actions, which the updated process and training programme are designed to address.

Long-Term Sickness Management

- A dedicated review of long-term sickness cases has commenced, with 27 cases identified for targeted case-management intervention.
- Tailored action plans are being developed with line managers to ensure earlier Occupational Health input, more consistent follow-up, and clearer expectations for return-to-work planning.
- Audit Yorkshire's review of long-term sickness management is underway and will provide further assurance and recommendations.

Occupational Health and Employee Assistance

- The Occupational Health SLA review is now completed, focusing on responsiveness, quality of reports and clarity of referral pathways.
- The Employee Assistance Programme contract has been extended, with enhanced promotion and targeted support in high-absence areas.
- Webinars and communications have been delivered or scheduled to increase staff awareness and uptake of support.

Organisational Health and Wellbeing

- Diagnostic work with priority services (including Dental and Police Custody) is planned to identify underlying team, culture and workload factors that may be influencing sickness absence.
- A wellbeing funding bid has been submitted to NHS Charities Together to support the development of a Health and Wellbeing Advocate network.

Recent Sickness Absence Spike, Data and Targeted Response

An internal review of the December sickness absence position, which increased to 8.2%, indicates that the deterioration is predominantly driven by long-term sickness, with materially elevated levels in several key services including Neighbourhood Teams, 0–19 Services, Police Custody, Dental and LSH. Stress, anxiety and depression remain the leading reasons for absence and appear to be contributing significantly to long-term cases. In response, a further round of focused, performance-led deep-dive reviews will be undertaken with these hotspot areas, supported by enhanced Trust-wide and service-level analysis to understand trends, contributory factors and the staff groups most affected. While this activity spans all four improvement workstreams, it is being treated as a specific and urgent priority in order to provide assurance and to mitigate the operational and cultural impact of sustained high absence levels within these teams.

2.2 Sickness Absence Target-Setting

Alongside the progress update, the paper presents the proposed approach to sickness absence target-setting for 2025/26. This work responds to Board and

Committee feedback requesting clearer expectations, stronger accountability and more robust modelling underpinning sickness absence forecasts

Business Unit Accountability

- To ensure fairness and drive ownership, business-unit-level targets have been set based on each service's historic performance and improvement potential rather than applying a uniform rate.
- This approach recognises the differing contexts of services while supporting a consistent organisational improvement trajectory.

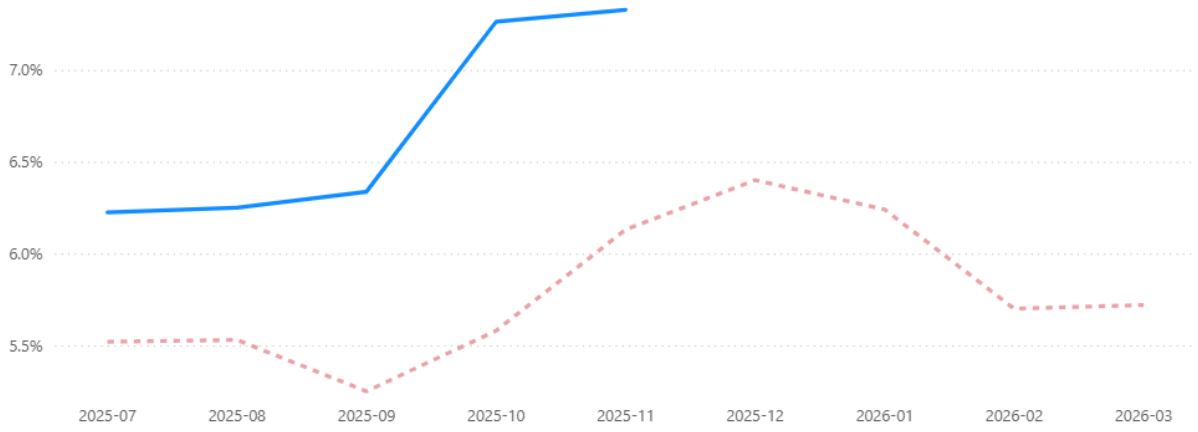
Dashboard and Monitoring

- A new sickness absence dashboard is in development to strengthen visibility, support monthly monitoring, and enable escalation where performance falls below expected levels.
- The dashboard will incorporate the new targets once finalised and ensure transparent reporting to the Board, Committee and operational leaders.

Rolling 12-month Sickness Rates with Business Unit Targets (December 2025):

Business Unit	Sickness Target	Sickness Rate (12m)
Adult Business Unit	6.00%	8.39%
Children's Business Unit	5.00%	5.86%
Operations Business Unit	6.00%	6.32%
Specialist Business Unit	5.00%	6.44%

Monthly Sickness Rates with Trust NOF Target:



3 Key risks and mitigations

Seasonal pressure and increased flu prevalence continue to influence sickness absence rates across the Trust. These pressures are being mitigated through strengthened short-term absence management, including closer monitoring, improved timeliness of interventions, and targeted health promotion activities designed to reduce preventable illness.

Long-term sickness duration continues to be a significant contributor to overall absence levels. In response, a dedicated resource has been allocated to review and manage long-term cases in a more proactive and structured manner. This work is supported by emerging recommendations from the Audit Yorkshire review, which

will further strengthen compliance with policy and improve the effectiveness of return-to-work planning.

4 Next steps

The next phase of work will focus on embedding the improvements made to date and ensuring that the revised approach to sickness absence management is applied consistently across all services. This will include the rollout of updated guidance and training materials to managers, supported by strengthened oversight through sickness review panels and the ongoing review of long-term cases.

In parallel, and in response to the recent deterioration in sickness absence, a further round of targeted, performance-led deep-dives will be undertaken in hotspot services, supported by enhanced analysis of Trust-wide and service-level patterns, reasons and staff groups affected. This focused activity will run alongside the established workstreams to ensure that contributory factors are fully understood and that appropriate, service-specific actions are implemented at pace.
Enhanced promotion of the Employee Assistance Programme will continue to ensure that staff have clear and timely access to support.

Implementation of the new sickness absence target-setting framework will commence, with business-unit-level trajectories communicated and incorporated into the performance dashboard currently in development. This will enable more consistent monitoring, greater accountability and earlier identification of services requiring additional support.

Audit Yorkshire's findings will be reviewed upon completion and integrated into the improvement plan to ensure alignment with best practice in the management of long-term sickness.

Collectively, these actions are intended to stabilise sickness absence rates, strengthen proactive and consistent management practice, and support the Trust in establishing a more sustainable improvement trajectory aligned with NOF expectations.

5 Recommendations

The Board is recommended to:

- Note the progress made within the NOF Sick Absence Improvement Project workstreams.
- Support the proposed approach to sickness absence target setting for 25/26 and the development of business unit level targets.
- Note the targeted actions being taken in response to the recent spike in sickness absence, including the focused deep-dives with identified services.

Hannah Stankler
People Project Manager
26th January 2026

Agenda item:	2025-26 (2025-26 (14ii)

Title of report:	Staff Engagement Improvement Project Update

Meeting:	Trust Board
Date:	5 February 2026

Presented by:	Jenny Allen, Director of People
Prepared by:	Hannah Stankler, People Projects Manager Catherine Hall, Associate Director People Solutions Laura Smith / Jenny Allen, Director of People

Purpose of the report:		
Provides the Board with assurance on the Staff Engagement Project to address our performance position in the NHS Oversight Framework 2025-6	Approval	
	Discussion	
	Assurance	X

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives		**Acceptable assurance** General level of confidence in delivery of existing objectives	X	**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:

- This paper provides Trust Board with assurance regarding the implementation of the Staff Engagement 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 3 for staff engagement, with a 2024 score of 6.95 , ranking 46th out of 61 comparable non-acute trusts against a sector average of 7.06.
- The project uses the NHS Employers' Dozen Do's of Staff Engagement as a framework and is structured around three workstreams: Leadership and Culture; Staff Voice, Advocacy and Involvement; Healthy Teams, Healthy Care.
- This paper outlines the project scope, governance structures, key risks, and monitoring arrangements to provide confidence that the Trust is taking decisive action to improve staff engagement.

Previously considered by:	People and Culture Committee, 11th December 2025
Outcome of previous discussion/s:	Assurance

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		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 Staff Engagement Improvement Project, including the engagement work undertaken, completion of the Project Initiation Document and governance framework. • Notes the proposed targets and ambitions to improve staff engagement scores through the annual staff survey.

List of Appendices:	Appendix One: Dozen Do's Engagement Table

1. Introduction

Staff engagement is a critical metric within the NHS Staff Survey and is a key indicator of organisational health, workforce experience, and cultural maturity. It directly influences retention, quality of care, and overall performance, and is closely monitored by regulators and stakeholders as part of the People and Workforce domain.

Based on its 2024 Staff Survey scores, Leeds Community Healthcare NHS Trust currently holds an engagement score of 6.95, which is broadly in line with previous years but sits against a backdrop of national downward trends and increasing operational pressures. This position presents both a challenge and an opportunity: maintaining current levels requires focused effort, while achieving the longer-term ambition of 7.2 by 2027 will demand a systematic, organisation-wide approach.

The Staff Engagement Improvement Project was started in recognition that incremental, ad hoc actions are insufficient to deliver sustainable improvement. This project represents a shift from isolated initiatives to a strategic, evidence-based programme embedded across the organisation, combining leadership visibility, staff voice mechanisms, and wellbeing infrastructure to create a consistent and positive engagement experience for all staff.

2. Project Aim and Scope

The Staff Engagement Improvement Project aims to strengthen organisational culture and staff experience by implementing a systematic programme that integrates leadership visibility, staff voice mechanisms, wellbeing support, and recognition practices to achieve measurable and sustainable improvements in engagement scores.

Key Characteristics:

- Delivery model linked to the Annual Staff Survey, our main feedback tool with staff, with iterative review and refinement throughout the year
- Internal resource allocation from the People Solutions team and Clinical Fellow post
- Integrated approach targeting both reactive and proactive interventions
- Applies to all staff groups across the organisation, with targeted support for areas below the target threshold for staff engagement scores

3. Work completed to date:

Following a “You Said, We’re Listening” questionnaire with managers during the initial phase and a comprehensive mapping exercise against the NHS Employers’ Dozen Do’s of Staff Engagement, several areas for improvement have been identified.

These include:

- Inconsistency in engagement practices across services, with varying visibility of leadership and feedback mechanisms.
- Limited clarity on how staff voice influences decision-making, alongside gaps in closing feedback loops.
- Opportunities to strengthen recognition and wellbeing infrastructure, ensuring staff feel valued and supported.

Staff feedback indicates that greater leadership visibility, clearer communication of “You Said, We Did” actions, and more structured engagement forums would help build trust and

improve the overall experience. Additionally, there is scope to enhance the promotion and accessibility of wellbeing resources, particularly for teams under operational pressure.

To address these findings, the project has already delivered several foundational actions:

- Mapped existing engagement tools to the Dozen Do's framework.
- Refreshed Pulse Survey dashboard, now incorporating accountability measures within performance panels.
- Reinstated Leaders Network Live to strengthen leadership visibility.
- Initiated engagement discussions at Board, TLT, and SLT levels to restore organisational focus on engagement.

4. Project Workstreams

The project is structured around three integrated workstreams, each with defined outcomes, deliverables, and accountability. Workstream leads are supported by the Project Steering Group which they report to monthly.

Workstreams:

- **Workstream 1: Leadership and Culture**
  The objective of this workstream is to enhance leadership visibility and accountability for staff engagement. It will focus on embedding engagement principles within leadership development programmes, reinstating Board-level service visits, and co-designing improvement plans with teams identified as having low engagement scores.
- **Workstream 2: Staff Voice, Advocacy and Involvement**
  This workstream aims to strengthen mechanisms for staff voice and advocacy across the organisation. It will establish structured engagement forums, implement robust feedback loops such as "You Said, We Did," and deploy accessible survey dashboards to ensure transparency and responsiveness in decision-making.
- **Workstream 3: Healthy Teams, Healthy Care**
  The objective of this workstream is to promote wellbeing and recognition as integral components of staff engagement. It will deliver psychological wellbeing training for staff and managers, coordinate a network of wellbeing advocates, and implement campaigns that foster healthy team culture and celebrate staff achievements.

5. Performance Targets and Data

Target-setting for staff engagement is currently in progress and will be guided by the following principles:

- **Baseline and Ambition:** Targets will reflect the immediate priority of maintaining the current engagement score of 6.95 in 2025, alongside the longer-term ambition of achieving 7.2 by 2027.
- **Benchmarking:** Targets will be informed by national and sector trends to ensure alignment with external expectations and realistic improvement trajectories.
- **Intervention-Linked Outcomes:** Improvements will be directly connected to the activities and interventions delivered through the project's workstreams, ensuring accountability for impact.
- **Dashboard Integration:** Engagement targets will be embedded within refreshed survey dashboards, providing real-time visibility of progress and enabling quarterly reporting to leadership and governance committees.

6. Key Risks

Several risks have been highlighted which may impact the ability to maintain or improve staff engagement scores during the next reporting period:

- **2025 Survey Results:** The annual Staff Survey 2025 results have been received, but cannot be shared in public until the embargo is lifted mid-late March 2026.
- **Organisational Change Pressures:** More than 25 services are currently undergoing Quality and Value (Q&V) change processes, which may create uncertainty and affect staff morale and engagement.
- **Place Provider Review:** The recent announcement regarding the Place Provider Review introduces additional complexity and potential anxiety among staff, which could influence engagement levels. The proposed integration with Leeds and York Partnership NHS Foundation Trust represents a significant organisational development and may require re-basing of targets for the eventual integrated organisation. Effective staff engagement throughout this process will be critical to maintaining trust and clarity
- **Integrated Provider Organisation (LCH / LYPFT):** A key risk is resource and capacity management, ensuring that aligned engagement work is delivered between both LCH and LYPFT. This will require careful planning and alignment with future organisational structures and between staff engagement teams. A transition team is in development to lead the integration from a People and Culture perspective.
- **National Context:** Broader system pressures and workforce challenges may contribute to a static or declining engagement trend across the sector, requiring proactive measures to sustain performance.

Mitigation:

- Continue monitoring engagement through Pulse Surveys to identify early trends and respond quickly.
- Strengthen leadership visibility and communication during change processes.
- Develop targeted engagement plans for integration and service redesign.
- Reinforce wellbeing and recognition initiatives to support staff through periods of uncertainty.
- Align resource planning with future organisational requirements to avoid duplication and ensure efficient use of capacity.
- Monitor engagement data closely and adjust interventions quarterly to maintain trajectory toward 2027 ambition.

7. Conclusion

The Staff Engagement Improvement Project has been active for 3 months and has delivered key foundational actions, including mapping current practices against the NHS Employers' Dozen Do's framework, refreshing engagement dashboards, and reinstating leadership visibility initiatives. Governance structures and workstreams are now established, providing a clear framework for delivery. Results from the Staff Survey 2025 have been received and, whilst remaining under embargo, are being analysed internally at organisation, business unit and team level to identify areas of focus for targeted staff engagement initiatives and support for leaders and managers.

The project's overarching ambition is to maintain the current engagement score of 6.95 in the 2025 NHS Staff Survey and achieve 7.2 by 2027. Setting and refining detailed targets, supported by robust monitoring and quarterly review, remains a priority to ensure progress is sustained despite external pressures and organisational change.

6. Recommendations:

It is recommended that the Board:

- Notes the ambition to maintain the engagement score of 6.95 in the 2025 NHS Staff Survey, recognising this as a realistic and stabilising target given current organisational pressures.
- Support the strategic goal of achieving an engagement score of 7.2 by 2027, ensuring this ambition is embedded in leadership priorities and organisational planning.
- Notes the intention approved by People & Culture Committee in December 2025, for continued investment in leadership engagement activities, including Board-level service visits and Leaders Network Live, to reinforce visibility and trust during periods of change.
- Notes the continued use of the Annual NHS Staff Survey and Pulse Surveys as indicators of staff engagement; with findings reported to Board, via People and Culture Committee.

Appendix One: Dozen Do's Engagement Table

Engagement Framework Table: "Dozen Do's"

Dozen Do's (NHS Employers)	Current LCH Practice	Even Better If…	Impact for staff
1. Give people a voice, one that is heard and that counts.	Annual staff survey, quarterly pulse surveys, local staff networks; feedback shared via internal comms.	Embed continuous 'You Said, We're Listening' updates at Trust and service levels; ensure feedback loops are closed. Consider staff engagement mechanisms, e.g. 50 Voices	Staff feel listened to and valued, with confidence that their feedback leads to real change. This builds trust and increases willingness to participate in future engagement activities.
2. Build a compassionate culture	Workforce strategy embeds compassion; values-based recruitment and staff wellbeing initiatives. Compassionate and Courageous Leadership Module	Develop structured programmes to grow compassionate leadership at all levels; embed this into culture change work. Work with Business Unit leadership to target leaders and managers who need this development/support	Staff experience a supportive environment where empathy and respect are embedded in everyday interactions, improving morale and psychological wellbeing.
3. Support line managers to lead their teams in a supportive and compassionate way and strengthen team working	Line management development underway through competency frameworks and training offers.	Provide more targeted coaching and peer learning for line managers on engagement and team leadership. Develop an engagement toolkit for managers.	Staff benefit from consistent, fair, and empathetic leadership, leading to stronger team cohesion and reduced stress.
4. Increase involvement: when people feel listened to and involved in decision making	Staff engagement in projects and forums; feedback channels for service-level decision-making.	Expand co-production in decision-making; increase opportunities for direct input at service-level. Share the making stuff better stories more widely in trust wide comms	Staff feel empowered and included in shaping decisions that affect their work, fostering ownership and commitment to organisational goals.
5. Give people autonomy, agency, and control over their working lives	Flexible working options, team autonomy in some services, local discretion on some operational decisions.	Increase autonomy by sharing best practice from highly engaged teams Increase comms on real-life stories on flexible working across trust wide comms	Staff experience greater flexibility and control, improving job satisfaction and reducing burnout.
6. Provide staff with support to develop in their job role and progress in their career	Learning and development pathways for clinical and non-clinical staff; appraisal process in place.	Promote visible success stories of career progression; enhance access to CPD for all roles.	Staff see clear pathways for growth and development, increasing motivation and retention.
7. Ensure senior leaders are visible, approachable, and communicate well	Senior leaders attend forums and some visits; ad-hoc comms through newsletters and briefings.	Reinstate regular, visible senior leader visits; introduce planned Q&A sessions and consistent comms.	Staff feel connected to organisational leadership, improving trust and confidence in strategic direction.
8. Build psychological safety	Freedom to Speak Up Guardian in place; HR support for raising concerns.	Create psychologically safe forums for staff to share concerns; train leaders in building psychological safety.	Staff feel safe to speak up without fear of negative consequences, encouraging openness and innovation.
9. Value, recognise, and celebrate staff regularly	Staff awards, newsletters, and recognition events.	Broaden recognition schemes to include peer-to-peer recognition and real-time celebration of achievements.	Staff feel appreciated and recognised for their contributions, boosting morale and engagement.
10. Reduce people's work pressures and ensure staff levels are safe	Health & wellbeing interventions and QV programme addressing efficiency and workforce pressures.	Review workload hotspots and staffing models; provide targeted support for teams under pressure.	Staff experience manageable workloads and safe staffing levels, reducing stress and improving wellbeing.
11. Provide improved health and wellbeing support	Employee Assistance Programme, wellbeing champions, mental health support initiatives.	Enhance proactive health interventions and tailor wellbeing offers to service-specific needs.	Staff have access to tailored wellbeing resources, helping them maintain physical and mental health.
12. Work in partnership with staffside	Partnership forums with staffside representatives; staff networks engaged in key initiatives.	Strengthen partnership working visibility by communicating outcomes from staffside collaboration more widely.	Staff feel represented and reassured that their interests are advocated for, strengthening trust in organisational processes.

Committee Escalation and Assurance Report

Name of Committee:	People & Culture	**Report to:**	Trust Board 5th February 2026
Date of Meeting:	11th December 2025	**Date of next meeting:**	17th March 2026

Introduction

A full agenda and set of papers leading to detailed discussions during the meeting and plenty of focus on staff voice which is a key function of the Committee. A "Staff Story" was heard for the first time on this agenda which proved to be a valuable and rich source of discussion and understanding of staff experience, with a particular focus on current concerns about racism incidents and attitudes.

