Bundle Public Board Meeting 27 March 2026

0 AGENDA
Agenda Public_Board_Meeting_27 March_2026 Final

1 09:00 - Welcome, introductions and apologies

2 Declarations of Interest
Item 2 - Directors DOI 2025-26 19 03 2026

3 Questions from members of the public
Minutes adoption for approval

4 Minutes of previous meeting action log and matters arising

4.a Minutes of the meetings held on: 5 February 2026
Item 4a - Draft Public Board minutes 5 February 2026 HR (002) v3

4.b Action log
Item 4b - Public Board Action Log - 27 March 2026

5 Patient Lived Experience: Wharfedale Physiotherapy Service

6 Interim Chief Executive's report: Medium Term Plan
Item 6 - Chief Exectutive's Report - March 2026

7 Quality Committee Chair's Assurance Report: 24 March 2026

8 Business Committee Chair's Assurance Reports: 25 February 2026 and 25 March 2026 (verbal report)
Item 8 - Chairs assurance report - Business Committee - 25 February 2026 - final

9 Audit Committee Chair's Assurance Report: 11 March 2026
Item 9 - Audit Committee Chair's Assurance Report March 2026 v2

10 Charitable Funds Committee Chair's Assurance Report: 17 March 2026
Item 10 - Charitable Funds Committee Chair Assurance Report March 2026 v1

11 Integrated Performance Report (incl Sickness Rate and Waiting List Trajectories)
Item 11i - Cover paper - IPR Board Mar
Item 11ii - IPR_March2026_Board_Published

12 Strategic Estates Plan
Item 12 - LCH Cover Report - Board March 2026
Item 12 - Strategic Estates Plan - updated for Public Board

13 People and Culture Committee Chair's Assurance Report: 17 March 2026
Item 13 - PCC Chairs assurance report - Mar 26 final

14 Freedom to Speak Up Report – Annual Report
Item 14 - FTSUG March 2026 board report - updated

15 Staff Survey 2025

Item 15 - 2025 Staff Survey Board Paper- 27th March
item 15a - Appendix 1 Staff survey results infographic 2025
Item 15b - Appendix 2 WRES and WDES Staff Survey 2025 data tables

16 Going Concern Statement
Item 16 - Going Concern Consideration 25-26

17 Significant Risks And Risk Assurance Report
Item 17 - Board Significant Risk Report 270326

18 Board Assurance Framework – Quarterly Update Report
Item 18i - Board Assurance Framework Quarterly update March 26 Cover
Item 18ii_2025_26_BAF_Mar_2026

19 Any Other Business. Questions On Blue Box Items And Close

20 BLUE BOX: Patient safety (including patient safety incident investigations) update report - Presented to the Quality Committee March 2026
Blue Box - Item 20 - QC Item 5b Patient Safety Report -Sept 25- Feb 26 Report FINAL QC word

21 BLUE BOX: Infection prevention control assurance framework – presented to the Quality Committee March 2026
Blue Box - Item 21 - QC Item 5c IPC BAF QC March 2026 V1.0
Blue Box - Item 21i - QC Item 5ci Copy of IPC BAF March 2026

22 BLUE BOX: Mortality and Learning from Deaths – follow up from Feb Public Board report
Blue Box - Item 22 - Mortality Report Q3_2526 v2 Board Update

23 BLUE BOX: Workplan – To Note
Blue Box - Item 23 - Public Board workplan 2025-26 v7 19 03 2026

Leeds Community Healthcare NHS Trust

Trust Board Meeting Held In Public
Meeting Rooms 1&2 First Floor Wetherby Health Centre
Hallfield Lane
Leeds LS22 6JS

Date 27 March 2026
Time 9.30am – 11.50am
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)*	**Y**
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: • 5 February 2026	**Y**
4b		Action Log	**Y**
STRATEGY AND PARTNERSHIPS			
2025-26 5	9.40	**Patient Lived Experience** Wharfedale Physiotherapy Service	**N**
2025-26 6	10.00	**Interim Chief Executive's Report** • Medium Term Plan *(Dr Sara Munro)*	**Y**
QUALITY AND SAFETY			
2025-26 7	10.15	**Quality Committee Chair's Assurance Report:** 24 March 2026 *(Professor Ian Lewis)*	Paper to be tabled
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2025-26 8	10.20	**Business Committee Chair's Assurance Reports**: 25 February 2026 and 25 March 2026 (verbal report) *(Lynne Mellor)*	**Y** (March report to be tabled)
2025-26 9	10.25	**Audit Committee Chair's Assurance Report**: 11 March 2026 *(Khalil Rehman)*	**Y**
2025-26 10	10.30	**Charitable Funds Committee Chair's Assurance Report:** 17 March 2026 *(Alison Lowe)*	**Y**
2025-26 11	10.35	**Integrated Performance Report** *(All Execs))* • Sickness Rate Trajectories (Jenny Allen) • Waiting List Trajectories (Sam Prince)	**Y**
2025-26 12	10.50	**Strategic Estates Plan** *(Andrea Osborne)*	**Y**
BREAK – 10 minutes			