Alert	Action

Advise

- Staff Side Chair (and Podiatrist) Rezwana Malik told her staff story. The Committee was delighted to learn of Rezwana's recent promotion within the Trust. She talked about her work on supporting the improvement of staff experience and culture and strengthening understanding between front line staff and management/leadership. She also reflected on some personal experiences of racism when carrying out her clinical duties. Due to promotion, the Staff Side Chair position has become vacant. The current climate and shifting attitudes to equality and diversity continues to be a theme which is discussed in this Committee. Executive leadership is encouraged to take every opportunity to listen to staff voices and to promote a positive culture where diversity is celebrated.
- Separately, the Committee heard about the Trust's approach to staff safety and support following the summer riots, including the detailed listening and engagement measures that had been put in place.
- The Committee approved the adoption of the IHRA internationally recognised definition of antisemitism.
- There was a discussion about difficulties in attracting people into network leadership roles and whether management afforded people sufficient time outside core duties to fulfil these roles. Committee encouraged a review of how such roles are advertised to encourage interest.
- The Committee welcomed Ruth Salthouse, Chair of the Trust's Pride Network to present on the work and achievements of the network and was struck by her passion and commitment. She raised similar themes to those highlighted across other networks around shifting attitudes and staff feeling more vulnerable in the current climate. The Committee reiterated its strong support for the Pride Network and all the other staff networks across the Trust and praised the dedication of those leading the way.

Committee Escalation and Assurance Report

Assurance

The Committee determined reasonable assurance levels in respect of the two strategic risks.

- A paper on people headlines and strategy update was presented and progress against strategic goals was noted. Response levels to staff survey had decreased at 55% and whilst the percentage was sufficient to produce meaningful data, there was a discussion about how better response rates could be encouraged. The Committee looks forward to sight of the new People Strategic Plan in March.
- 41 leavers were exiting as part of the MARS scheme which was delivered withing the approved financial envelope, most would be leaving by 12th January. The scheme was considered to be successful.
- The Committee reviewed the data pack for the Well Led metrics and discussed how individual teams were being supported and encouraged to use the data to drive performance locally. The detail now provided in the data sets has the potential to be a powerful tool to drive improved performance, focussing on critical areas such as sickness absence. The Committee also approved the KPIs which will be gradually introduced into the new Integrated Performance Report. The Committee welcomed the increasing quality and depth of the data and metrics available.
- The human factors trends as part of the Q&V programme were reviewed and it was noted that service redesigns continued to progress well with no obvious adverse impact on people. Sickness levels continue to be a strong focus for the Trust leadership and meetings are now set up to triangulate data and identify issues.
- The Committee heard about the Staff Engagement Improvement Project which is the approach to tackling the NOF drivers and which utilises the “Dozen Dos” of staff engagement. The Committee felt reasonably assured that the approach was appropriate to drive targeted improvements in key metrics. The next Committee meeting will hear more detail on deep dive outcomes and action plans, to maintain a sharp focus on NOF improvements.
- The Committee reviewed the employee relations and F2SU activity and noted the continuing higher volumes and complexity of employment cases.
- Committee was assured that all actions arising from Audit Yorkshire’s appraisal audit had been fully completed, including strengthened guidance and training and improved appraisal documentation. There have also been enhancements to dashboard reporting.
- Committee was also pleased to see the outcome of “significant assurance” in respect of the e-rostering audit.

Risks Discussed and New Risks Identified

- The People related risks were presented and discussed and it was noted there are no risks currently rated as “extreme” although 9 risks had a high score. There are a number of static risks which are being discussed at the RMG and these will be discussed at the March Committee.

Committee Escalation and Assurance Report

Author:	Rachel Booth
Role:	Committee Chair
Date:	10/01/26

Agenda item:	2025-26 (16i)
Title of report:	Freedom To Speak Up Reflection and Planning Tool
Meeting:	Trust Board Meeting Held in Public
Date:	5 February 2026

Presented by:	Sara Munro
Prepared by:	John Walsh Freedom To Speak Up Guardian

Purpose of the report:		
This report provides: an update on the agreed Reflection and Planning Tool agreed with the board in 2024 with actions to go to the People and Culture Committee. The tool is to renewed every two years.	Approval	
	Discussion	
	Assurance	x

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives	x	**Acceptable assurance** General level of confidence in delivery of existing objectives		**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:

- The new tool will be passed onto the new organisation so the FTSUG service and board of the new organisation can create a new joint planning tool.
- There are some ongoing actions from the original tool which are mentioned in the attached paper.
- The issue of mandating training was raised in the audit on LCH FTSU work. The paper raises options for the trust to consider on this.

Previously considered by:	Discussion with the Chief Executive and the FTSUG.
Outcome of previous discussion/s:	

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?	Once agreements are made on the planning tool, we can look at any Health Equity needs.

Recommendation(s)	The board agrees to the reflection and planning tool paper to go to the People and Culture Committee with a recommendation on the issue of mandating training.

List of Appendices:	Paper attached outlining thinking, progress and options on the planning tool.

The FTSU Reflection and Planning Tool Update

EXECUTIVE SUMMARY

The FTSU Planning and Reflection Tool is a plan NHS boards are to undertake.

In February 2024 the LCH Board agreed the FTSU Reflection and Planning Tool. This enumerated reflections on the strengths and future work of speaking up at the trust. The tool marked us as making positive progress in this work. The tool was to be renewed after two years.

Due to the creation of the new organisation, we are seeking to continue with the actions of the 2024 plan rather than create a new tool / plan. When the new organisation is established the FTSUG service will support a new reflection and planning tool with the new board.

There are two key aspects from the 2024 plan – the agreed high-powered actions and other developmental actions. Both aspects need ongoing work. This paper offers an update and suggestions

UPDATE

The three high-powered actions are -

(1) To undertake how we as a trust work best with detriment / reported negative impact for staff who speak up.
(2) For the FTSU training to be mandated for all new starters
(3) For a review of how the FTSU links with patient care / patient safety issues in the trust

On the first action we have a joint paper on detriment by the LCH FTSUG and FTSUG's from LCC, Locala and LTHT. This looks at detriment, work addressing reported negative impact and suggestions about good practice. This has been shared with the Director of People. We are also dealing with live cases of reported detriment, so learning is being collated into the best ways to work in this area. Some recent work with the Chief

Executive and the FTSUG with a staff member who has reported detriment offers a possible model of working with reported detriment enshrining collaboration, co-production and resolution. More work is needed in this area and the development of an agreed process when someone reports detriment. There is also work on a new Whistleblowing policy (apart from the Raising Concerns policy) which will assist us.

On the second action, we looked at mandating training for new starters. The FTSUG service being well known and used and national expectations to rationalise mandatory training led us to continue what we presently do and not mandate any training. In the recent audit of the FTSUG service the issue of mandating training was raised as an action. The FTSUG agreed with the Chief Executive and Director of People to raise options in this paper.

The options would be

- Mandate the training – This would align us with national guidance. LYPFT don't mandate the training so we will need to address this again in the new organisation if we do. Mandating may not necessarily bring the awareness of speaking up we seek.
- Continue as we are – We still find staff who do not know about the work and service (although past and current staff surveys show staff feel safe to speak and raise issues). The argument against is that it doesn't align us to national guidelines.
- Move to Priority Training now - LYPFT have a category of priority training on its training matrix. This isn't mandated but encourages staff and managers to undertake the training. The argument for this is that it aligns us to LYPFT for the new organisation. I have spoken to a senior colleague at LCH People Systems and we could do this. The issue raised was the need of a LCH resource to create this.
- Continue with what we do then plan with the new organisation - to continue as we are and when we create the new organisation revisit this with the board of the new organisation to plan the way forward.

The last high powered- action was to continue to challenge whether we are encouraging patient safety concerns to be escalate. We have established the Clinical Concerns Forum with the Executive Medical, Operations and Nursing Directors and the FTSUG

quarterly to look at concerns regarding clinical practice. This is working well. The FTSUG is also linked to the PSIRF work.

On the other development actions some have been carried out, others are ongoing work and some actions such as a peer review of the service have not happened yet.

NEXT ACTIONS

The Reflection and Planning Tool to be discussed at the board. To offer a recommendation on the issue of whether we should mandate training. For the People and Culture Committee to review the paper as it overlaps with work we have to do to respond to the national ask on reducing statutory and mandatory training.

The Board is recommended to action the above next actions

John Walsh

Freedom To Speak Up Guardian

Leeds Community Healthcare NHS Trust

5/1/26

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I have led a review of our speaking-up arrangements at least every two years	5*
I am assured that our guardian(s) was recruited through fair and open competition	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	5
Enter summarised commentary to support your score. **Freedom to Speak Up is well embedded in the organisation** ***The previous Chief Executive ensured this took place prior to August 2023. This review is the first since that time.** **Monthly 1:1s in place – evidence available through 1:1 notes and email exchange**	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up	5
I effectively monitor progress in board-level engagement with the speaking-up agenda	5
I challenge the board to develop and improve its speaking-up arrangements	5
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am involved in overseeing investigations that relate to the board	5
I provide effective support to our guardian(s)	4

Enter summarised evidence to support your score.

The FTSUG arrangements at LCH are both mature and constantly evolving when improvement opportunities or national imperatives are identified.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Continue to challenge whether we are encouraging patient safety concerns to be escalated.

2

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	5
We regularly and clearly articulate our vision for speaking up	5
We can evidence how we demonstrate that we welcome speaking up	5
We can evidence how we have communicated that we will not accept detriment	3
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	5
We regular discuss speaking-up matters in detail	5
Enter summarised evidence to support your score. Good culture, managers referring staff to FTSU services, good stories of change	
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	
1 To develop thinking and practice plan on detriment	
2	

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	Yes
We support our guardian(s) to make effective links with our staff networks	Yes
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes
Enter summarised evidence to support your score. There is an embedded culture of speaking up in LCH, staff are aware of who to approach and this is validated historically by our Staff Survey results and the previous National Guardian Office Index while it operated.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	5
We have reviewed the ringfenced time our Guardian has in light of any significant events	5
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	5
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	5
Enter summarised evidence to support your score. The board has created and shaped the role including the hours and time, There has been a recent change in this to best reflect the work in the last two years. The FTSUG controls his own diary and is fully supported. He has never made a request for help or assistance that has been refused.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	Yes
Enter summarised evidence to support your score. We have used national policy and our own approach in the policy. The policy was peer reviewed by a FTSUG at another trust. It has also gone through consultation with key stakeholders including staff who have spoken up.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 weblink to actual national policy in policy. Change some features that no longer exist.	
2	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	5
We have an annual plan to raise the profile of Freedom to Speak Up	5
We tell positive stories about speaking up and the changes it can bring	4
We measure the effectiveness of our communications strategy for Freedom to Speak Up	3
Enter summarised evidence to support your score. Regular Communications, high visibility of the Guardian and the work	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 need to share more stories of positive change across the trust.	
2	

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	No
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	Yes corporate but locally varied
Our HR and OD teams measure the impact of speaking-up training	No

Enter summarised evidence to support your score.

Everyone goes to corporate induction. Also new starters have a forum with the Chief Executive, FTSUG and Director of Workplace and clinical student forum, preceptorship and International Nurses..

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1
To consider making the FTSUG training mandatory for all new starters. To consider whether when serious issues in a team occur there is an insistence that all staff have done the staff training and all managers the manager training.

2 To look at measuring training.

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	Yes
All managers and senior leaders have received training on Freedom to Speak Up	No
We have enabled managers to respond to speaking-up matters in a timely way	Yes
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	Yes
Enter summarised evidence to support your score. There is a good culture of speaking up. Managers support this and refer staff to the service. We work with managers to ensure they work with speaking up. We have seen in the last seven years a real development of how managers work and learn from cases.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes
We use triangulated data to inform our overall cultural and safety improvement programmes	Yes

Enter summarised evidence to support your score.

Our FTSUG regularly raises potential areas of concern and we have supported him to work with staff where there were potential issues such as unvaccinated staff refusing the Covid vaccine and staff who are Clinically Extremely Vulnerable and who were shielding during the pandemic. The FTSUG flows into ODI, HR, leadership, PSIRF and other trust work.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	Yes
We use this information to add to our Freedom to Speak Up improvement plan	Yes
We share the good practice we have generated both internally and externally to enable others to learn	Yes
Enter summarised evidence to support your score. We have an improvement approach. This listens to all concerns. We use gap analysis and this feeds into FTSU practice. We share information internally for services. We share good practice in the wider system including the local authority. The FTSU service is continually reflecting and acting on what we see and learn.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	Yes
Our guardian(s) has been trained and registered with the National Guardian Office	Yes
Enter summarised evidence to support your score. Advertised and Staff assessment and interview used. FTSUG has done training and refresher training and is registered.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	Yes
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
Our guardian(s) has access to a confidential source of emotional support or supervision	Yes
There is an effective plan in place to cover the guardian's absence	Yes
Our guardian(s) provides data quarterly to the National Guardian's Office	Yes
Enter summarised evidence to support your score. We have an informal plan and objectives. We have culture of many doors to speaking up which allows cover for absence. Support is given and psychological supervision is enacted via the ICS. Regular co-mentoring with another FTSUG in place. Regular data to NGO	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	Yes
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	Yes
We are assured that confidentiality is maintained effectively	Yes
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	Yes
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	Yes
Enter summarised evidence to support your score. Record kept. Learning and new approaches for managers on speaking up. Confidentiality maintained (no cases in last seven years of breach in confidentiality). We strive to work in timely ways. The positive experience will be being heard and understood as we cannot guarantee what someone speaks up will be the organisational answer. There can be delays in timings for some cases usually due to complexities.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 written briefing with the Chief Executive, NED and FTSUG on how we document.	
2	

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	Yes
We know who isn't speaking up and why	Yes (often)
We are confident that our Freedom to Speak Up champions are clear on their role	Yes
We have evaluated the impact of actions taken to reduce barriers?	Yes
Enter summarised evidence to support your score. Work on barriers. Horizon scanning work. Looking at protected characteristics – work with networks would helps with who isn't speaking up. Increase in race, disability, mental health concerns. Its difficult to totally know who isn't speaking up and why unless we know who they are and they find a way to share their concern with us.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	Yes
We monitor whether workers feel they have suffered detriment after they have spoken up	Yes
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	Yes
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	Yes
Enter summarised evidence to support your score. Monitored by the FTSUG. We inform and involve the NED. We have some ways in place to respond to detriment. We do need to deepen and create best practice in this area.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 joint paper on detriment and repairing what has happened. Joint paper to be prepared by LCH FTSUG and FTSUG's from LCC, Locala and LTHT .	
2	

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	Yes
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	Yes
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	Yes
Our improvement plan is up to date and on track	Yes
Enter summarised evidence to support your score. We have a strategy linked to the LCH Workforce strategy. We work on improvements to enhance speaking up.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	Yes
Our plan follows a recognised ‘plan, do, study, act’ or other quality improvement approach	Yes
Our speaking-up arrangements have been evaluated within the last two years	Yes
Enter summarised evidence to support your score. We use the PDSA cycle for developing speaking up. We had a peer review by another NHS organisation several years ago and we are planning an independent peer review in 2024. LCH evaluates the service and offers recommendations and changes.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Peer review to be arranged for 2024.	
2	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	Yes
We have we evaluated the content of our guardian report against the suggestions in the guide	Yes
Our guardian(s) provides us with a report in person at least twice a year	Yes
We receive a variety of assurance that relates to speaking up	Yes
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	Yes
Enter summarised evidence to support your score. We have created organisational assurances. The FTSUG is doing a new evaluation of the report and the guide and other factors.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 FTSUG to undertake new evaluation.	
2 Look at how we measure training	

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1 Work on Detriment / reported negative impact	June 2024	Director of Workforce, Head of HR and FTSUG
2 Reflection on the FTSU link with clinical care issues	March 2024	Executive Medical Director, Executive Director of Nursing and AHPs and FTSUG
3 Look at mandatory training for all new starters on speaking up E learning.	June 2024	Director of Workforce FTSUG and Head of Learning and Development
4		
5		
6		
7		
8		

Development areas to address in the next 12–24 months	Target date	Action owner
1 Developing FTSU champions work	December 2024	FTSUG
2 Completing, sharing and embedding any learning from the peer review	March 2025	FTSUG
3		
4		
5		
6		
7		
8		

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1 Weblink to actual national policy in policy	January 2024	FTSUG
2 Peer review to be arranged for 2024.	Details to be agreed March 2024and completed by end of 2024	FTSUG
3 To develop thinking and practice plan on detriment. joint paper on detriment and repairing what has happened. Joint paper to be prepared by LCH FTSUG and FTSUG's from LCC, Locala and LTHT . Written briefing with the Chief Executive, NED and FTSUG on how we document	March 2024	FTSUG
4 FTSUG to undertake new evaluation of annual report and national guide and other national learning	June 2024	FTSUG
5 Considerations around mandatory nature of FTSU training in the trust	June 2024	FTSUG
6 Sharing positive stories of change	June 2024	FTSUG
7 Peer review	September 2024	FTSUG
8 Work on how we measure training	September 2024	FTSUG

Agenda item:	2025-26 (17)
Title of report:	Guardian For Safe Working Hours - Quarterly Report
Meeting:	Trust Board Meeting Held In Public
Date:	5 February 2026

Presented by:	Ruth Burnett, Medical Director
Prepared by:	Nagashree Nallapeta, GoSWH

Purpose of the report:		
This report provides: Provides board with an update around national changes terms and conditions for resident doctors, Exception reporting reforms and local implementation. Quarter 2 update	Approval	
	Discussion	
	Assurance	X

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives	X	**Acceptable assurance** General level of confidence in delivery of existing objectives		**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:

- Implementation of the NHS England 10 point action plan, with GOSWH progressing key improvements to resident doctor working lives and appointing appropriate board level leads.
- Introduction of the new exception reporting system, with GOSWH and the People's Directorate rolling out an MS Forms process from 4 February 2026 to replace email based reporting.
- Dr Salma Elhag's appointment as LNC Resident Doctors' Representative and peer representative from Jan 2026.
- CAMHS NROC monitoring remains a concern due to low RD engagement, with the Medical Director offering to liaise with the CAMHS team to identify any additional support needed.

Previously considered by:	GoSWH Quarter 1 report presented Sep 2025
Outcome of previous discussion/s:	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	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?	GoSWH will consider steps to include this information in future reports.

Recommendation(s)	• The board is recommended to endorse the implementation of the NHS England 10-Point Plan, including the appointment of the Medical Director and the LNC Resident Doctor representative as the trust's named leads for resident-doctor issues. • Board is recommended to note the introduction of the new MS Forms exception reporting system launching on 4 February 2026. • Board is recommended to note the appointment of Dr Salma Elhag as the LNC Resident Doctors' Representative from January 2026.

List of Appendices:	Nil

Gurdian of Safe working hours report

➢ 1 Executive Summary

Key work continues to improve resident-doctor experience. GOSWH is progressing the NHS England 10-point action plan with appropriate board-level leads in place. A new MS Forms exception-reporting system will launch on 4 February 2026, replacing email reporting. Dr Salma Elhag has been appointed as the LNC Resident Doctors' Representative from January 2026. CAMHS NROC monitoring remains a concern due to low engagement, and the Medical Director will work with the CAMHS team to identify any additional support needed.

➢ 2 Main body of the report

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

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

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

➢ 3 Impact

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

- **Quality**

Exception reports
No exception reports were filed during this quarter.

Fines
No fines levied by the GOSWH during this quarter

- **Resources**

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

Rota Gaps (number of night shifts needing cover)		Sep 2025		Oct 2025		Nov 2025	
		CT	ST	CT	ST	CT	ST
	Gaps	n/a	4	n/a	16	n/a	16
	Internal Cover	n/a	2	n/a	7	n/a	7
	External cover	n/a	2	n/a	9	n/a	9
	Unfilled	n/a	0	n/a	0	n/a	0

- **Risk and assurance**

Appointment of LNC Resident Doctors' Representative
From January 2026, Dr Salma Elhag has been appointed as the LNC Resident Doctors' Representative and peer representative for the trust. Support for her transition into the role has been provided by GoSWH, the Medical Director, the BMA IRO, and the previous RD representative.

Feedback from Junior doctors
The Resident Doctors Forum (RDF) met on MS Teams on 08/01/2026 and welcomed Dr Elhag into her new role as RD LNC representative and peer representative. Members discussed progress on exception reporting reforms, updates on the 10-point action plan, and the launch of the Learner Information Hub, which brings undergraduate and postgraduate information together. The BMA IRO was unable to attend. CAMHS NROC monitoring was highlighted as an area needing improvement due to low engagement, and the Medical Director has agreed to liaise with the CAMHS team to explore what support may be required.

These discussions reflect ongoing efforts to strengthen representation, improve training communication, and advance reporting reforms. The new Learner Information Hub supports more streamlined access to learning updates, while limited engagement with CAMHS NROC monitoring raises concerns about compliance and oversight. The absence of the BMA IRO means some input may have been missed.

The forum will support Dr Elhag as she settles into her role, continue monitoring progress on reforms and the action plan, and follow up with the BMA IRO for any outstanding updates. Work with the Medical Director and CAMHS team will focus on identifying barriers to NROC engagement and ensuring resident doctors receive the support needed to meet monitoring requirements.

Exception reporting Reforms
Exception reporting reforms for doctors and dentists on the 2016 Terms and Conditions of Service introduce major changes to be implemented by February 2026. Educational exception reports will now go directly to Directors of Medical Education, while all other reports will be routed to HR or Medical Workforce teams, with Guardians of Safe Working Hours retaining oversight to monitor patterns and ensure appropriate use. At LCH, GoSWH has collaborated with the People's Directorate, resident doctors, and the Medical Education team to prepare for these changes, including creating a new Microsoft Forms system that

incorporates resident doctor feedback and will launch on 4 February 2026. This replaces the current email-based reporting process, which will end on the same date.

These reforms represent a significant shift in how exception reporting is managed, aiming to streamline processes, improve accountability, and ensure reports reach the most appropriate teams. The move to Microsoft Forms modernises the system and reduces reliance on manual email submissions, while continued oversight from GoSWH helps maintain consistency and safety monitoring. Clear communication has been essential, as the change affects all resident doctors and alters long-standing reporting habits.

GoSWH will continue working with the People's Directorate to support a smooth transition as the new system goes live. Resident doctors are expected to begin using the Microsoft Forms process from 4 February, and ongoing communication will reinforce the new requirements. Monitoring early use of the system will help identify any issues, ensure compliance, and support resident doctors as they adapt to the updated reporting structure.

- **Equity**

NHSE 10 Point Plan to improve resident doctors' working lives
Trust Medical Education, in collaboration with the Medical Directorate, DME and GoSWH, is progressing NHS England's 10-Point Plan (August 2025) aimed at improving resident doctors' working lives. As part of this programme, the trust is required to appoint two board-level leads: a senior leader responsible for resident-doctor issues and a peer representative who is a resident doctor, both reporting directly to the board. At present, these responsibilities are considered to be appropriately met by the Medical Director and the LNC Resident Doctor representative.

These arrangements ensure that resident-doctor issues are formally represented at the highest level of the organisation, aligning the trust with national expectations and strengthening governance. Having clearly identified leads supports accountability, visibility and a direct route for escalating concerns or priorities affecting resident doctors. The current alignment with existing roles also avoids unnecessary structural change while still meeting the requirements of the 10-Point Plan.

The trust will continue to deliver the 10-Point Plan through joint work between Medical Education, the Medical Directorate, DME and GoSWH, ensuring that board-level oversight remains active and effective. Ongoing review of these appointed roles will help confirm they continue to meet national expectations and the needs of resident doctors. Further communication with resident doctors will support awareness of these structures and how they can use them to raise issues or contribute to improvement work.

➢ 4 Next steps

GoSWH will work collaboratively with key stakeholders across the trust to ensure effective and timely implementation of the 10 point plan.

GoSWH will Oversee the rollout and early implementation of the new MS Forms exception-reporting system from 4 February 2026, ensuring resident doctors are supported during the transition.

5 Recommendations

The Board is recommended to:

- The board is recommended to endorse the implementation of the NHS England 10-Point Plan, including the appointment of the Medical Director and the LNC Resident Doctor representative as the trust's named leads for resident-doctor issues.
- Board is recommended to note the introduction of the new MS Forms exception reporting system launching on 4 February 2026.
- Board is recommended to note the appointment of Dr Salma Elhag as the LNC Resident Doctors' Representative from January 2026.

Name of author Nagashree Nallapeta
Title Guardian of Safe Working Hours
Date paper written 23/01/2024

Agenda item:	2025-2026 (18ai)
Title of report:	Board Assurance Framework Quarterly Update
Meeting:	Trust Board held in Public
Date:	5 February 2026

Presented by:	Dr Sara Munro, Interim Chief Executive Officer
Prepared by:	Helen Robinson, Company Secretary

Purpose of the report:		
This report provides the outcome of the third quarterly review of the 2025/26 BAF.	Approval	
	Discussion	
	Assurance	✓

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives		**Acceptable assurance** General level of confidence in delivery of existing objectives	✓	**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:

- Any amends made during the January review remain in red font in the Appendix.
- The current scores for strategic risks 2 and 3 have both reduced during this quarterly review, and it is anticipated that the scores for strategic risks 1, 4, and 6 will reduce by the end of Quarter 4.
- The outputs of all committees overseeing strategic risks during Q3 resulted in reasonable assurance, but with comments added where individual items led to limited assurance.

Previously considered by:	N/A – review meetings held with individual Execs
Outcome of previous discussion/s:	

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_Jan_2026

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 January 2026, meetings were held with the Executive Directors in order to undertake the third 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 8 January the Board reviewed it's risk appetite at a Board development session, and this information was updated in the BAF document.

2.3 During October – December 2025 the Audit, Quality, People and Culture, 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.

2.5 The Board is reminded that the BAF is presented here for assurance on its completeness as of January 2026.

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 continue to 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

26 January 2026

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 20 January 2026

Ref	Strategic Risk	Lead Director	Current Score (Jan 2026)	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	At the end of the third quarter of 2025/26 there is no change to the risk score. Actions relating to EQIA and CQC are ongoing to reduce the score to 12 by year end.
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	12	At the end of the third quarter of 2025/26, the risk has reduced from 16 to 12. The likelihood of failing to respond to increased demand has reduced from almost certain to likely, due to the appetite to seek opportunities to reduce waiting lists and the progress made against the actions including the waiting list initiatives, quality and value programme and Northpoint contract to deliver the MindMate Single Point of Access (SPA)
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~~ 12	6	At the end of the third quarter of 2025/26, the risk has reduced from 15 to 12. The likelihood of the risk has reduced from almost certain to likely. The Trust remains in segment 4 following the latest segmentation, however, there has been improvement, the provider capability self-assessment showed no areas of non-compliance. The Board will continue to have oversight of the NOF metrics. There remain actions relating to CQC compliance.
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	At the end of the third quarter of 2025/26 there is no change to the risk score, however the risk is on target to reduce to 12 by the year-end. An Internal Audit of Financial Sustainability has provided Significant Assurance. Actions relating to the medium-term financial plan, approval of the Estates Strategy, stocktake of the Digital Strategy and implementation of the IPR are due to be completed by the year-end.
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	At the end of the third quarter of 2025/26 there is no change to the risk score. Actions relating to climate adaptability, business continuity and EPRR resilience are ongoing. 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	At the end of the third quarter of 2025/26 there is no change to the risk score. Actions focus on engagement and sickness management are ongoing. The score is expected to reduce to target, supported by the staff survey results at the year end.
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	At the end of the third quarter of 2025/26 there is no change to the risk score. It is not expected that the risk will reduce to 9 by the end of the year, actions are on-going in relation to the development of health equity data dashboard and strategy. It should be noted that the Population Care Boards have been paused during the development of the Provider Alliance impacting on the ability of the city to prioritise.
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	At the end of the third quarter of 2025/26, there is no change to the risk score. The actions internal to the Trust have been substantially completed, however the risk has not reduced due to the risk relating to external capacity of the ICB and NHSE to collaborate with partners during the period of change in the external environment.

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**				✓		Nov Quality Committee - Reasonable overall but: • Clinical Essential skills recording – limited assurance received • Medical device compliance – limited assurance received • Quality of Care report – lacked assurance on actions being taken • Quality Strategy report – lacked information on achievements to date
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	3	4	**12**	Reduced from 16 to 12			✓		Oct Business Committee: Noted that the enteral feeds business case would be recommended to Board for approval. Nov Business Committee: Noted that the current instability at both Place and system level could have an impact on the Trust. Nov Quality Committee: Reasonable assurance overall but National Oversight Framework – limited assurance received
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	4	3	**12**	Reduced from 15 to 12			✓		
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**				✓		Oct Business Committee: Reasonable overall but lacking assurance around the gap between the Estates strategic plans and whether it was looking sufficiently far ahead.
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**				✓		Oct Business Committee: Reasonable overall but lacking assurance around the gap between the Estates strategic plans and whether it was looking sufficiently far ahead.

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**				✓		
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**				✓		
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**				✓		Oct Business Committee: Limited regarding the contractual position in relation to digital letters but reasonable overall.

Strategic Risk 1:

Failure to deliver high-quality, equitable care and continuous improvement:
If the Trust fails to identify, deliver, and sustain high-quality care, promote learning, and drive continuous improvement in an equitable manner, there is an increased risk of unsafe or ineffective services. This may lead to preventable harm, poor patient outcomes, and a diminished patient experience.

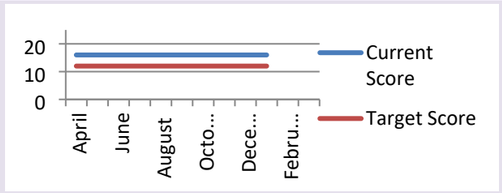
Strategic Objective: Work with communities to deliver personalised care / To embed equity in all that we do

Risk Appetite	Cautious (4-6)	**Status: In or out of Appetite**	Out	**Lead Director/risk owner:** Executive Director of Nursing and Allied Health Professionals

Committee with oversight: Quality Committee

Date last reviewed: 5/1/26

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.
At the end of the third quarter of 2025/26 there is no change to the risk score. Actions relating to EQIA and CQC are ongoing to reduce the score to 12 by year end.

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**
There is a gap in control in relation to the implementation of the new CQC Single Assessment Framework, aligned with the Quality Challenge+ programme. Actions are in play 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 (cancelled by CQC) to be rearranged.	Executive Director of Nursing and AHP's.	March 2026
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. Complete – conversations have taken place – see corresponding action in relation to sources of assurance.	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 • 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. An audit has been added to the 25/26 Internal Audit plan for assurance to the March Audit Committee.	Executive Director of Nursing and AHP's	~~October 25~~ ~~Dec 25~~ Mar 26
There is a gap in assurance in relation to medical device compliance – Quality Committee not assured re compliance with procurement, servicing and maintenance, decommissioning and disposal procedures. Relates to risks 1392, 1393 and 1395 on the risk register) Further work with BU and the Medical Devices team and monthly monitoring through QAIG.	Executive Director of Nursing and AHP's	End Mar 26

Link to Risk Register (material scoring 10 or above):

1179: Impact/Management of Neurodevelopmental Assessment Waiting List (15)
1383: Mind Mate Neurodevelopmental Referral Triage Waiting List (15)
1384: Mind Mate Mental Health Referral Triage Waiting List (12)
1396: Closure of 18 Leeds City Council run children's centres (12)
1373: Complaint actions (12)
1198: Impact of ADHD medication waiting list (12)
1366: Manual STI test requests risk patient safety and increase operational burden (12)
1125: National Supply Issues with Enteral Feeding Supplies by Nutricia (12)
1356: Patient Safety Incident Investigations (12)
1405: Police Custody Suites unserviced equipment (12)
1426: Staff shortages across police custody suites
1307: Triage Hub clinical decision making due to the impact of managing capacity and demand (12)
1353: Home Oxygen Fire Risk (10)
1354: Patients may not receive MRSA decolonisation as a result of GP collective action (10)
Medical Devices risks included for completeness:
1392: Risk of non-concordance with procurement & Processes with the organisational process for medical devices (9)
1393: Servicing & Maintenance risk of non-concordance with the organisational process for medical devices (9)
1395: Decommissioning and disposing risk of non-concordance with the organisational process for medical devices (9)

Strategic Risk 2:

Failure to respond to increasing demand for services:

If the Trust fails to respond to population growth and presentation, and the consequent increase in demand, then the impact will be potential harm to patients, inability to strengthen equity of access, additional pressure on staff, financial consequences and reputational damage.

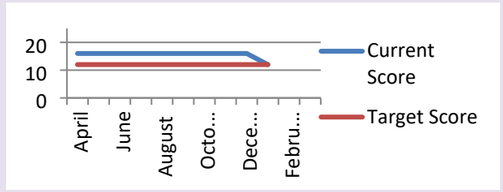
Strategic Objective: Work with communities to deliver personalised care / To embed equity in all that we do

Risk Appetite	Seek (15-20)	**Status: In or out of Appetite**	In	**Lead Director/risk owner:** Executive Director of Operations

Committee with oversight: Quality and Business Committees

Date last reviewed: 15/1/26

Risk Rating
(likelihood x consequence)
Current score:
~~4~~ 3 x 4 = 12
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.
At the end of the third quarter of 2025/26, the risk has reduced to 12. The likelihood of failing to respond to increased demand has reduced from almost certain to likely, due to the appetite to seek opportunities to reduce waiting lists and the progress made against the actions including the waiting list initiatives, quality and value programme and Northpoint contract to deliver the MindMate Single Point of Access (SPA)

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The target score reflects an appetite to seek measured risks in pursuing innovation and transformation of current working practices without compromising the quality of patient care.

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
- Northpoint contract / contract management – MindMate SPA

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
Further actions to address the gap in control 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
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. In the process of being implemented.	Executive Director of Operations	Sept - Dec 2026
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 has transferred 1st January 2026.	Executive Director of Operations	~~31 Oct 25~~ ~~1 Jan 2026~~ Complete
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. Action has been completed, awaiting completion of internal audit of DQ prior to closure of this action. Due date extended to Q4.	Executive Director of Operations / Executive Director of Finance	~~Q3~~ Q4

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) • Digital strategy update (BC)	• Risk register report (QC/BC) • Patient Safety (including patient safety incident investigations) update report (QC) • Performance Brief (Responsive: waitlists) (QC/BC) • 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. Minutes have been requested from the Chief Scrutiny Officer and if received on time will be included in the Feb Board.	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 Neurodevelopmental Referral Triage Waiting List (15)
1384: Mind Mate Mental Health Referral Triage Waiting List (12)
954: Diabetes Service waiting times (12)
1391: Faster Data Flow will not accurately reflect 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.

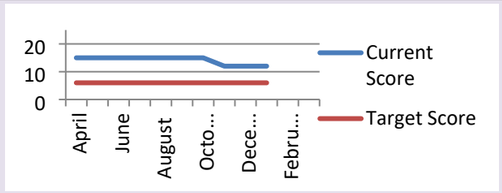
Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity 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: 16/12/25

Risk Rating
(likelihood x consequence)
Current score:
4 x 3 = 12
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 (NOF) 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.
At the end of the third quarter of 2025/26, the risk has reduced to 12. The likelihood of the risk has reduced from almost certain to likely. The Trust remains in segment 4 following the latest segmentation, however there has been improvement, the provider capability self-assessment showed no areas of non-compliance. The Board will continue to have oversight of the NOF metrics. There remain actions relating to CQC compliance.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The risk appetite for this risk is minimal, the target score for 2025/26 has been set above appetite as an interim target until the actions are progressed. After which further progress is expected toward aligning with risk appetite in 2026/27.
Quality Committee regular assurance that demonstrates compliance with CQC standards is required to reduce the risk to 6 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**
There is a gap in control in relation to the implementation of the new CQC Single Assessment Framework. 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. Complete 8/1/26 • 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. LCH CEO to meet with CQC relationship managers in January 2026.	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.	TLT	~~End of Q1 Q3 2025/26~~ 31 Jan 2026

A paper was taken to TLT on 11 June. The Board capability assessment has been completed. CQC requirements will be covered as part of the January 2026 Board workshop.			

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
• 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 (P&CC) • Information Governance Reporting (BC) • CEO report to Board (Board) • Employee relations report (Board) • Code of Governance compliance report (Board) • NOF metric assurance and oversight reporting (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) • Qtly counter fraud report (AC) • Fraud annual report (AC) • Fraud self-review toolkit (AC)	• 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). The internal audit has provided significant assurance.	Head of Strategy, Change and Development	~~End Q1 2025/26~~ Q4 Complete
There is a gap in assurance in relation to the implementation of the CQC Single Assessment Framework. A Board workshop on CQC Assurance – readiness for inspection at Board level has been scheduled for 8 Jan 2026 to provide further assurance.	Executive Director of Nursing and Allied Health Professionals	~~Jan Board Workshop~~ Complete

Link to Risk Register (material risks scoring 10 or above):

1329: Failure to Deliver the Financial Plan (12)
1391: Faster Data Flow will not accurately reflect waiting times (12)
1312: The Trust Risk and Incident reporting system is preventing accurate reporting / assurance both internally and externally. (12)

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.

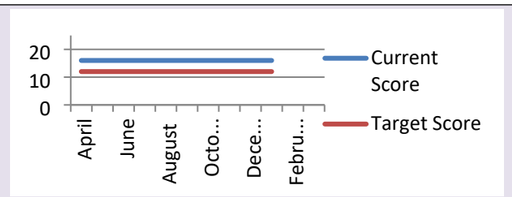
Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do

Risk Appetite	Open (8-12)	**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: 12/1/26

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.
At the end of the third quarter of 2025/26 there is no change to the risk score, however the risk is on target to reduce to 12 by the year-end. An Internal Audit of Financial Sustainability has provided Significant Assurance. Actions relating to the medium-term financial plan, approval of the Estates Strategy, stocktake of the Digital Strategy and implementation of the IPR are due to be completed by the year-end.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months)
The appetite for this risk is open (8-12), whilst remaining compliant with statutory requirements (SR 3). This will enable the Trust to take measured financial risks that will support innovation and transformation to achieve long-term financial sustainability, improvements to service delivery, patient safety and quality of care. The target score is 12 is at the top end of this appetite.

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)
- Implementation of enabling strategies e.g. Digital, Estates

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 The draft plan will be reviewed by the Board Committees in January and taken to the Board for sign-off in February 2026.	EDFR	~~Q3 25/26~~ Q4 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) Work has commenced – moved to Q4 due to capacity to complete	EDFR	~~Q3 2025~~ Q4 25/26
4. Refresh of Performance & Accountability Framework - aligned to outputs from Well Led review. Signed off by TLT in Dec 2025. To go to Audit Committee in March 2026	EDFR/COO	~~Q3 25/26~~ Complete
5. Implementation of IPR process	EDFR	Q1 26/27
There is a gap in control in relation to the strategies that enable / support financial sustainability, the following actions are in place to strengthen:		
6. Development and approval of the Estates strategy.	EDFR	Q4 25/26
7. Digital strategy – stocktake of progress.	EDFR	Q4 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) • Digital strategy update (BC) • Estates strategy update (BC)	• 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 • Qtly counter fraud report (AC) • Fraud annual report (AC) • Fraud self-review toolkit (AC)	• 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. Reporting on Q&V is well established through committees. There is a gap around triangulation of efficiency savings on performance		
1. 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 Complete.	EDFR/COO	~~Q3 25/26~~ Complete
2. Embedding of the new approach to IPR reporting	EDFR	Q1 26/27

Link to Risk Register (material risks scoring 8* or above):

1329: Failure to Deliver the Financial Plan (12)
1217: Digital and BI teams have insufficient capacity
* For this SR risks scoring 8+ due to smaller number involved

1318: Corporate Funding Reduction (9)
1328: Less capital resources available nationally (8)
1187: Insufficient IT Resilience leading to the risk of extended outages of the infrastructure (8)

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.

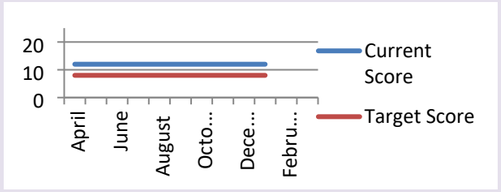
Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

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: 15/1/26

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.
At the end of the third quarter of 2025/26 there is no change to the risk score. Actions relating to climate adaptability, business continuity and EPRR resilience are ongoing. 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):
The risk appetite for this risk is minimal, the target score for 2025/26 has been set above appetite as an interim target until the actions are progressed. After which further progress is expected toward aligning with risk appetite in 2026/27.

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) Improvement in 25/26 from not compliant to partially compliant, no individual standards that are not compliant standards. Independent assurance from NHSE was received by the Board Jan 2026 Update on BCPs expected in the Annual Report to the Board June 2026	Executive Director of Operations	~~End Q2~~ ~~Q3 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. CE+ recertification was not achieved during the recent reassessment audit. The team continue to work through the single outstanding action and are confirming the value of re-certifying CE+ given the proposed integration with LYPFT who do not hold the certification and limited credit provided within the Data Security and Protection Toolkit assessment. Timescale to review the value of CE+ certification, 28/02/26. • 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. Complete • Cyber Security Board training session – complete	Executive Director of Finance and Resources	~~Sept 2025~~ Feb 2026
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. The core components of the plan are complete. Completion of departmental risk assessments are required to ensure compliance with the Task Force on Climate-related Financial Disclosures (TCFD). In addition, there is a gap in control in relation to embedding and engagement with business units as a result of the vacant Sustainability and Environmental Manager role – the trust is actively exploring recruitment options with a view to securing additional capacity and expertise.	Executive Director of Finance and Resources	~~End Q3~~ End Q4

	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 Discussions have commenced and there is a plan to merge LCH / LYPFT EPRR functions before the end of March 2026 to improve resilience	Executive Director of Operations	~~End Q3~~ End Q4

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 AAA report (BC) • Digital strategy update (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)
1303: Loss of Cyber-Essentials+ certification - Out of compliance mobile devices (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.

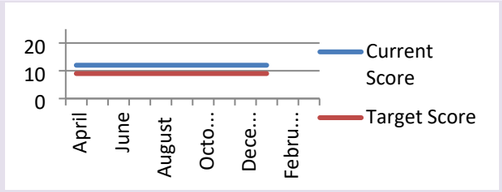
Strategic Objective: Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

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: 6/1/26

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.
At the end of the third quarter of 2025/26 there is no change to the risk score. Actions focus on engagement and sickness management are ongoing. The score is expected to reduce to target, supported by the staff survey results at the year end.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The risk appetite for this risk is cautious, the target score for 2025/26 has been set above appetite as an interim target until the actions are progressed. After which further progress is expected toward aligning with risk appetite in 2026/27.
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 engagement KPIs

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 gap in control creating 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. PCC scrutinise engagement KPIs on a quarterly basis – provided reasonable assurance in December 2025.	CEO / DoP	~~Dec 2025~~ Complete
As a result of a gap in control relating increased civil unrest and the risk to staff physical and psychological safety, a 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. Staff safety and support actions are embedded in the formal EDI action plan, scrutinised by PCC and Board.	DoP	~~Dec 2025~~ Complete
As a result of the current NHS climate both internal and external to the Trust there is a gap in control creating 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
As a result of gaps in control identified through the staff survey, targeted engagement with services in response to staff survey engagement scores will take place.	DoP	Jun 26

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

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Service spotlight/focus • Sickness absence service level deep dives via sickness absence project update to PCC • Staff survey analysis at service level via annual staff survey results (PCC) • Digital strategy update (BC)	• Performance Brief (staff turnover figures, recruitment timescales, sickness absence, appraisal rate) • Safe staffing report • Guardian for safe working hours report • Priorities Quarterly Report • Quarterly and annual staff survey results • People and Culture Committee workforce deep dives • 6-monthly Well-Led updates to Board • People Key Performance Indicators and Data (including well-led Performance Brief Data) (PCC) • EDI/inclusion action plan updates to PCC • 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 • Organisation Strategy Update (BC/QC)	• 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 relating to hotspot sickness absence, in response PCC will receive additional detail about hotspot sickness absence.	DoP	Mar 26

Link to Risk Register (material risks scoring 9 or above):
1379: Political Climate / protests, staff safety (12)
1327: Finance Team Capacity & Capabilities (12)
1426: Staff shortages across police custody suites (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.

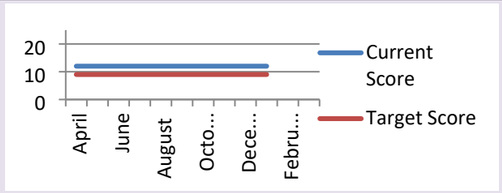
Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity 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: **12/1/26**

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

At the end of the third quarter of 2025/26 there is no change to the risk score. It is not expected that the risk will reduce to 9 by the end of the year, actions are on-going in relation to the development of health equity data dashboard and strategy. It should be noted that the Population Care Boards have been paused during the development of the Provider Alliance impacting on the ability of the city to prioritise.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The risk appetite reflects an appetite to seek opportunities for collaboration with people and communities to ensure their experience influences equitable approaches to innovation and transformation. The target is lower than appetite due to financial and capacity factors at play to seek opportunities and put in place controls to reduce the likelihood of inequity. After which further progress is expected toward reaching the target and aligning with risk appetite.

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)
- Waiting Well Initiative - equity measures

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: A reporting development plan has been laid out in the 5-year tactical plan. This aligns to the measurement. Year one (2026/27) includes 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.	Chairs of relevant Committees Head of Business Intelligence and Performance	~~1 Jan 2026~~ 31 Mar 2026
There is a gap in control in relation to the implementation of the Health Equity Index (action from Citywide Group), Implementation of the Health Equity Index is planned for 2026/27 as per the 5-year tactical plan for equity. Work to obtain and understand the technical requirements for implementation is underway.	Head of Business Intelligence and Performance	31 Mar 2027

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 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. The draft health inequalities tactical plan was presented at the Trust Board meeting on 6 November 2025, comments raised at the Board meeting will be discussed and a further paper to be taken to the Board to address the comments raised.	Medical Director	~~End Q3~~ Q4 2025/26
There is a gap in assurance regarding the EQIA methodology, in that the EQIA process may not be applied consistently across all service changes (such as clinical service changes vs nonclinical service changes), projects, or cost improvement plans. This inconsistency can lead to gaps in assessing equity and quality impacts, resulting in decisions that unintentionally disadvantage certain patient groups or staff. To address this an Internal Audit of the EQIA methodology has been requested.	Medical Director	Q4 2025/26

Link to Risk Register (material risks scoring 10 or above):
1383: Mind Mate Neurodevelopmental Referral Triage Waiting List (15)
1384: Mind Mate Mental Health Referral Triage Waiting List (12)

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.

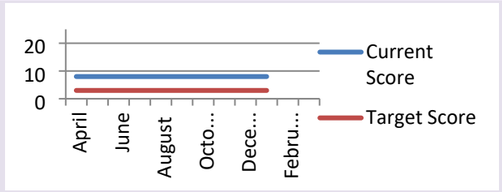
Strategic Objective: Collaborating with partners to enable people to live better lives / To embed equity in all that we do

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: 16/12/25

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.
At the end of the third quarter of 2025/26, there is no change to the risk score. The actions internal to the Trust have been substantially completed, however the risk has not reduced due to the risk relating to external capacity of the ICB and NHSE to collaborate with partners during the period of change in the external environment.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The risk appetite for this risk reflects an appetite to seek opportunities across current and future services through system-wide partnership and seek risks associated with collaborative and new ways of working. The target is lower than appetite due to the changes to be made in relation to the Leeds Provider Review which will support future opportunities for collaboration. After which further progress is expected toward reaching the target and aligning with risk appetite.

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~~ Complete
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 - Complete • Fully engage in the Leeds provider partnership review - LCH CEO appointed SRO for the Leeds Provider Partnership review - Complete • 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. Seek to understand and contribute to the changes to the ICB functions / operating model	Chief Executive Officer	End ~~Q3~~ Q4

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

Agenda item:	2025-26 (18b)
Title of report:	Significant Risks and Risk Assurance Report
Meeting:	Trust Board Meeting Held in Public
Date:	5 February 2026

Presented by:	Lynsey Ure, Executive Director of Nursing, Allied Health Professionals and Quality
Prepared by:	Anne Ellis, Risk Manager

Purpose of the report:		
The report provides the Trust Board with an overview of the Trust's clinical and 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 12 January 2026.	Approval	
	Discussion	
	Assurance	✓

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives		**Acceptable assurance** General level of confidence in delivery of existing objectives	✓	**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:

At the date of this report:

- There are 117 open risks on the risk register, ten of which have been managed to the target level.
- Two risks score 15 (extreme) and 20 risks score 12 (high)
- The number of static risks scoring 12 or above has reduced from 3 in November 2025 to 2. The Risk Management Group has identified actions to further understand and address static risks.
- Patient harm is the most common risk theme, followed by demand exceeding capacity and compliance with standards and legislation.

Previously considered by:	Trust Leadership Team by email 12 January 2026 Risk Management Group 22 January 2026 Quality Committee 27 January 2026 Business Committee 28 January 2026
Outcome of previous discussion/s:	See Committee Chair Assurance Reports

Link to strategic goals: (Please tick any applicable)	
Work with communities to deliver personalised care	✓
Use our resources wisely and efficiently	✓

Enable our workforce to thrive and deliver the best possible care	✓
Collaborating with partners to enable people to live better lives	✓
Embed equity in all that we do	✓

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

Recommendation(s)	• Note the changes to the significant risks since the last risk report was presented to the Board; and • Consider whether the Board is assured that planned mitigating actions will reduce the risks.

List of Appendices:	No appendices

Significant Risks and Risk Assurance Report

1. Introduction

1.1 The risk register report provides the Board with an overview of the Trust's material risks currently scoring 15 and above (extreme risks). It summarises all risk movement, the risk profile, themes and risk activity since the last risk register report was received by the Board (November 2026).

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 (November)
Total Open Risks	117	106
Risks Scoring 15 or above	2	2
New Risks	22	19
Closed Risks	11	4
Risk Score Increasing	0	4
Risk Score Decreasing	11	13

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
1179: Impact/Management of Neurodevelopmental (ND) Assessment Waiting List.	**Operational**	**15**	**15**	**Cautious (4 – 6)**
Due to ND Right to Choose navigation work undertaken by Northpoint and ongoing waiting list validation, the assessment waiting list is 623 and continuing to decrease every week. There are potential plans to address the remaining waiting list to ensure needs are considered if assessment remains outstanding. The risk owner has been contacted to consider whether the score can reduce because of the reduction in the waiting list. (update 4/11/25)				

Risk	Risk Type	Current Score	Months at current score	Risk Appetite
1383: Mind Mate Neurodevelopmental Referral Triage Waiting List	**Operational**	**15**	**3**	**Cautious (4 – 6)**
There are currently 2180 children on the ND triage waiting list. Opt-in letters have been sent to all waiters on the ND list which resulted in approximately 957 opting in. Work has commenced to respond to each child/young person/parent/carer to support the needs identified. This includes 5 clusters testing out a new needs led model. It is expected that the waiting list will be addressed by 31st March 2026. (update 30.12.25)				

3. Summary of risks scoring 12 (high)

3.1 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by the Board is not limited to extreme risks. Senior managers are sighted on services where the quality of care or service sustainability is at risk; many of these aspects of the Trust's business being reflected in risks recorded as 'high' and particularly those scored at 12. The Quality and Business Committees have oversight of risks categorised as 'high' (risks scored at 8 – 12).

3.2 The table below details risks currently scoring 12 (high risks)

ID	Description	Rating (current)	Rating (previous)	Months at current score
877	Risk of reduced quality of patient care in neighbourhood teams (NT) due to an imbalance of capacity and demand	12	12	17
954	Diabetes Service waiting times	12	12	8
957	Increase in demand for the adult speech and language therapy service.	12	12	9
1125	National supply issues with enteral feeding supplies by Nutricia	12	12	8
1221	Likelihood of a cyber attack	12	12	12
1303	Out of compliance mobile phones (Operating system not compliant with CE+)	12	12	9
1313	Climate Adaptability Resilience Planning	12	12	8
1319	The number and long waits of high priority patients on the ABU Therapy waiting lists	12	12	6
1327	Finance Team Capacity & Capabilities	12	12	3
1329	Failure to deliver financial plan	12	12	7

ID	Description	Rating (current)	Rating (previous)	Months at current score
1356	Patient Safety Incident Investigations	12	12	3
1366	Manual STI test requests risk patient safety and increase operational burden	12	12	3
1379	Political Climate / protests, staff safety	12	12	3
1384	Mind Mate Mental Health Assessment Triage Waiting List	12	12	3
1373	Complaint actions	12		New
1391	Faster Data Flow will not accurately reflect waiting times	12		New
1405	Police Custody Suites un-serviced equipment	12		New
1419	Primary care reduced staffing levels - Wetherby YOI, Adel Beck and Aldine House Staffing levels below safer staffing numbers	12		New
1426	Staff shortages across police custody suites	12		New
1437	Failure to comply with ionising radiation requirements	12		New

Since the previous report in November six risks scoring 12 have reduced to below 12 and six new risks scoring 12 have been added.
In the previous report three risks scoring 12 and above had been at the same score for more than 12 months (static), the number of static risks has reduced to two risks (Risks 877 and 1179).

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).

The RMG focused on static risks at the meeting held on 22 January 2026. Discussion highlighted the following circumstances and actions in relation to risks that had been the same score for over 12 months:

- Actions taken to manage risk had had an impact on the risk as described when opened, however the risk had changed over time and further actions were required to manage. In this circumstance, risk owners will rewrite and replace the original risk to reflect the current risk position.
- The risk description was broad and encompassed several smaller risks that could be managed more effectively as separate risks. In this circumstance risk owners will rewrite and replace the original risk with separate risks to reflect the mitigations required.
- The Trust had completed all actions within the control of the Trust. In one case outstanding mitigations were outside the control of the Trust and were dependent on partners. In these cases, the risk owner will benchmark similar risks with partners and propose further action / acceptance of the risk.

- Risk owners have been requested to include clear updates on static risks to provide ongoing assurance on their management.

4. Risk profile – all risks

4.1 The total number of risks on the risk register is currently 117. Of these there are 48 clinical risks and 69 operational risks. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	2	1	0	0	3
4 - Major	0	4	9	0	0	13
3 - Moderate	2	19	35	11	1	68
2 - Minor	1	8	13	6	1	29
1 - Negligible	0	3	1	0	0	4
Total	3	36	59	17	2	117

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-nine 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: Demand for Services	
The second strongest risk theme is demand for services exceeding capacity, due to an increase in service demand and high numbers of referrals [2]	The BAF strategic risks directly linked to demand for services are: BAF Risk 2 Failure to respond to increasing demand for services BAF Risk 6 Failure to effectively engage staff and leaders as well as to support their health and well-being in the current context BAF Risk 7 Failure to reduce inequalities experienced by the population we serve
Theme Three: Compliance with Standards/Legislation	
There is also a risk theme relating to compliance with standards/ legislation[3]. This includes health and safety, compliance with information governance and cyber security, and business continuity and emergency planning.	The BAF strategic risks directly linked to compliance with standards / legislation are: BAF Risk 3 Failure to comply with legislative and regulatory requirements BAF Risk 5 Failure to maintain business continuity
Theme Four: Transformation of services - Impact	
Five risks relate to transformation of services and concern the impact on staff and patients and equity of care[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 BAF Risk 7 Failure to reduce inequalities experienced by the population we serve

[1] Risks: 877, 1109, 1125, 1168, 1169, 1187, 1196, 1231, 1284, 1285, 1301, 1307, 1308, 1319, 1335, 1341, 1342, 1353, 1354, 1356, 1359, 1361, 1363, 1364, 1365, 1366, 1369, 1373, 1392, 1393, 1395, 1396, 1405, 1419, 1426, 1437, 1374, 1387, 1414
[2] Risks: 772, 954, 957, 994, 1015, 1098, 1179, 1198, 1311, 1383. 1384, 1433
[3] Risks: 902, 1206, 1221, 1242, 1303, 1312, 1313, 1379, 1391, 1428

[4] Risks: 1227, 1228, 1318, 1412, 1413

Theme Five: Transformation - Capacity	
Four risks relate to digital transformation and finance and resources, including capacity to deliver transformation [5]	The BAF strategic risk directly linked to 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. 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 27 March 2026.

7. 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: 23 January 2026

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

Agenda item:	2025-26 (19)
Title of report:	Updated standing orders, reservation and delegation of powers and standing financial instructions
Meeting:	Trust Board Meeting held in Public
Date:	5 February 2026

Presented by:	Helen Robinson, Company Secretary
Prepared by:	Helen Robinson, Company Secretary

Purpose of the report:		
To inform the Board of the review undertaken in updating the Trust's standing orders and standing financial instructions.	Approval	√
	Discussion	
	Assurance	

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives	√	**Acceptable assurance** General level of confidence in delivery of existing objectives		**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:
• SOs and SFIs have been updated to reflect: - new regulations and legislation - establishment of the People and Culture Committee - changes to committee Terms of reference.

Previously considered by:	Audit Committee 9 Dec 2025
Outcome of previous discussion/s:	Recommended that the Board approves the proposed changes

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

Is Health Equity Data included in	Yes		What does it tell us?	

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

Recommendation(s)	The Board is recommended to: • approve version 3.6 standing orders, reservation and delegation of powers and standing financial instructions in line with the summary of changes outlined in this paper.

List of Appendices:	Appendix 1 – Summary of changes to standing orders and standing financial instructions

Review of standing orders, reservation and delegation of powers and standing financial instructions

1 Introduction

The Trust has an established set of standing orders and standing financial instructions which also include a schedule of powers reserved to the Board and a scheme of delegation. Together, these provide a governance framework that enables the organisation to demonstrate it is well governed and meets the requirements of key corporate governance codes.

In order to ensure that the Board is discharging its role effectively it should regularly review the components of the standing orders and standing financial instructions and receive assurances that it is meeting the requirements contained within these documents.

This paper summarises a number of amendments and updates. Once approved, a fully updated version of the whole document will be made available electronically to Board members and more widely through the Trust's intranet and website.

The Audit Committee reviewed this paper at its meeting on 9 December 2025 and agreed to recommend that the Board should approve the proposed amendments.

2 Background

NHS trusts are required to adopt standing orders and standing financial instructions and to establish a schedule of powers reserved to the Board and a scheme of delegation.

Under its terms of reference, the Audit Committee is required to review the adequacy of policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements.

Standing orders and standing financial instructions are essential foundations for the good governance of the Trust and set out:

- Mechanisms for how the Trust Board conducts its business
- Decision making powers delegated from the Board
- Expectations of the Trust as to the conduct of individuals entrusted with public resources
- Principles and procedures that direct financial conduct

3 Current Position

The Trust's Board approved an amendment to the standing orders, reservation and delegation of powers and standing financial instructions on 2 February 2024 (version 3.5).

The current standing orders and standing financial instructions are fully functional but there are a number of aspects that, on review, require updating.

Recent review recommended changes to be made in order to amend and update content and takes account of: new regulations and legislation, changes in the Trust's structure – notably the establishment of the People and Culture Committee; changes to committee terms of reference since the last review; and changes that the Trust's executive directors wish to introduce to better regulate good governance and management.

The Audit Committee reviewed this update at its meeting on 9 December 2025 and agreed to recommend that the Board should approve the proposed amendments

4 Proposed Changes

The table shown at appendix 1 summarises the changes to be made in order to amend and update content. The revised version, if approved, will be numbered as version 3.6 and retained by the Company Secretary.

5 Resources

There are no resource consequences resulting from this paper and its proposals.

6 Risks

Failure to establish, implement and assure compliance with standing orders and standing financial instructions may impact on the Trust's decision making and

assurance processes, and may adversely affect its reputation and CQC rating.

7 Regulatory and Legal

These changes to the standing orders and standing financial instructions ensure compliance with all applicable legislation and NHS regulations and guidance.

8 Next Steps

Once approved, an electronic version of the full amended document will be made available to Board members and managers and staff. Use will be made of the Trust's intranet and website to publish the documents.

➢ 9 Recommendations

The Board is recommended to:

- approve version 3.6 standing orders, reservation and delegation of powers and standing financial instructions in line with the summary of changes outlined in this paper.

Helen Robinson
Company Secretary
15 January 2026

APPENDIX 1

Leeds Community Healthcare NHS Trust
Summary of changes to standing orders and standing financial instructions

Section	Change
Section B: Standing orders	
Paragraph 4.9.6	**Reference added to new People & Culture Committee** The Trust Board has established a People and Culture Committee to enable the Board to promote best practice in workforce culture, HR, learning and development and leadership and help identify priorities and risks on a continuing basis. The People and Culture Committee will provide assurance that the Trust understands its strategic workforce needs (including wellbeing, culture, recruitment, retention, development of people, and organisational design) and to oversee the development and monitoring of plans to progress their delivery. It will ensure that equality and inclusion and due consideration to the Equality Act 2010 are embedded in all aspects of the committee's work.
Section C: Schedule of Reservation and Scheme of Delegation	
	Decisions/Duties delegated by the Board to Committees (as contained in terms of reference)
	Audit Committee Addition of 'Other external advisers may be called upon where specialist assurance is required, with the prior agreement of the Committee Chair.' Addition of Information Governance section and related duties.
	Business Committee Addition of 'Emergency Preparedness, Resilience and Response': Maintain oversight of the Emergency Preparedness, Resilience and Response Framework and receive updates against the action plan. Addition of 'Board Assurance framework': Monitor the strategic risks assigned to it; check that the controls are working by agreeing the sources of assurance needed, reviewing the evidence provided and then it will inform the Board whether those risks are being effectively controlled.
	Quality Committee Addition of 'Have oversight of the strategic risks that relate to health equity' Addition of 'Board Assurance framework': Monitor the strategic risks assigned to it; check that the controls are working by agreeing the sources of assurance needed, reviewing the evidence provided and then it will inform the Board whether those risks are being effectively controlled.
	Addition of People & Culture Committee • Develop and oversee implementation of the Trust's People Strategy and provide assurance to the Board of Directors that this is being delivered in line with the annual planning process. • Monitor and review workforce key performance indicators to ensure achievement of the Trust's strategic aims and escalate any issues to the Board of Directors. This should include but not be limited to metrics monitoring the use of bank and agency staff, recruitment and attendance.

	• Review any changes in practice required following any internal enquiries that significantly impact on workforce issues. • Review and approve partnership agreements with staff side. • Seek assurance to ensure that the Trust fulfils all legislative and regulatory requirements pertaining to workforce and organisational development issues, including but not limited to equality and diversity. • Monitor cases of Freedom to Speak Up and escalate as appropriate to the Board. • Oversee the monitoring of staff engagement levels and views as evidenced by the results of the national and any other staff surveys; and Trust actions in response to these. • Oversee and support the Trust's progress towards its workforce equity and inclusion ambitions, with particular regard to NHS requirements and the perspectives of LCH Staff Networks • Oversee the development of relationships with further and higher education institutions to ensure the Trust is able to influence the supply of practitioners and professionals with the skills and competencies required by the organisation. • Receive assurance on the effectiveness of staff health and wellbeing programmes, including the delivery of Occupational Health services. • Approve the terms of reference and membership of its reporting groups and overseeing the work of those groups, receiving reports from them for consideration and action as necessary and routinely receiving the minutes of their meetings. • Receive and review of relevant risks (including those referred from other committees or subcommittees) concerned with workforce and organisational development matters as identified through the Board Assurance Framework. Monitor progress made in mitigating those risks, identifying any areas where additional assurance is required, escalating to the Board of Directors as required. • Receive reports (in full or summary) from internal audits which relate to the responsibilities of the Committee. • Review quantitative and qualitative indicators to consider the extent to which the culture that the Trust seeks to create and sustain, embodied by the Trust Values and Behaviours, is embedded; identifying any areas where additional assurance is required.
	Scheme of Delegation Derived from the Accountable Officer Memorandum
Paragraph 26.2.2	Reference to the CFSMS Regional Team amended to the NHS Counter Fraud Authority (NHSCFA)
Section D: Standing Financial Instructions	
Throughout	Reference to 'Fixed Asset' amended to 'Non-current asset' Reference to 'EU' amended to 'UK'
Paragraphs 11.5.3 and 11.5.4	Reference to the 'Department of Health and Social Care Fraud and Corruption Manual and guidance' amended to the 'NHS Counter Fraud Manual'
Paragraph 17.2	European Union Directives governing Public Procurement amended to Directives Governing Public Procurement, to reflect change to UK legislation
Paragraph 17.3.2	Under Article 35 (Use of e-Auctions) of the Public Sector Directive 2014/24/EC – amended to reflect change to UK legislation
Paragraph 17.5.1	Formal competitive tendering – General Applicability - Procurement between £5,000 and £30,000: Public Contracts Regulations amended to Procurement

	Act 2023 and the Provider Selection Regime Regulations (Healthcare provision ONLY). Procurement between £30,000 and Procurement Act procurement threshold – wording amended to reflect updated process for tenders. Requirements above the Procurement Act threshold – updated to reflect change to UK legislation
Paragraph 17.5.1	Exceptions and instances where formal tendering need not be applied– updated to reflect change to UK legislation
Paragraph 17.6.1.2	Use of Electronic Tendering e-tendering - wording amended to reflect updated process for tenders.
Paragraph 17.6.6.1	Most Economically Advantageous Tender (MEAT) amended to Most Advantageous Tender (MAT).
Paragraph 17.7.2	Competitive quotations section removed
Paragraph 17.13	Cancellation of contracts: Prevention of Corruption Acts 1889 and 1916 updated to Bribary Act 2010
Paragraph 17.16c	Disposals: Figure amended
Paragraph 21.1.4	Non-Pay Expenditure – Delegation of Authority: Addition of new paragraph 'To enable a requisitioner access to the Trust's ordering system they must first undertake the appropriate training. It is also required that they undertake refresher training when there are any changes in systems, legislation or financial processes or any other change that could impact on procurement.'
Paragraph 21.2.2	System of payment and payment verification – paragraph updated to read: 'The Director of Finance shall be responsible for the prompt payment of accounts and claims *in accordance with the Better Payment Practice Code (BPPC). Employees are responsible for processing invoices in a timely manner.'*
Paragraph 24.3.2	Asset registers: Paragraph expanded to read 'Each Trust shall maintain an asset register recording non-current assets to enable financial reporting in accordance with the requirements of International Financial Reporting Standards (IFRS). Guidance on the interpretations of the above is contained in the Department of Health Group Accounting Manual (DH GAM) and the FT Annual Reporting Manual (FT ARM).
Paragraphs 24.3.6 – 24.3.8	Asset Registers – paragraphs updated to current manuals.
Paragraph 24.4.1	Security of Assets: 'The overall control of fixed assets is the responsibility of the Chief Executive' – addition of 'as advised by the Director of Finance'
Paragraph 26.1.1	Disposals and Condemnations, Losses and Special Payments: Addition of 'Material disposals will be defined annually with reference to the Trust's capital plan and replacement program. Responsibility for the approval of material disposals will rest with the Director of Finance.'
Paragraph 26.1.2	Disposals and Condemnations, Losses and Special Payments: Clarification of relevant person.

Agenda item:	2025-2026 (21i) Blue Box
Title of report:	Mortality and Learning from Deaths
Meeting:	Trust Board Held in Public
Date:	5 February 2026

Presented by:	Dr Ruth Burnett
Prepared by:	Geraint Jones

Purpose of the report:		
This report provides: An update on the monitoring of and learning from deaths of patients under the care of LCH.	Approval	
	Discussion	
	Assurance	X

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives		**Acceptable assurance** General level of confidence in delivery of existing objectives	X	**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:

- Increase in overall deaths this quarter (934 vs 704), above the mean but still within control limits.
- Spike in child deaths in November, including deaths by hanging, resulting in special cause variation and escalations to senior leadership and CDOP.
- Systemwide PSII involving multiagency care, with LCH required to review syringe driver competency and an independent NHSE investigation underway.
- Significant rise in Coroner inquest statement requests, placing pressure on clinical services and governance capacity.
- Ongoing variability in quality of MCA assessments and inconsistencies in safeguarding notification within mortality reviews.

Previously considered by:	Quality Committee January 27th 2026
Outcome of previous discussion/s:	Report noted, no amendments,

Link to strategic goals: (Please tick any applicable)	
Work with communities to deliver personalised care	X
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	X

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes	X	What does it tell us?	PPD achievement remains broadly equitable across deprivation and ethnicity groups, though small-cohort variation highlights the need for continued focus on data completeness and access to end-of-life planning.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	Accept this report as an accurate reflection of mortality activity, learning and assurance across Adults, Children and LD.

List of Appendices:	Adult and Children's AAA reports

Current Position

During the reporting quarter, 934 deaths were notified to the Trust. This represents an increase from 704 deaths in the previous quarter. Although this is above the mean, the overall position remains within expected statistical control limits, indicating normal variation rather than a concerning upward trend.

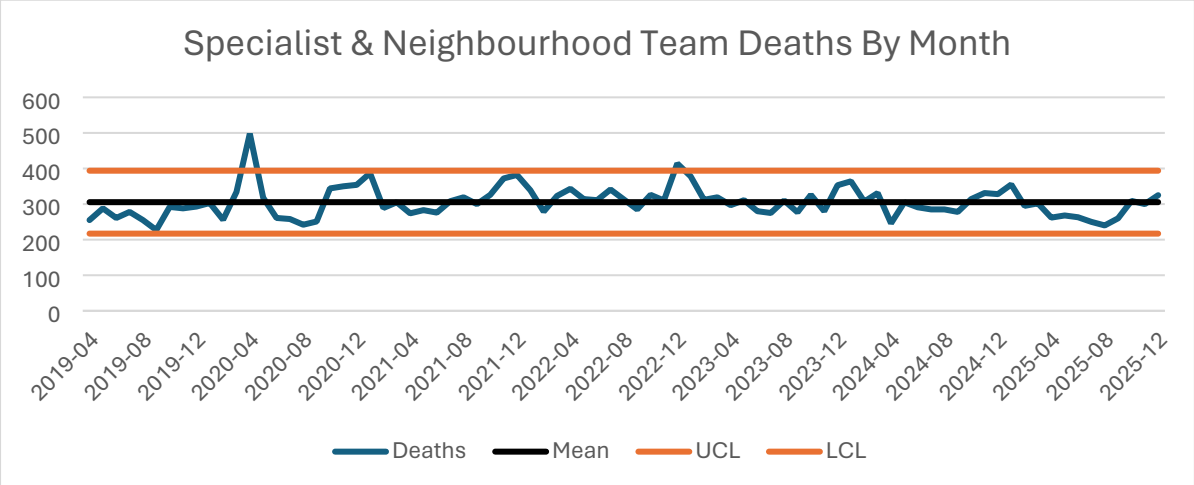
Of the total deaths, 815 occurred in people known to the Neighbourhood Teams (NTs) at the time of death.

There were 6 deaths recorded for people with a learning disability (LD). 4 of these individuals were known to the NTs, the other two were open to the Specialist Business Unit (SBU) dietetic services but not under active care at LCH at the time of death.

- 3 LD deaths were under the care of LCH at the time of death, and were reviewed at Level 2, in line with Trust policy.
- The fourth LD death were under the care of the hospice, and the mortality review responsibility lies with them, learning is fed back through the LeDeR process.

There were 56 unexpected deaths this quarter.

A total of 96 deaths received a Level 2 mortality review, which includes the 2 LD deaths for which LCH held review responsibility, 0 inpatient/CCB deaths and 4 patients under the Leeds Mental Health and Wellbeing Service. Learning for 9 cases was presented at the monthly Trust Mortality Case Review meeting.



Learning Disability (LD) Update

Themes this quarter continue to highlight the need for greater specificity in MCA assessments, and this has been escalated to the MCA Lead for review of guidance and training. A new requirement has been identified to routinely record deaths of people who are Autistic, and a Q4 data capture update will be requested from the Performance Team. Safeguarding notification prompts in Level 1 mortality reviews were not consistently followed; further communications will be issued by the Named Nurse for LD and reinforced through Quality Leads.

Two cases were inaccurately recorded as open to Adult Dietetics and Nutrition despite no clinical involvement, and mortality reviews were completed by other organisations, St Gemma's and Primary Care. This will be discussed further with Quality Leads. Wider learning from Leeds focussed reviews includes strengthening awareness of health passports, Restore2, and the LD register, with ongoing joint work across LCH and LYPFT. Yeadon NT demonstrated excellent person-centred care and communication, with families expressing gratitude. Regional West Yorkshire themes relating to transition processes and equipment provision, this has been added to the "what makes good care" slide on the LD Hub. LD related learning will be shared through the Trust website and Library Learning Newsletter.

Child Deaths Update

Between September and December 2025, there was a significant spike in child deaths in November, generating a special cause signal on SPC charts for both expected and unexpected deaths. All cases progressed through Child Death Rapid Review processes, with one. One child known to LMWS (and previously CYPMHS) died unexpectedly and was reviewed via both the SUDIC process and an internal PSIRF rapid review, which has subsequently been escalated to a PSII.

There have been four deaths by hanging this financial year to date, two in November. Only one case involved recent LCH care. These have been escalated to senior leadership and discussed at CDOP, with further multi-agency review agreed between the Child Death Review Chair and SUDIC paediatricians.

Operational improvements include logging all child deaths in the Datix Inquest Module, although this currently limits LD, autism and ethnicity recording. Work is underway to develop a SystmOnebased rapid review tool to improve data capture and reduce workload. There are currently 32 Leeds cases awaiting Child Death meeting review, consistent with previous reports. Additional meetings are scheduled, with volumes expected to reduce to around 17 outstanding cases by February 2026.

The number of overdue Child Death reviews noted at the previous Quality Committee was reviewed through QAIG in January 26. See Appendix: CBU Mortality AAA.

Adult Deaths Update

The Adult Mortality meeting was quorate with strong clinical challenge and discussion. A system-wide PSII continues following a multi-agency death requiring LCH to review competency requirements for staff initiating syringe drivers. There has been a sharp increase in Coroner inquest statement requests, particularly affecting LMWS, with a Trust wide deep dive underway. Additional advisory notices relate to delays in blood sampling/results in CCB and NTs, an increased number of LMWS statements for deaths occurring outside Leeds, and three deaths in Adult Social Care Reablement now under review.

Collaborative discussions have begun with St Gemma's Hospice to strengthen shared clinical guidance and training in end of life care. Mortality Surveillance Meeting leadership will transfer to the Chief Information Officer in March 2026, and SBU mortality data is trending towards the lower control limits, potentially indicating improved referral accuracy.

Assurance activities remain robust. A Q3 audit showed 95% of required Level 1 reviews completed, and updates to the S1 template will allow clearer identification of reviews that are not required. Annual audits of Level 1 and 2 reviews in ABU achieved 100% compliance, with two retrospective Datix submissions completed. Learning from a Coroner's inquest into an LMWS case resulted in new SOPs for unplanned staff absence and use of generic email accounts. A Datix access issue for the End-of-Life Lead has been resolved, and a dashboard is now in place.

Equity Update

Equity analysis of Preferred Place of Death (PPD) achievement across Neighbourhood Teams shows no major inequity by deprivation. PPD achievement ranged from 74% to 86% across IMD deciles, with the most deprived (IMD 1–3) achieving 80–82%, comparable to the Trust average (81%). Lower achievement in IMD 10 (74%) appears influenced by small cohort size.

PPD by ethnicity shows broadly similar rates to the Trust average (80%), with Asian/Asian British (83%) and White (81%) groups performing well. Lower rates in Mixed and Other ethnic groups (67%), and slightly lower performance in Black/Black British (76%), should be monitored, although small denominators limit interpretation. The data reinforces the need for stronger ethnicity recording, especially within end of life planning.

Internal Audit report/Trust Wide Update

All evidence for the Internal Audit has been submitted and Business Committee updated. We are awaiting feedback from the IA with regards to level of assurance. Challenge remains case of Learning from deaths vs surveillance. Opportunity this year to develop learning from deaths, alignment with LYPFT and consider reintroduction of a Learning from deaths/Mortality review group to be able to consider areas of good practice, areas for improvement and themes or trends in deaths in the LCH population.

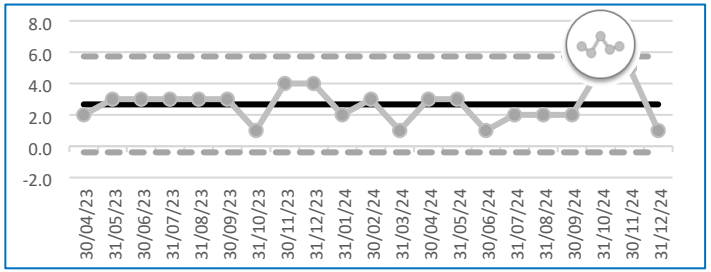
Recommendations:

Board is recommended to:

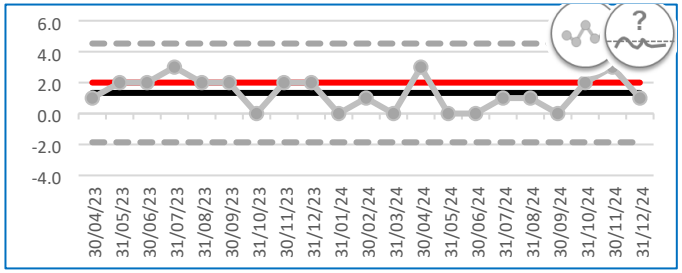
- Accept this report as an accurate reflection of mortality activity, learning and assurance across Adults, Children and LD.
- Support continued systemwide oversight, particularly regarding the spike in child deaths and the multiagency PSII.
- Note the equity position and endorse ongoing monitoring as data quality and review processes are strengthened.

Key Opportunities Risks and Successes – Child Deaths Q3 2024/2025

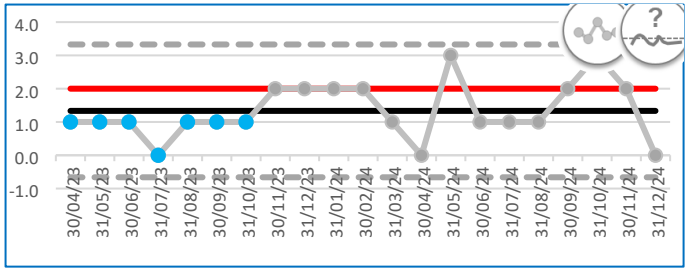
All Child Deaths



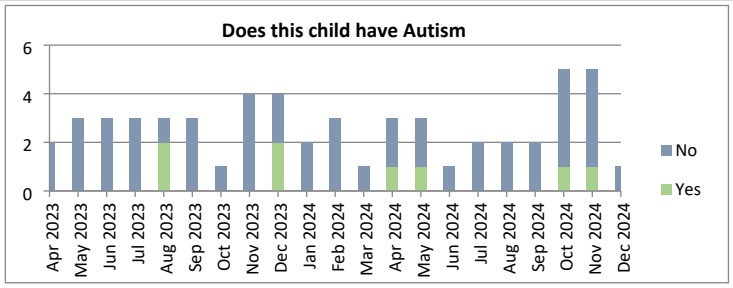
Unexpected Child Deaths

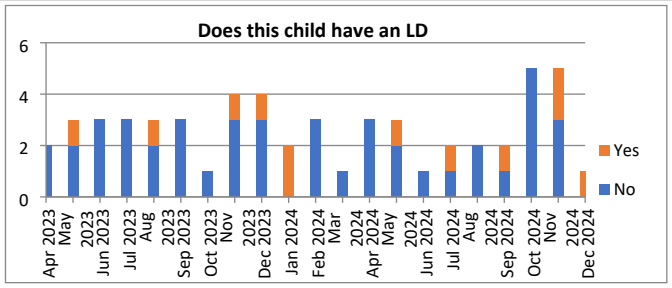


Expected Child Deaths



It is evident the deaths have increased within month (October and November), and quarter (overall), this will be monitored to determine whether this becomes a cause for concern. There has been an early conversation with the Consultant Paedatrcian who chairs both THE TRUST Child Death Review Group and the Leeds Child Death Overview Panel to consider immediate learning, no escalations at this time. All deaths have been subject to the Trust Rapid Review process. There is some early learning in relation to communciation between teams when there is a known change in the childs health which could impact on another service. The information is scrutinised at the THE TRUST Child Death meeting and Citywide, Child Death Overview Panel.



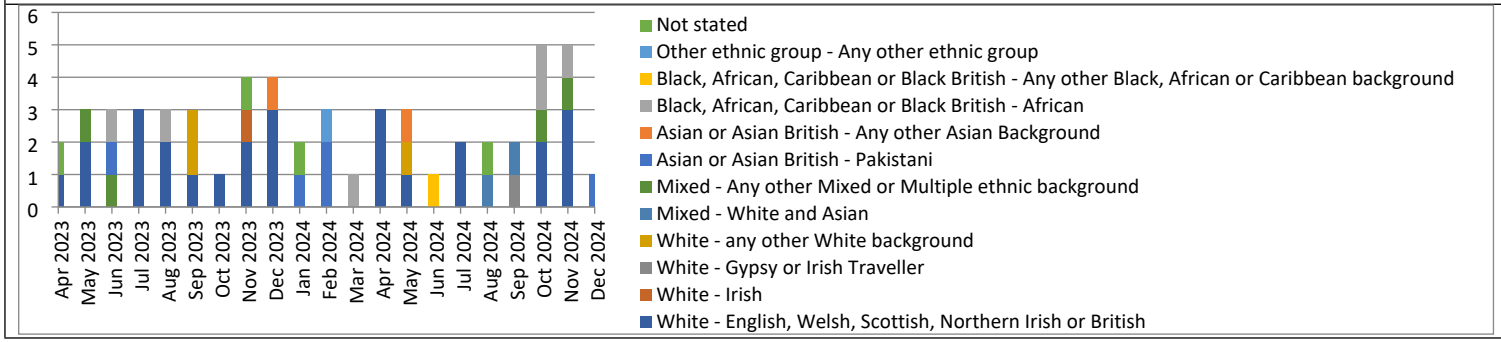


This information needs to be considered in relation to

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

Therefore, it is limited in its usability.

Ethnicity



The ethnicity of the children who have died has been reviewed, this has been compared to the national data, to note the national data has a different data set (also includes neonatal deaths) to the Trusts EPR therefore it not possible to compare like for like. CDOP review ethnicity with a Leeds wide approach, and this is included in their annual report. Therefore, this will not be included in future reports. Ethnicity data is considered as part of the Trust EQIA process when making any changes to service delivery.

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

Key Opportunities Risks and Successes – Child Deaths Q3 2024/2025

Opportunities/Successes (Making Stuff Better/Celebrations)

Opportunity/Success
Data has been reviewed in line with the Trust direction to included SPC charts.

*BAF RISK 1	BAF 2	BAF 3 √	BAF 4

Opportunity/Success
Following a conversation with the CrISSP (Critical Incident Staff Support Pathway) Team the Child death group has changed its format. This allows more time for reflection, camera's on / off if needed, heads up about which child will be presented next, having deputies if people need to opt out of specific cases, finishing the meeting earlier to allow time to decompress before finishing work.

BAF 1 √	BAF 2	BAF 3	BAF 4

Opportunity/Success
There is a new immunisation template for the 2-to-2.5-year check within the 0-19 PHINS template, this aids conversation/information sharing and support in receiving the necessary immunisations. This had previously been identified as missing during a child death review.

BAF 1 √	BAF 2	BAF 3	BAF 4

Opportunity/Success
There is work underway for children missing from education, there is now a code where if the school is unknown, then the child will be classed as missing in education.

BAF 1 √	BAF 2	BAF 3	BAF 4

Risks/issues

RISK
There are currently thirty-six child deaths to review, this has increased from last quarter (27) due to an increase in deaths this quarter.

Mitigation
Continue to review between 6 and 8 cases every 2 months.

*BAF 1 √	BAF 2	BAF 3 √	BAF 4

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

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

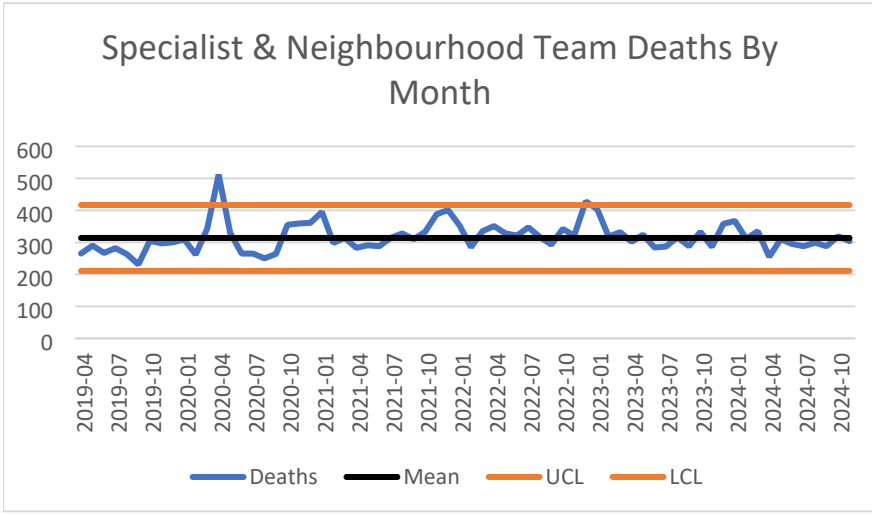
BAF 1 √	BAF 2	BAF 3	BAF 4

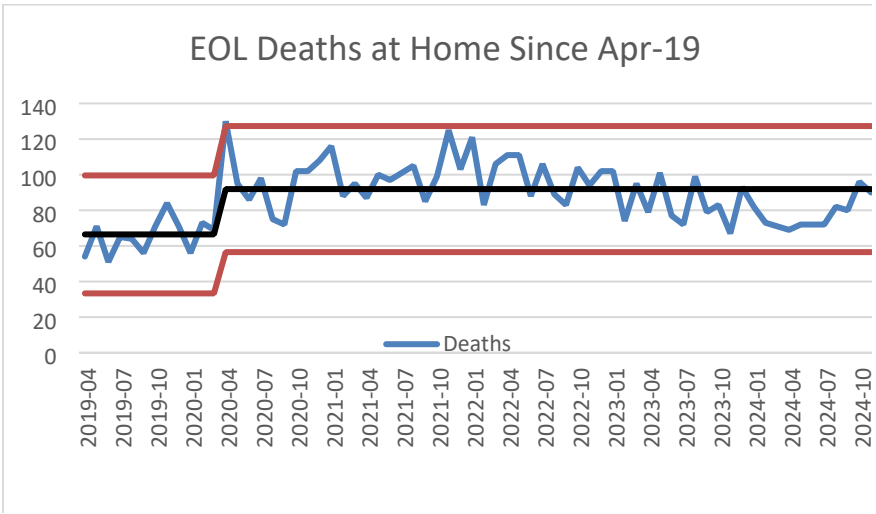
Additional or supporting information (optional)

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

~~Key Opportunities Risks and Successes Adult Mortality Report flash report, Q[3] 24/25~~

Quantitative Data:





Plan to include: Further exploration to take place to review to include more SPC charts for quality data. Ready for Q1 25/26.

Analysis/Narrative:*** Data for this report is from 1st Oct-15th Dec due to timescales required for submission***.
There were a Total of 735 Adult Deaths in Quarter 3 2024/25. Adult deaths are tracking within normal variation levels for reporting, Individual reporting for Team/services for SBU and ABU shows all teams are within usual variation with no outliers.

Learning Disability

There has been 5 people with a learning disability (LD) who died in Q3 open to ~~LCH~~THE TRUST. Due to the timing of the report and systems been inaccessible, it has not been possible to review the level 1 and level 2 mortality data for learning. This was low last quarter and will therefore be completed as soon as possible and highlighted in the next report with Q4 data. There have not been any focused reviews from LeDeR from Leeds, generic themes across west Yorkshire continue to be shared.

Preferred place of Death: The numbers of patients dying at home continue to move towards pre pandemic levels. (PIP report) PPD achieved for patients included on EPaCCS: November 24

- 1st choice 73.8%
- 1st or 2nd choice 79.6%

Reason PPD is not achieved isn't routinely recorded, where it has been recorded the most common factors are clinical or environmental risks requiring admission, and reflecting the increasingly complex nature of some EoL Care patients wishing for their care to be provided in the community. Recent examples include risks around drug misuse, safeguarding concerns or clinical factors such as potential sepsis, acute bleed etc.

Leeds Citywide Planning Ahead report from the Leeds Palliative Care Network shows a similar figure for all deaths of patients included on EPaCCS. Understanding the factors for different population groups and how they may impact on end of life care is being increasingly explored within the network. This will be considered for ~~LCH~~THE TRUST reporting for Q1 25/26.

Ethnicity data: There were no new ethnicity trends identified for preferred place of death. We will review 24/25 ethnicity data in Q1 25/26 as this is supplied annually from BI.

ReSPECT: Progress is being made in the number of patients that have an up-to-date ReSPECT document and planning discussions are taking place earlier. This has been a common theme identified in learning within mortality case reviews in both BU's.

Expected/Unexpected deaths.

SBU = 63 Expected and 5 unexpected deaths. (Lower due to partial reporting in Dec)
ABU = 274 Expected and 48 Unexpected deaths 322 were not recorded.
It is noted that the numbers of reported deaths that were not recorded as either expected or unexpected is very high for adults which is a risk for both inaccurate reporting and missed opportunity for learning. (ABU = 50% and SBU 70%) Further exploration to take place to understand the data quality which will inform. Meeting arranged with BI and clinical systems to understand whether it's a recording or reporting issue. Further information will be available in Q4.
Clinical Leads have re circulated the National definitions for Expected/Unexpected death to all Teams and services to promote accurate recording.

SBU: Open Serious and Internal Concise Investigation Status: 1: LMWS PCMH: 99238: Moderate harm reported in May: PSII led by LYPFT. Timescales overdue due to LYPFT capacity.

ABU: Delay in audit of New Mortality questionnaire level 2 due to sickness. Update to be provided in Q4.

Inquests: Increase in inquests noted this year trust wide. SPC chart completed for 2 years and reported 7 data points above mean, consistently above mean since May 2024. Patient safety team have been in contact

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

~~Key Opportunities Risks and Successes Adult Mortality Report flash report, Q[3] 24/25~~

Opportunities/Successes (Making Stuff Better/Celebrations)

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

Opportunity/Success

Business units and QPD have been working together to develop an improved mortality review process and are now piloting and developing as one integrated team. Within ABU the palliative clinical quality leads are providing a significant contribution to the ABU mortality reviews which includes more sharing of thematic learning. Chairing of Mortality care review meeting has been shared which has provided development opportunities and resilience within the clinical leadership across ABU/SBU. Review of Adult mortality case review meetings underway. Part of this will be to think about how we can incorporate inclusion for reporting requirements. Further update in Q4.

*BAF RISK 1	BAF 2	BAF 3	BAF 4

Opportunity/Success

Inclusion on the LD Lead within the mortality quarterly review process. LD website underway for staff support and learning from LD deaths will be included.

LD Lead reviews every LD death recorded by ~~LCH~~THE TRUST and has plans to bring an ~~LCH~~THE TRUST LD death to LeDeR Network. Generic themes across west Yorkshire continue to be shared.

BAF 1	BAF 2	BAF 3	BAF 4

ReSPECT column in appendix embedded shows an increase this year in completion of ReSPECT plans for patents not included on EPaCCS. This is likely to be a mix of patients in hospital and more completion of the planning ahead documentation with patients, who present with a more uncertain prognosis e.g. those with LTCs, frailty, and dementia. A further community audit of ReSPECT completion is planned for Q1 2024-25. See appendix.

Appendix for Q3 24 25 mortality flash re

BAF 1	BAF 2	BAF 3	BAF 4

Risks/issues

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

RISK

RISK/Opportunity

LTHT discharge pathways 1 & 2 means there are changes in the proportion of discharges from hospital to home and therefore more poorly patients are being discharged home and community care beds are seeing more frail patients that are not for active rehabilitation. This is affecting the length of stay in CCB beds. This remains an escalation for Q3.

Mitigation

To be closely monitored and update to be shared in next report.

*BAF 1	BAF 2	BAF 3	BAF 4

RISK

Difficulty in obtaining data due to submission timescales, this is ongoing. Data can be pulled on the first working day of the month after the quarter and this is usually the submission date for QAIG. This means that completing analysis of data is difficult to include. In Q3 data has been pulled earlier and therefore goes up until 15th Dec only.

Mitigation

In Q3 data has been pulled earlier and therefore goes up until 15th Dec only due to bank holidays and deadline dates.

BAF 1	BAF 2	BAF 3	BAF 4

RISK

Potential data inaccuracies in some of the mortality data i.e., level 1 and 2 completions and expected or unexpected deaths. A large amount state 'unknown' and therefore rates are expected to be higher.

Mitigation

Business unit's have requested a review of data to ensure accurate and sensitive reporting.
This came out as a recommendation from internal audit.
Further exploration to take place to understand the data quality which will inform.
Meeting arranged with BI and clinical systems to understand whether it's a recording or reporting issue. Further information will be available in Q4.

BAF 1	BAF 2	BAF 3	BAF 4

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

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

Agenda item:	2025-26 (22)
Title of report:	10 Point Plan for Resident Doctors – Update to Trust Board
Meeting:	Trust Board Held In Public
Date:	5 February 2026

Presented by:	Dr Ruth Burnett – Executive Medical Director
Prepared by:	Leanne Wilson – Head of Medical Education and Revalidation

Purpose of the report:		
This paper provides Leeds Community Healthcare NHS Trust Board with an update on targets against NHS England's 10 Point Plan for improving the working lives of Resident Doctors.	Approval	
	Discussion	
	Assurance	X

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives		**Acceptable assurance** General level of confidence in delivery of existing objectives	X	**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:

- This paper summarises Trust progress and compliance against the requirements of the NHS Ten Point Plan to improve working lives of resident doctors.
- Since circulation of the paper with People and Culture Committee in December, the Resident Doctor Representative has been recruited.

Previously considered by:	People and Culture Committee – 11th December 2025.
Outcome of previous discussion/s:	The Committee • Received assurance on the progress made to meet with requirements of the '10-point plan'. • Committed to resource being available from the 'People Directorate' to support the ongoing work.

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	

	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?	N/A

Recommendation(s)	• Take assurance of the progress made to meet with requirements of the '10-point plan'. • Commit to resource being available from the 'People Directorate' to support the ongoing work.

List of Appendices:	N/A

10 Point Plan for Resident Doctors – Update to Trust Board

1 Introduction

In August 2025 Sir Jim Mackey Chief Executive Officer and Professor Meghana Pandit National Medical Director for NHS England wrote to Trusts to launch the NHS 10 Point Plan. The plan is a set of commitments from NHS England to improve the working lives of resident doctors by addressing issues such as payroll errors, rota management, and access to facilities. It includes directives for trusts to take action on improving workplace wellbeing through better rest facilities and out-of-hours food access, ensuring accurate payroll and no unnecessary repeat mandatory training, and ensuring work schedules and rota information are provided on time. The plan also requires trusts to report on progress to their boards, who must appoint dedicated leads for resident doctor issues.

The letter set out a 12-week delivery window for initial actions with further milestones extending into 2026, this paper provides assurance to Trust Board that progress has been made to address the issues raised in the plan.

2 Current position

NHS England had previously set out a 13 point 'Improving the lives of Doctors in Training' plan that had a number of actions mirroring those in the '10 Point Plan', the Trust had therefore already made significant progress which has been reported to the Directors of Workforce and Medical Director.

3 Impact

A summary of the progress made towards the 10-point plan:

1. **Workplace wellbeing**

Improve workplace wellbeing for our resident doctors

Action: Trusts should take action to improve the working environment and wellbeing of resident doctors. Trusts should undertake an audit into the feasibility of improving priority areas like rest areas, parking when on call, mess facilities

and 24/7 hot meals, as well as allowing resident doctors autonomy to complete portfolio and self-directed learning from an appropriate location for them.

Intended impact for resident doctors: Doctors can expect better access to essential facilities like on-call parking, rest areas and hot meals, enhancing comfort and wellbeing during shifts.

Response: As a Community Trust there isn't a designated Resident Doctors Mess, rest facilities are shared with other members of staff, but Resident Doctors are advised on where belongings can be stored safely. Hub car parks are accessible for on-call, so designated spaces are not required. On call arrangements are non-resident so an out of hours menu is also not required. A new Learner information hub has been developed by the Medical Education Team to provide information on bases such as parking, access to lockers, kitchens and prayer facilities. There is also a dedicated 'Resident Doctors Page' with information on Payroll and Exception reporting.

2. Rota and schedule transparency

Resident doctors should receive work schedules and rota information as per the requirements of the Rota Code of Practice

Action: NHS England should: provide 90% of trainee information to trusts 12 weeks before rotations. Trusts should issue work schedules at least 8 weeks in advance and detailed rotas no later than 6 weeks before rotations. Performance data should be submitted and monitored nationally.

Intended impact for resident doctors: Giving doctors more certainty and control over their work-life balance, reducing last-minute changes and stress.

Response: The Medical Education Team notify 'People Business Partners' and Recruitment 3 months ahead of Resident Doctors start dates, so that 'People Business Partners' can provide Generic Work Schedules no later than 6 weeks before start date.

During 2025 there have been 2 rotations of Resident Doctors employed directly by the Trust that required Generic Work Schedules to be issued. During the February 2025 rotation, all 5 schedules were only issued a week prior to start date due to pressures in the People Business Partnering Team. Changes were made for the August 2025 rotation, and all 5 schedules were issued 6 weeks prior to start date.

Rotation	Feb-25	Aug-25
Generic Work Schedule (GWS) Due	5	5
GWS Issued at least 6 weeks prior to start date	0	5
GWS Issued 1 week prior to start date	5	0

3. Annual leave reform

Action: Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing

Intended impact for resident doctors: Doctors will benefit from fairer and more consistent annual leave policies, supporting better rest and recovery.

Response:

Hub Leads and Rota Coordinators approve annual leave based on the service and rota requirements in line with NHS England Guidance.

4. Board-level leadership

Action: Trusts should appoint a senior named lead for resident doctors' issues (where one is not already in place), and a resident doctor peer representative, to report to the board. Each board should also ensure the executive team engages with resident doctors to understand and address local issues.

Intended impact for resident doctors: Stronger engagement and accountability will ensure that doctors' working conditions are regularly reviewed and issues can be escalated.

Response: The Trust Senior named lead for resident doctors' issues is the 'Guardian for Safe Working Hours' (GSWH), who continues to work on recruitment to the Resident Doctor lead role with the Trust and the BMA, but without success. In the interim she attends Board as the GSWH and is confident she raises their issues appropriately and has access and means to do so.

The Resident Doctor Representative post is currently a vacancy due to the postholder qualifying and securing a Consultant Post within the Trust, expressions of interest have been sought. Directors of Workforce, Deputy Medical Director and Director of Medical Education attend the Resident Doctors Forum to listen to issues.

5. Payroll accuracy

Resident doctors should never experience payroll errors due to rotations

Action: Within the next 12 weeks, trusts should: participate in the national payroll improvement programme. By March 2026: rotation-related payroll errors should be reduced by at least 90%. Trusts should establish board-level governance and begin national reporting.

Intended impact for resident doctors: Resident doctors will experience significantly fewer payroll errors as a result of rotations, improving financial stability and trust in the system.

Response: Currently the Head of Medical Education meets with the Operational Managers with a copy of the Generic Work Schedule to complete the SW1 payroll forms, this is done to ensure that hours and allowances are correctly applied reducing the risk of payroll errors. There have been issues relating to 'Less than full time' (LTFT) Resident Doctors who have experienced inconsistences with allowances, having a dedicated 'People Business Partner' has helped to improve consistency.

The table below shows the number of Resident Doctors that joined the Trust for each rotation over the past 4 years, with the number of payroll issues that were reported and required an SW2 form to be completed to correct pay.

Rotation	Spring 22	Autumn 22	Spring 23	Autumn 23	Spring 24	Autumn 24	Spring 25	Autumn 25
Resident Doctors Onboarded	4	5	5	4	5	5	5	5
Resident Doctors with Payroll issues	2	1	1	1	2	0	0	0

6. Eliminating mandatory training duplication

Action: Trusts should comply with the May 2025 Statutory and Mandatory Staff Movement MoU to accept prior mandatory training, where this is not already the case.

Intended impact for resident doctors: Doctors will no longer need to repeat mandatory training unnecessarily, saving time and allowing more focus on clinical duties.

Response: Currently LCH does not have the 'Training Information System' (TIS) to ESR link enabled which would allow for 'training portability'. The Medical Education Team follow a manual process where the Resident Doctors provide a screenshot of completed training and Medical Education update ESR records to ensure training isn't unnecessarily repeated. Head of Medical Education has spoken to the Head of People Partnering - People Operations regarding the link up which would remove the manual process and free up some capacity. The Trust would need to commit some resource to the TIS to ESR link being enabled. Costs are being worked up with the Associate Director of People Operations and will be included in the next paper.

7. Exception reporting

Action: Resident doctors should be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours

Intended impact for resident doctors: The reforms to the Exception Reporting process will improve safe working practices and ensure doctors are paid fairly when they are asked to work extra hours.

Response: The People Services Analyst for the People Service Analysis Team and the Trusts Guardian for Safe Working Hours have been reviewing the new requirements for exception reporting. LCH has produced a digital solution for exception reporting that will enable easier reporting.

8. Course-related expenses reimbursement

Action: Resident doctors should receive reimbursement for course-related expenses within 4 to 6 weeks of submitting their claims. Trusts should review their current reimbursement processes to ensure they can reimburse resident doctors upon submission of valid receipts for all approved study leave-related expenses, including travel and subsidence – not evidence of

attendance/completion – so that reimbursement can take place within 4 to 6 weeks of claims being submitted.

Intended impact for resident doctors: Doctors will be reimbursed faster for training costs and feel more able to prioritise their professional development.

Response: The Head of Medical Education manages the study leave expenses process, previously NHSE advised that only when training had been completed should the Trust reimburse within 4-6 weeks, the new guidance was released 08/10/2025 so all 6 'Curriculum Delivery' expenses from that date have been processed according to the new guidance, and reimbursed by BACS through the Trust's 'Manual Payment Request' process.

9. Rotation reform

Action: We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery Department of Health and Social Care and NHS England will develop and launch pilot rotational schemes and continue to look at wider reform.

Intended impact for resident doctors: Pilot reforms will aim to make rotation management smoother and more predictable.

Response: When the review is conducted and guidance released processes will be updated accordingly.

10. Lead employer model expansion

Action: In October 2025 NHS England will produce a roadmap for extending the Lead Employer model to cover all resident doctors and dentists.

Intended impact for resident doctors: Doctors will no longer need to change employers with each rotation, reducing paperwork and improving consistency in employment and training.

Response: Release of the roadmap for extending the Lead Employer model to cover all resident doctors and dentists has been delayed from NHS England, when this has been released the Trust will work with partners across the city. Approximately half of the LCH Resident Doctors are already on Lead Employer agreements with LTHT or LYPFT currently, Medical Education will continue to support the Lead Employment processes.

4 Risk

Deterioration of training quality: The plan aims to address issues like "tick-box" training and lack of consistent feedback. Without implementation, the quality of medical education could further erode, leaving new doctors feeling unprepared for senior roles.
Erosion of trust: Many of the issues, such as payroll errors and poor working conditions, have persisted for years and have eroded trust between resident doctors and the health service. A failure to deliver on the plan would further damage this relationship.

Risk of further industrial action: Failure to address the concerns of resident doctors could lead to further strikes and industrial action, which are costly and disruptive to patient care.

Impact on patient safety: A well-supported and well-trained workforce is crucial for safe and sustainable care. If resident doctors feel undervalued, unsupported, and undertrained, it can negatively affect the quality of patient care in the long term.

Continued operational inefficiencies: The plan focuses on fixing operational issues like payroll errors and poor rest facilities. Without implementation, the NHS will continue to rely on expensive and inefficient fixes like locums.

Impact on workforce planning: The plan is intended to be a crucial part of retaining doctors. Without it, there is a significant risk that the NHS will not be able to meet future workforce needs, leading to staff shortages and recruitment challenges.

5 Next steps

Some resource will be required from the 'People Directorate' to support the NHS England 'Training Information System' (TIS) to ESR link up, this is currently being scoped by the Associate Director of People Operations.

There will need to be ongoing commitment from the 'People Directorate' to prioritise timely completion of the Generic Work Schedules, and to support the Payroll Reforms. Audits of Generic Work Schedules and regular monitoring of rotas will mitigate risks set out above.

Expressions of interest will be sought from the incoming Resident Doctors for the February 2026 rotation to try to secure a Resident Doctor Representative, in the meantime any decisions or messages from the Trusts Joint Negotiating Committee will be circulated to all Resident Doctors to vote on.

6 Recommendations

The Committee is recommended to:

- Take assurance of the progress made to meet with requirements of the '10-point plan'.
- Commit to resource being available from the 'People Directorate' to support the ongoing work.

Agenda item:	2025-26 Blue Box Item: (23i)
Title of report:	Quality Strategy November 2025 Update
Meeting:	Trust Board Meeting Held In Public
Date:	5 February 2026

Presented by:	Lynsey Yeomans, Exec Director for Nursing and AHP
Prepared by:	Claire Gray-Sharpe, Head of Clinical Governance

Purpose of the report:		
This report provides: This paper provides the first update of the operational implementation and outcome measures that underpin the 2024-2027 Quality Strategy principles that were agreed by Quality Committee in November 2024.	Approval	
	Discussion	
	Assurance	x

Level of Assurance (please tick one)							
Substantial assurance High level of confidence in delivery of existing objectives		**Acceptable assurance** General level of confidence in delivery of existing objectives		**Partial Assurance** Some confidence in delivery of existing objectives	x	**No assurance** No confidence in delivery	

Summary of Key Issues:

Due to the delay in bringing the Quality Strategy to Quality Committee the year one actions were reported on in November 2025. A request was made to resubmit this paper to February 2026 Board.

As the strategy is in PowerPoint format, an additional slide has been added after each of the priority slides to provide the evidence for the evidence measures.

For example: slide 4 includes the year one strategic action, what we will do and evidence measure for Safe. Slide 5 has been added to detail the evidence from slide 4.

A separate CQC paper is being submitted to this agenda with additional information and suggested next steps.

Previously considered by:	Quality Committee November 2025
Outcome of previous discussion/s:	NA

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		Why not/what future plans are there to include this information?	The report responds to the elements of the Strategy,

Recommendation(s)	Review the Quality Strategy update. Equity is held within the actions.

List of Appendices:	Quality Strategy

The Quality Strategy 2024-2027 Year One Update

1 Executive Summary

Quality Strategies set out how NHS Trusts will improve the quality and safety of the services they provide. The aim of a Quality Strategy is to put quality at the heart of service development and delivery. It recognises that the quality-of-care patients' experience when accessing the NHS is what matters most to them.

The LCH Quality Strategy 2024-27 was delayed meaning that the November 2025 report to Quality Committee provided a year one update.

2 Main body of the report

Progress has been initiated to implement the Strategy; the detail is held in the attached Powerpoint. An overview is shared below:

Safe:
Year One actions, five or six actions are complete. Year Two and Three are in progress.

Effective:
Year One, Two and Three actions in relation to aligning the Quality Challenge Plus with the CQC Single Assessment Framework has progressed but is not complete. There is a separate paper into the progress and risks on the February 2026 Board agenda.

Year One action to develop Goals Based Outcomes is in progress.

Year One action to review the Trust Annual Audit Programme (AAP) to include policy compliance is in progress, the AAP will be launched for 2026/27, and policy compliance will be added to the plan as they are ratified.

Year Two and Three actions are ongoing.

Experience:
Year One and Year Two actions for the Parliamentary Health Service Ombudsman standards improvement plan is in place and is progressing. The second phase of

the pilot will lead into full implementation. An EQIA is currently being developed to support the changeover.

Year Three for compliance with the standards is in progress.

Year One and Two actions for an EQIA dashboard with appropriate involvement is ongoing and not yet completed.

Year Three, the action for assurance of the process is ongoing.

3 Impact

Quality
The initiation of the Patient Safety Incident Response Framework and reporting in the Safe section has been completed. Work is ongoing to support colleagues across the Trust to report incidents accurately and the training for incident reporting and management has been reviewed following findings from the associated internal audit.

Risk and assurance
Progress to align the Quality Challenge+ programme for the CQC Single Assessment Framework and subsequent CQC preparedness has not progressed as planned. Although services are aware of the requirement to hold their evidence locally during the Quality Challenge training there is a lack of assurance of this happening. A separate CQC paper is being submitted to this agenda more additional information and suggested next steps.

➢ 4 Next steps

Work to implement the strategy continues.

A separate CQC paper is being submitted to this agenda with additional information and suggested next steps.

➢ 5 Recommendations

The Board is recommended to:

Review the Quality Strategy update.

Claire Gray-Sharpe/Head of Clinical Governance
27 January 2026

NHS
Leeds Community Healthcare
NHS Trust

Quality Strategy Implementation Plan: 2024-2027

Gil Ramsden, December 2024. Version 6.0

Quality Strategy Priorities

2024-2027

NHS
Leeds Community Healthcare
NHS Trust

Our priorities:

Safe

Ensuring patient safety is our top priority

Effective

Providing care that achieves the best care and outcomes for people

Experience

Creating a positive experience to improve how satisfied people are when engaging with our services

We will gather feedback from service users to track progress towards our priorities so that we can stay on track and improve care.

What we will do to continually improve:

We will improve patient safety by fully implementing the National Patient Safety Strategy.

We will improve outcomes by delivering evidence-based care and comply with statutory and regulatory standards

We will improve patient experience by fully implementing the Parliamentary and Health Service Ombudsman (PHSO) standards and building partnerships with the people who use our services

Priorities for implementation:

Safety: Ensuring patient safety is our top priority

1. We will regularly ask if people felt safe in our care and we will use that insight to improve our care for everyone through the implementation of PSIRF

Effectiveness: Providing care that achieves the best care and outcomes for people

2. Our processes will fully comply with Care Quality Commission (CQC) standards.

3. Feedback will inform and improve safety and quality of care

Experience: Creating a positive experience to improve how satisfied people are when engaging with our services

4. We will implement PHSO standards to ensure effective feedback

5. We will consider quality & equity in our quality and safety improvements

SAFE

SAFE: Key Priority 1 (Aligns with CQC Quality statements 3, 4. 10, 14, 15, 16, 17, 18, 20, 21, 23, 25, 26, 27, 29, 32, 33)

We will regularly ask if people felt safe in our care and we will use that insight to improve our care for everyone through the implementation of PSIRF

	Strategic action:		What we will do:		Evidence:
Year 1 1 April 2024 – 31 March 2025	1.1.1	We will have trained and supported six LCH Patient Safety Specialists (PSS), in line with the national patient safety syllabus (level 3 and 4 training). They will have undertaken specific training, allowing them to focus on broad patient safety initiatives, conduct investigations, analyse data, and implement systemic improvements across LCH	1.1.1	Our patient safety specialists will use investigation tools to promote system thinking and quality improvement methodology in 100% of their reports and will explain the process to colleagues involved in the learning process, so more colleagues can take the learning methodology forward.	**1.1.1**: Certificate of completion for all Patient Safety Specialists The safety team will hold a database of all investigations and those involved in investigations
			1.1.1b	100% patient safety incident investigations (PSII) will be conducted in line with the Patient Safety Incident Response Framework (PSIRF) and the LCH Patient Safety Incident Response Plan (PSIRP), ensuring a thorough and balanced response that prioritises learning and indicates how services will evidence / measure improvement.	**1.1.1** **6** monthly report to Board for learning from PSII
	1.1.2	We will ensure that we offer adequate support to colleagues affected by patient safety incidents, and we will be able to demonstrate our 'just culture'*	1.1.2	80% of staff involved in incidents will be issued with verbal information explaining where to access support, including via the LCH Health and Wellbeing Hub . A survey will be developed to monitor impact and identify ongoing process improvements, so we know our staff are as well supported as possible	**1.1.2:** Feedback will inform improvements – narrative from survey – narrative box in survey
	1.1.3	We will report our incidents to the national Learn from Patient Safety Events (LFPSE) system.	1.1.3	LCH will contribute to the LFPSE system national system to improve learning and help make care safer	**1.1.3**: Exception reporting through Performance Brief if LFPSE uploads do not take place
	1.1.4	We will ensure all appropriate system-wide patient safety incidents led by LCH are carried out as a joint investigation with partners to ensure patients / families receive one single joined up response.	1.1.4	We will demonstrate collaboration through joint investigations in 100% appropriate situations, and the lessons leaned will be shared across the organisation / system in a way that is transparent to patients / families	**1.1.4** Multi-agency Patient Safety Incident Investigations will be evident
	1.1.5	We will develop dashboards for use by the Chairs of the Trust Improvement Groups which align to the LCH Patient Safety Incident Reporting Plan (PSIRP)	1.1.5	Review of the data visualised in the dashboard will reveal trends in activity supporting the interrogation of the information to be understood and remedial action implemented when necessary.	1.1.5: Information and assurance will be reflected in reports to QAIG and by exception to Quality Committee

SAFE

SAFE: Key Priority 1 (Aligns with CQC Quality statements 3, 4. 10, 14, 15, 16, 17, 18, 20, 21, 23, 25, 26, 27, 29, 32, 33)

We will regularly ask if people felt safe in our care and wewill use that insight to improve our care for everyone through the implementation of PSIRF

Evidence for Quality Committee May 25		

Year 1
1 April 2024 – 31 March 2025

1.1.1:
Certificate of completion for all Patient Safety Specialists
The safety team will hold a database of all investigations and those involved in investigations
Update:
All Patient Safety Specialists have completed the Level 3 and 4 training this is recorded on the central training register held and managed by the Patient Safety Team
All Patient Safety Incident Investigations are recorded on the Incident Management System (Datix) there has been an additional field added to the QPD page in Datix to record the names of Learning Response Leads, Patient Safety Specialists and Subject Matter Experts.
Completed.

1.1.2:
6 monthly report to Board for learning from PSII
Update:
A six-monthly report is provided to Quality Committee and Board in March (including PSII September-February) and September (including PSII March-August)which details learning from all Patient Safety Incident Investigations for the trust, this was last submitted in September 2025.
Completed.

1.1.3:
Feedback will inform improvements
Update:
This work has not progressed due to vacancies in the Patient Experience and Engagement Team who were supporting development of a survey and vacancies and significant increased demand from inquests in Patient Safety (Opel 3e). This work will be restarted as part of the recently established Patient Safety/Engagement monthly meetings.

1.1.4:
Exception reporting through Performance Brief if LFPSE uploads do not take place
Update:
There have not been any failed uploads. A flag appears in Datix when an upload has failed and this can be resubmitted.
Completed.

1.1.5:
Multi-agency Patient Safety Incident Investigations will be evident
Update:
Four of the five PSII led by LCH which concluded in Quarter One and Two had multi provider involvement and reports were reviewed and approved via partner organisations internal governance processes prior to final LCH approval, the remaining incident did not require other provider involvement.

1.1.6:
Information and assurance will be reflected in reports to QAIG and by exception to Quality Committee
Update:
AAA reporting is in place to QAIG and exception reporting to Quality Committee.
Completed.

SAFE	Key Priority 1 continued				
	Year 2 1 April 2025 – 31 March 2026	1.2.1	We will support and train 15 Learning Response Leads (LRLs) to work on improving patient safety, recognising and addressing unwarranted variation in care delivery in line with the national patient safety syllabus. They will lead investigations, gather views from patients, families, and staff, analyse data to find trends and areas to improve, make changes to prevent future incidents via a range of internal processes by involving the Patient Safety Specialists (PSS).	1.2.1	Our 15 LRLs will have successfully completed selected Health Services Safety Investigations Body (HSSIB) modules, in line with national requirements and availability of the national training)	**1.2.1**: Safety Team maintain a record of training undertaken and refresher dates
				1.2.1b	We will be able to demonstrate a greater understanding of the gap between 'work-as-done' and 'work-as-imagined' and the improvement activity needed to reduce this.	**1.2.1b**: This will be reflected in the improvement activity undertaken in the Trust.
				1.2.1c	100% of staff involved in incidents will be issued with written information explaining where to access support, including via the LCH Health and Wellbeing Hub. A survey will be developed to monitor impact and identify ongoing process improvements, so we know our staff are as well supported as possible	**1.2.1c**: Feedback will inform improvements
				1.2.1d	We will ask for feedback from all service users who have been involved in a patient safety incident to ensure we focus on the things that are important for our service users when investigating and improving safety	**1.2.1d**: Feedback will inform improvements
		1.2.2	We will contribute to the development of the 'LCH Learns' platform for all staff and then work with our Patient Safety Partners (PSP) to extend the learning platform to our patients, carers and stakeholders when it is appropriate	1.2.2	The PSP journey will have been shared at Board and we will have: • Evidence of co-produced system learning to reduce harm and innovate through new ways of working together. • Evidence of patient, staff and others involved in patient safety incidents throughout our quality and safety assurance process. It will be inclusive of people with any protected characteristics • The Patient Safety Partner Policy PL390 will be updated in partnership with our Patient Safety Partners by March 2025 • The Trust's quarterly Patient Safety Summit will be formalised within the Trust governance structure for sharing learning from a variety of feedback sources	**1.2.2**: Learning and improvements to be captured in PSII reports to Board Those involved in investigations will be captured in PSII reports signed off by Trust Executive Directors Policy to be accessible on Trust intranet Evidence of shared learning at safety summit and feedback in to Trust governance processes as agreed
	Year 3 1 April 2026 – 31 March 2027	1.3.1	We will make a strategic shift from learning reactively when failures and errors have already occurred (Safety-I) to include learning from things that are going well (Safety-II)	1.3.1	Patient safety investigations will incorporate tools to explore system thinking and human factors science, to identify meaningful quality and safety improvements.	**1.3.1**: Evidence in PSIIs of application of new learning tools

SAFE	Key Priority 1 continued	
	Year 2 1 April 2025 – 31 March 2026	**1.2.1**: Safety Team maintain a record of training undertaken and refresher dates **Update**: Training related to Patient Safety Incident Investigation is held on a central register overseen by the Patient Safety Team. Certificates of completion for these courses are also held centrally alongside the register. The Trust has 21 Learning Response Leads identified across the Children, Specialist, Adult and Corporate Business Unit. This is in addition to the six trained Patient Safety Specialists. 19 of the 21 have completed the 'Systems Approach to Investigating' provided by HSSIB, one is booked to complete this and the remaining person is awaiting course availability. Only 9 of the 21 have completed the Involvement of 'Those Affected by Patient Safety Incidents' due to limited course availability. This is ongoing as a result. This action may be impacted by the upcoming Leadership Review and reporting will continue to Quality Committee.
		1.2.1b: Demonstrate a greater understanding of the gap between 'Work-as-Done (WAD)' and 'Work-as-Imagined (WAI)' will be reflected in the improvement activity undertaken in the Trust. **Update:** The Trust have undertaken three MDT reviews in line with PSIRP utilising methodologies such as Accimap and Hierarchical Task Analysis (HTA) to review incident themes related to lower limb wound care, wound infection and diabetes. This has led to updates of the lower limb framework, wound infection framework and development of a diabetes pathway. PSII reports are structured between WAD/WAI and Work as Prescribed utilising the 'Humanistic Systems: Proxies for Work-as-Done' (Shorrock, 2020).
		1.2.1c: Staff feedback will inform improvements **Update**: As 1.1.2, not progressed due to engagement gaps and patient safety capacity.
		1.2.1d: Patient feedback will inform improvements **Update**: As above.
		1.2.2: Learning and improvements to be captured in PSII reports to Board **Update:** Included in the six monthly report to Quality Committee and Board. Those involved in investigations will be captured in PSII reports signed off by Trust Executive Directors **Update:** We include this within the note of acknowledgement within the PSII reports and organisations involved are listed on the cover page with sign off details Patient Safety Partner Policy to be accessible on Trust intranet **Update**: This is available on the Trust intranet. Evidence of shared learning at the Patient Safety Summit and feedback into Trust governance processes as agreed **Update:** The Patient Safety Summit is planned quarterly and chaired by the Deputy Director for Nursing and Quality. Learning is shared at each Summit. An overview of the Summits are included in the Quality Account.
	Year 3 1 April 2026 – 31 March 2027	**1.3.1**: Evidence in PSIIs of application of new learning tools **Update:** Evidence of inclusion is varied currently. Work continues to develop the governance process of the supporting meetings to ensure the report content is at the standard expected by the Clinical Governance Team. Those meetings include setting the standard at the initial Terms of Reference meeting, assessing progress of the use of the tools at the interim update meeting and ensuring they have been included at the final approval meeting. There is also a planned workshop at QAIG to discuss the quality of the PSII reports currently being submitted by the Business Units, to the Patient Safety Team, and the work involved by Clinical Governance to bring those reports to an acceptable standard to submit for Exec Director sign off. A risk will be assessed from the workshop and added to the risk register.

Effective (CQC)

Key Priority 2 (Applies to CQC Quality Statements 1, 2, 4, 5, 6, 9, 10,11, 13, 20, 23, 25, 26, 31)

Our process will fully comply with Care Quality Commission standards (CQC).
By working closely with you, we will ensure that our care not only meets regulatory standards but is also truly responsive to your needs and preferences

	Strategic action:		What we will do:		Evidence
Year 1 1 April 2024 – 31 March 2025	2.1.1	We will use our Quality Challenge Plus (QC+) programme to align with the CQC Single Assessment Framework (SAF). This includes the self-assessment process to gather evidence around the CQC quality statements which be uploaded directly to the CQC portal, once this is available to the Trust.	2.1.1	• Pilot of the proposed approach to be undertaken by 0-19 PHINS, Neuro Rehab, CAMHS and Diabetes to establish training requirements and documentation required. • Services will pilot the evidence matrix to ensure all key questions are answered • 100% of LCH clinical services will have a named SAF Champion by March 2025 who is responsible for: i. Attending CQC SAF internal training and keeping their team / service fully informed of change. ii. Ensuring the QC+ self assessment form and improvement plan is completed accurately, on time and shared with CET.	**2.1.1** Feedback from pilot to inform final model **2.1.1i**: CET will maintain a record of training undertaken, achieved and refresher dates **2.1.1ii:** CET maintain a database of all QC+ assessments and outcomes
	2.1.2	To explore the potential for a digitalised Clinical Effectiveness Plan to provide an automated approach to oversight - enabling identification of non-compliance and to inform reporting and assurance	2.1.2	CET to initiate and track progress of conversations re concept of digital clinical effectiveness plan by February 2025, setting realistic milestones for design and analysis. Start to engage with commercial teams / procurement. Aim to have consensus within 6 months to enable development of business case.	**2.1.2:** Business case to be developed in year 2 after scoping in year 1

Effective (CQC)

Key Priority 2 (Applies to CQC Quality Statements 1, 2, 4, 5, 6, 9, 10,11, 13, 20, 23, 25, 26, 31)

Our process will fully comply with Care Quality Commission standards (CQC).
By working closely with you, we will ensure that our care not only meets regulatory standards but is also truly responsive to your needs and preferences

Evidence for Quality Committee May 2025:		

Year 1
1 April 2024 – 31 March 2025

2.1.1
Quality Challenge Plus (QC+) programme to align with the CQC Single Assessment Framework (SAF). Feedback from pilot to inform final model
Update: Two teams, Neuro Rehab and 01-9 PHINS, piloted the evidence log to identify documentation supporting the QC+ self-assessment. While the pilot demonstrated that substantial and high-quality evidence exists for each key question, the process was time-intensive. Additionally, Quality Walkers were unable to access evidence stored in shared folders, limiting the model's practicality for wider implementation. In addition, the Clinical Effectiveness Team is currently operating at Opel 3, which has significantly limited capacity to implement planned updates. As a result, the rollout of this model to other services has been paused. However, learning will be taken forward to inform final model.
Mitigation Measures and Next Steps:
The CQC is currently reviewing its approach to the Single Assessment Framework. To date, we have not been asked to submit evidence via email or the portal but continue to submit evidence when requested at time of inspection.
A consolidated list of suggested evidence has been shared with services to support their QC+ self-assessments.
Services have documented relevant evidence within their QC+ self-assessments, which can be retrieved if requested by the CQC.
The Clinical Effectiveness Team (CET) is reviewing Quality Walk process to support efficiencies within this part of the QC+ whilst further information is disseminated from CQC to inform next steps for the self-assessments. This will be phased improvement work and will aligned through the Quality and Value transformation plan and schedule.

2.1.1i:
CET will maintain a record of training undertaken, achieved and refresher dates
Update: CET provided training in March 2025 regarding the self-assessment framework and disseminated information via MyLCH and midday brief. Planned training sessions in Q1 and Q2 have not been completed due to competing demands and Clinical Governance reporting Opel 3.

2.1.1ii:
CET maintain a database of all QC+ assessments and outcomes
Update: CET maintain a database for the above. CET have received QC+ self assessments from all services within LCH.

2.1.2:
Business case to be developed in year 2 after scoping in year 1
Update: Scoping for digital products is ongoing as this needs to be aligned to all Clinical Governance workstreams to support the vision that the various governance processes align and evidence concordance with the CQC Key Questions that are demonstrated within the Trusts Quality Challenge Plus programme.
There has been progress on automating the record keeping audit using Sharepoint, which has reduced email traffic, improved transparency, increased accountability for staff. This will be utilised for the Clinical Audit plan when this is launched for 2026-27 programme.

Effective (CQC)	Key Priority 2				
	Year 2 1 April 2025 – 31 March 2026	2.2.1	We will implement our approach to the CQC Single Assessment Framework	2.2.1	• Develop a training programme for SAF Champions to disseminate; attendance at service-level training will be monitored against a plan developed by March 2025. • All Services will be prepared and ready to action their live submissions to the CQC Provider Portal • Work with SAF Champions and ensure that as an organisation we are developing key principles • Services will collect examples of evidence according to each of the five key questions • Services will use the evidence matrix to ensure all key questions are answered • The CET will ensure Director approval then upload to the CQC portal.	**2.2.1** CET will maintain a record of training undertaken, achieved and refresher dates CET will maintain a database CQC portal will be in active use
		2.2.2	To progress concept of digital clinical effectiveness plan including engagement with commercial teams / procurement if agreement to proceed with business case and funding approved.	2.2.2	• Develop a business case and take it through standard processes including sourcing potential funding • If successful, monitor progress of procurement conversations / commercial teams involved, ensuring successful agreements and smooth processes or escalating delays / concerns. • If a digital solution is not possible, work with the Chief Information Officer (CIO) and Business Intelligence Team (BI) to create a good oversight tool (compliance spreadsheet) until a case for change is developed / funding made available.	**2.2.2:** See priority 2.4

Effective (CQC)

Key Priority 2		
Year 2 1 April 2025 – 31 March 2026	**2.2.1** Develop a training programme for SAF Champions. CET will maintain a record of training undertaken, achieved and refresher dates **Update:** This has not progressed due to the changes with CQC portal. A decision was taken to focus on Quality Walks whilst further information is disseminated from CQC. CET will maintain a database **Update:** As above CQC portal will be in active use **Update:** Paused as CQC have not launched the use of the portal.	

Effective (CQC)	Key Priority 2				
	Year 3 01 April 2026 – 31 March 2027	2.3.1	We will improve the processes implemented in year 1 and 2 in relation to the SAF, embedding 5 principles to demonstrate effectiveness: • Is it person-centred? • Is it inclusive? • Is it evidence-based? • Is it ambitious? • Is it affordable?	2.3.1	• The Trust will seek to improve ways of gathering and using data, including the impact of patient experience, working in conjunction with Patient Experience Team (PET). • The Trust will continue involving patients, families, and staff in learning and improvements and include this feedback in the evaluation of the 2024-27 strategy and inform the successor document • Seek and apply learning from SAF design process and incidents to continually improve. • Service level CQC Champions will ensure service-level sign-off • Service-level CQC Champions will quality assure all evidence and save in the specified secure drive and confirm action complete via the CET	**2.3.1**: Evidence of feedback informing quality and safety improvements Case studies to be added to patient information hub
		2.3.2	Implement the most cost and clinically effective compliance tool, making the most use of innovations and funding streams available	2.3.2	• Deliver on the implementation of any successful business case	**2.3.2**:Clinical effectiveness compliance tool to be operationalised

Effective (CQC)	**Key Priority 2**		
	Year 3 **01 April 2026 – 31 March 2027**	**2.3.1**: The Trust will seek to improve ways of gathering and using data, including the impact of patient experience, working in conjunction with Patient Experience Team (PET). Evidence of feedback informing quality and safety improvements. **Update**: Data is not currently available and has been escalated via the AAA QAIG report for onward discussion. Case studies to be added to patient information hub **Update:** Not yet initiated due to Patient Safety and Patient Engagement capacity.	
		2.3.2:Clinical effectiveness compliance tool to be operationalised **Update:** Scoping for digital products is still ongoing as this will be aligned to all governance workstreams.	

Effective

Key Priority 3 (Applies to CQC Quality Statements: 2, 3, 4, 5, 7, 9, 10, 11, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 31, 32, 33)

Feedback will inform and improve safety and quality of care

Strategic actions			What will we do:		Where to find the evidence:
Year 1 1 April 2024 – 31 March 2025	2.4.1	We will make patient data more available and accessible so we can improve how we address equity and health outcomes	2.4.1	A series of follow-up meetings is booked between the Chief Information Officer, Business Intelligence Manager and other strategic leads following an initial QAIG and QC workshop (held 28/10/2024 with a range of strategic colleagues). They will enable LCH to reach a consensus on which metrics are deemed most appropriate to measure effectiveness across the organisation.	**2.4.1:** Agreed metrics to be included in Trust reporting
	2.4.2	We will strengthen our commitment to evidence-based practice by addressing consistency in the ways we work, especially regarding compliance with local and national requirements in: • Clinical audit • Clinical and corporate policies • Equity and Quality Impact assessments (EQIAs) • National Institute for Health and Care Excellence (NICE) This will ensure clinical effectiveness remains a priority throughout LCH as we deliver against the quality and value programme and other innovations and transformation across the Trust	2.4.2	We will move from efficiency-based metrics to outcome and impact-based metrics to demonstrate learning and improvement aligned with the Trust key performance indicators	**2.4.2**: These metrics will be reported on within appropriate existing reports to Board +/- sub-committees Relevant audit against Trust policies reflected in annual clinical audit plan and reported to QAIG and Quality Committee through existing corporate governance arrangements

Effective

Key Priority 3 (Applies to CQC Quality Statements: 2, 3, 4, 5, 7, 9, 10, 11, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 31, 32, 33)

Feedback will inform and improve safety and quality of care

Evidence for Quality Committee May 2025:		

Year 1
1 April 2024 – 31 March 2025

2.4.1:
Agreed metrics to be included in Trust reporting
Update: An update was presented to QC in July 2025. Goal Based Outcomes (GBOs) have been selected as a Trust-wide effectiveness metric due to their simplicity and evidence base. Pilots are underway in the Active Recovery Unit and Children's Business Unit. The effectiveness dashboard has been paused to align with KPI development, ensuring integration and resource efficiency. Clinical Systems and BI teams are collaborating on GBO data infrastructure. Patient reported outcome measures and equity-linked metrics are being explored for broader use. Other effectiveness data is collected but not yet centralised with BI access. Timeline pressures and dependencies on other workstreams have delayed progress, but alignment with existing initiatives aims to optimise resources and reduce duplication

2.4.2:
We will move from efficiency-based metrics to outcome and impact-based metrics to demonstrate learning and improvement aligned with the Trust key performance indicators
These metrics will be reported on within appropriate existing reports to Board +/- sub-committees.

Update: Update currently unavailable.

Relevant audit against Trust policies reflected in annual clinical audit plan and reported to QAIG and Quality Committee through existing corporate governance arrangements

Update: The development of the new clinical audit programme is in progress, with a proposal presented through the Quality Committee audit paper in May and discussed at Clinical Leads meeting on 16/10/2025. The new programme will include of a review of all National Audits, Policy Compliance Matrices, and NICE Quality Standards that are relevant to each business unit which will then be included on the business unit audit plan. Work has begun to complete this for SBU with the other business units to follow. The audit plans will be held on Sharepoint as the record keeping audit currently is, to reduce email traffic, transparency, and for ease of completion. This work will support the move from reporting on number of audits registered to being able to identify learning from audits and impact on clinical effectiveness.

Effective

Key Priority 3

Year 2
1 April 2025 – 31 March 2026

2.5.1	We will ensure the Trust uses all feedback to evidence +/- improve quality care

2.5.1	• Ensure feedback is gathered from all service user groups so all voices are heard • 100% services will fully align their 2025/26 clinical audit plan to LCH vision, priorities and risks. • CET will undertake quality assurance checks on at least 25% clinical audits and policies to assess adherence to agree processes. • Provide advanced training for staff to enhance their skills in applying evidence-based practices across teams; develop broader training networks where they add value • Use analytics and research skills to review patient level data so we can better understand how protected characteristics affect patient experience and outcomes and identify health disparities for redress. • Collaborate with university research partners to learn how to deliver and monitor effective, evidence-based care when there is insufficient evidence or assurance

2.5.1:
Board and relevant sub-committees to be informed about feedback through existing reporting structure

2025/26 clinical audit plan to reflect the alignment to Trust priorities and risks

Increase in research activity to be reflected in information shared to QAIG

The Trust will ensure they are able to identify and report on the number of staff trained on how to use data analysis and interpretation tools / methodology

Effective

Key Priority 3

Year 2
1 April 2025 – 31 March 2026

2.5.1:
Board and relevant sub-committees to be informed about feedback through existing reporting structure.
Update: A six-monthly experience and a six-monthly engagement report are completed for Quality Committee that includes Friends and Family Test information, feedback and learning. There are now separate quarterly AAA reports to QAIG in addition.

2025/26 clinical audit plan to reflect the alignment to Trust priorities and risks

Update: The 2026-27 audit plan will clearly identify audit priorities and where audits are unable to be completed due to competing demands, which can then be logged as a risk on the risk register.
Quality assurance checks for compliance with clinical audits is completed monthly through business unit reporting. Compliance with policy process is completed for all policies through CCPG meeting and review of Policy database. The planned 26/27 approach to the audit plan will include consideration of the Trust Strategic and Important Goals since movement away from priorities.

Increase in research activity to be reflected in information shared to QAIG
Update: - The QAIG report has been changed since this measure was written to a AAA format.
- There were 60% more studies in 2025/26 Q2 than the previous year (10 to 16, with the Q4 figure being 16 in the previous year).

The Trust will ensure they are able to identify and report on the number of staff trained on how to use data analysis and interpretation tools / methodology

Update: This measure is being assessed with the Head of Business Intelligence to understand the requirement to enable an update.

Effective	**Key Priority 3**				
	Year 3 1 April 2026 – 31 March 2027	2.6.1	We will ensure the Trust has embedded and sustained a range of robust feedback mechanisms to gather insights and information to assess if the workplace supports effective care delivery	2.6.1	• Use agreed clinical effectiveness measures (including FFT) to provide assurance around new ways of working / service improvement • Ensure that the improvements made re priority 2 in years 1 and 2 are sustained and become part of LCH culture. • Introduce new evidence-based practices and innovative solutions to enhance clinical effectiveness, using insight from audit / EQIAs undertaken between 2024 - 2026 • Measure the impact of initiatives introduced in priority 1 and 2 to track and report key outcomes. • Share best practices and success stories within LCH and with external local / regional / national stakeholders via social media and appropriate networks, including the Future Collaboration Platform. • Seek recognition for achievements through awards and certifications.	2.6.1: Reporting of quality metrics through governance reports Quality Committee workplan Quality account to note local and national awards

Effective	Key Priority 3			
	Year 3 **1 April 2026 – 31 March 2027**	2.6.1: Use agreed clinical effectiveness measures (including FFT) to provide assurance around new ways of working / service improvement: Reporting of quality metrics through governance reports Quality Committee workplan Quality account to note local and national awards **Update:** CET have improved reporting on National Audits relevant to LCH through the development of a new process where the Clinical Effectiveness and Compliance Manager receives monthly updates from audit lead and Clinical Lead. This has led to a better understanding of relevant audits, leading to a further 3 audits being identified as relevant to LCH which we are submitting either full or partial datasets to. Feedback is pending regarding the proposed effectiveness measures from the July 2025 report to Quality Committee per action 2.4.1.		

Key Priority 4 (Applies to CQC Quality Statements: 1, 2, 3, 4, 5, 6, 7, 8, 13, 14, 18, 23, 24, 27, 29, 31, 32, 33, 34)

We will implement PHSO standards to ensure effective feedback

	Strategic action:			How will we do it:		Evidence:
Experience	**Year 1 1 April 2024 – 31 March 2025**	3.1.1	We will have identified required improvements to embed the 2023 Parliamentary Health Service Ombudsman Standards into our Patient Experience / Complaint pathway	3.1.1	By March 2025 we will have: • Completed a PHSO benchmarking exercise to inform required improvements • Identified training requirements • Sought staff and patient feedback to inform improvements • Improve how we analyse 3C information collected via the incident management platform to align with Leeds priorities • Undertake a baseline audit of compliance with complaint processes to inform improvements • Develop a process to gather patient feedback regarding complaints process, from all patients and understand whether we receive feedback from all patient groups • Utilise a new dashboard for monitoring trends and themes	**3.1.1:** Improvement plan to be in place and evidence of progression, reported through Patient Experience reports and clinical fellow activity
Experience	**Year 2 1 April 2025 – 31 March 2026**	3.2.1	We will further embed the 2023 Parliamentary Health Service Ombudsman Standards into our Patient Experience / Complaint pathway	3.2.1	• We will deliver training and act on feedback • We will ensure resources are easily accessible for staff • 100% of complainants will be offered a resolution meeting • 100% of staff participating in resolution meetings will be asked for their feedback • We will ensure and evidence that we are communicating with people in line with their communication needs and that we record and act on reasonable adjustments	**3.2.1:** Metrics will be reported through governance processes Feedback will inform improvements
Experience	**Year 3 1 April 2026 – 31 March 2027**	3.3.1	We will confirm we are a mature organisation that has significant and proven development in handling complaints and is an exemplar site.	3.3.1	We will be able to demonstrate evidence of shared decision making in line with NICE guidance	**3.3.1:** Evidence of compliance with PHSO standards

Experience

Key Priority 4 (Applies to CQC Quality Statements: 1, 2, 3, 4, 5, 6, 7, 8, 13, 14, 18, 23, 24, 27, 29, 31, 32, 33, 34)

We will implement PHSO standards to ensure effective feedback

Strategic action:	How will we do it:	Evidence:
Year 1 **1 April 2024 – 31 March 2025**	**3.1.1:** PHSO implementation: Improvement plan to be in place and evidence of progression, reported through Patient Experience reports and clinical fellow activity **Update:** The PHSO improvement plan is progressed on weekly basis and reported through the patient experience workstream. Phase one of the pilot for PHSO rollout is completed with CYMPHS and MSK being the first two services. Phase two of the pilot is due to commence and will bring ABU North Neighbourhood Teams, SBU Leeds Mental Health and Wellbeing Service and Leeds Sexual Health and CBU ICAN Team into the pilot. Learning from phase one is to deliver some PHSO standards training and update the Datix feedback module (completed) prior to initiation. The training is being developed with a planned phase two start of 1 December 2025. The Clinical Fellow role ended in September 2025 with a handover to the Patient Experience Manager to have oversight of the end of Phase One of the pilot and suggested next steps.	

Experience

Key Priority 4

Year 2 **1 April 2025 – 31 March 2026**	**3.2.1:** We will further embed the 2023 Parliamentary Health Service Ombudsman Standards into our Patient Experience / Complaint pathway. Metrics will be reported through governance processes: **Update**: Training is being developed for teams to provide an overview of the standards prior to the team coming into the pilot. There is elearning available via the PHSO website that will be shared when the Clinical Governance training portfolio is developed for the Quality and Value transformation plan. Resolution meetings are being offered when assessed appropriate and currently when a response does not resolve the initial issue for the complainant. There is a plan to offer a resolution meeting at first contact as part of the early resolution element of the PHSO standards and requires further alignment with the PHSO project outlined in 3.1.1. Feedback will inform improvements **Update:** Feedback will be sought once the base processes are established.		

Experience

Key Priority 4

Year 3 **1 April 2026 – 31 March 2027**	**3.3.1:** Evidence of compliance with PHSO standards **Update:** Will be assessed when the standards have been implemented fully		

Experience (EQIA)

Key Priority 5 (Applies to CQC Quality Statements: 1, 2, 3, 4, 14, 15, 16, 18, 19, 23, 24, 25, 28, 29, 31, 32, 33)

We will consider quality & equity in our quality and safety improvements

Strategic actions:			What will we do:		Evidence:
Year 1 1 April 2024 – 31 March 2025	3.7.1	• We will establish and evolve the EQIA process across the Trust	3.7.1	• We will deliver training which will include the need for system-level engagement and patient inclusion. • Case studies and impact statements will be added to our intranet and extranet so all can see the impact we are making. • We will develop a dashboard, using data extracted from the incident management platform (Datix) to evidence progress and highlight where attention should be focused next	**3.7.1:** EQIA dashboard to provide updates to Quality & Value Board

Experience (EQIA)

Key Priority 5

Year 2 1 April 2025 – 31 March 2026	3.8.1	• We will consider if and how we can improve digitalisation of the EQIA process in embedding the processes as business as usual	3.8.1	• We will incorporate patient feedback at every opportunity, and we will invite Patient Safety Partners to join our EQIA panel, to strengthen the patient voice • We will request feedback from services 12m after their EQIA has become embedded as business as usual, to identify unexpected learning and impact that can be shared with others • We will set up a system to get feedback from service users to see if they notice any changes in the services we provide, as required by Section 242 of the National Health Service Act 2006	3.8.1: Evidence of appropriate involvement through EQIAs, signed off by Executive Directors

Experience (EQIA)

Key Priority 5

Year 3 1 April 2026– 31 March 2027	3.9.1	• We will audit and evidence the Trusts approach to equality and quality in care delivery changes	3.9.1	• We will audit and evidence the Trusts approach to equality and quality in care delivery changes	

Experience (EQIA)

Key Priority 5 (Applies to CQC Quality Statements: 1, 2, 3, 4, 14, 15, 16, 18, 19, 23, 24, 25, 28, 29, 31, 32, 33)

We will consider quality & equity in our quality and safety improvements

Strategic actions:	What will we do:	Evidence:
Year 1 1 April 2024 – 31 March 2025	**3.7.1:** EQIA dashboard to provide updates to Quality & Value Board **Update:** The action requires Business Intelligence input and will be updated when further information is known.	

Experience (EQIA)

Key Priority 5

Year 2 1 April 2025 – 31 March 2026	3.8.1: Evidence of appropriate involvement through EQIAs, signed off by Executive Directors **Update:** The Patient Engagement/Involvement Manager has now joined the EQIA panels from October 2025 to provide expert subject matter advice and scrutiny on engagement and involvement at EQIA panels. Provide support and comments on all EQIA submitted in advance of the panel.	

Experience (EQIA)

Key Priority 5

Year 3 1 April 2026– 31 March 2027	3.9.1: We will audit and evidence the Trusts approach to equality and quality in care delivery changes **Update:** This measure will be assessed as the strategy progresses.		

Leeds Community Healthcare NHS Trust

Agenda item 2025-26 (25)

Public Board workplan 2025-26
Version 5: 29 01 2026

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	27 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 - Children's Takeover	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		
Estate Strategy	2xyear (March 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 NOW P&CC	annual	EDN&AHPS	SR 1	Deferred X -Blue box							
Patient Safety Strategy Implementation Update	Final report to Board Dec 24	EDN&AHPS	SR 1,2,3								
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 Q2 Report	Blue Box Q3 X	
Patient safety (including patient safety incident investigations) update report	2 x year (March and Nov)	EDN&AHPS	SR 2,3	X -Blue box					X -Blue box		X -Blue box
Infection prevention control assurance framework	Annual (March)	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
Charitable Funds Annual Report and Accounts	Annual (November)	EDFR	N/A							Ratified by Trustees 8 January 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					Approved in Private 8 January 2026X	
Integrated 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					
Medium Term Plan	Every meeting	EDFR								X	X
National Operating Framework -Segmentation Update	every meeting	CEO							X	X	X
Sustainability (Green) Plan	2x year (June and Feb)	EDO	SR 3		Deferred -July 2025 (Extraordinary meeting)		X			X - Blue box item	
WORKFORCE											
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 (Sept and March)	FTSUG	SR 6	X						X Toolkit	X
Guardian for safe working hours report	4 x year (April, June, Sept, Feb)	GoSWH	SR 6	X	X			X plus 2024-25 Annual Report		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	Annual	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	
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	Deferred	
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 March 2026)	EDFR	SR 3								X
Senior Information Risk Officer - Annual Report	annual (March)	EDFR	SR 3,5	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