WORKFORCE			
2025-26 13	11.10	**People and Culture Committee Chair's Assurance Report: 17 March 2026** *(Rachel Booth)*	**Y**
2025-26 14	11.15	**Freedom to Speak Up Report – Six Monthly Update – Annual Report** *(John Walsh)*	**Y**
2025-26 15	11.20	**Staff Survey 2025** *(Jenny Allen/ Laura Smith)*	**Y**
GOVERNANCE AND WELL LED			
2025-26 16	11.30	**Going Concern Statement** *(Andrea Osborne)*	**Y**
2025-26 17	11.35	**Significant Risks And Risk Assurance Report** *(Sara Munro)*	**Y**
2025-26 18	11.40	**Board Assurance Framework – Quarterly Update Report** *(Dr Sara Munro)*	**Y**
CLOSING BUSINESS			
2025-26 19	11.50	**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 19.

***Blue Box**		
2025-26 20	**Patient safety (including patient safety incident investigations) update report – Presented to the Quality CommiTtee March 2026**	**Y**
2025-26 21	**Infection prevention control assurance framework – presented to the Quality Committee March 2026**	**Y**
2025-26 22	**Mortality and Learning from Deaths – follow up from Feb Public Board report**	**Y**
2025-26 23	**Workplan – To Note**	**Y**

Employee	Role	CSU	Interest Type	Date Arose	Year	Decision Making Groups	Interest Description (Abbreviated)	Provider	Value £'s
Samantha Prince	Operational Director of Care Services	Executive Business Unit	Outside/Secondary Employment	01/04/2024	2024/25,2025/26	Board of Directors	Justice of the Peace for England and Wales (West and North Yorkshire)	HM Courts and Tribunals Service	0
Ruth Burnett	Medical Director	Executive Business Unit	Outside/Secondary Employment	01/04/2024	2024/25,2025/26	Board of Directors	Executive Medical Director and Caldicott Guardian	Leeds GP Confederation	0
Ruth Burnett	Medical Director	Executive Business Unit	Outside/Secondary Employment	01/04/2024	2024/25,2025/26	Board of Directors	Sessional GP.Not in partnership, not salaried, no enumeration received but regular sessions as CPD	Crossley Street Practice	0
Ruth Burnett	Medical Director	Executive Business Unit	Loyalty Interests	01/04/2024	2024/25,2025/26	Board of Directors	Community and primary care representative on RSET (Rapid Service Evaluation Team)	NIHR	0
Ruth Burnett	Medical Director	Executive Business Unit	Outside/Secondary Employment	25/11/2024	2024/25,2025/26	Board of Directors	Specialist reviewer bid paperwork for musculoskeletal and pain services. South of England only, non-compete and NDA agreed.	Practice Plus Group	0
Alison Lowe	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	16/04/2024	2024/25,2025/26	Board of Directors	Trustee	Together Women	0
Alison Lowe	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	16/04/2024	2024/25,2025/26	Board of Directors	Trustee	Citizens Advice - Leeds	0
Alison Lowe	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	16/04/2024	2024/25,2025/26	Board of Directors	DMPC in West Yorkshire, employed by the Mayoral Combined Authority. We commission services within the CJS, e.g., the SARC and so on. There is a potential conflict if LCH bids to supply	Deputy mayor Policing and Crime	0
Alison Lowe	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	01/04/2025	2024/25,2025/26	Board of Directors	Director	Association Police and Crime Commissioners	0
Jennifer Allen	Director of People	Executive Business Unit	Loyalty Interests	01/04/2024	2024/25,2025/26	Board of Directors	Husband is a partner at KPMG	KPMG	0
Jennifer Allen	Director of People	Executive Business Unit	Loyalty Interests	01/04/2024	2024/25,2025/26	Board of Directors	I volunteer regularly for Zarach a Leeds based charity.	Zarach	0
Jennifer Allen	Director of People	Executive Business Unit	Loyalty Interests	01/05/2024	2024/25,2025/26	Board of Directors	Husband is a Trustee for Age UK Leeds	Age UK Leeds	0
Jennifer Allen	Director of People	Executive Business Unit	Outside/Secondary Employment	01/04/2024	2024/25,2025/26	Board of Directors	I am also the Director of Workforce for the Leeds GP Confederation	Leeds GP Confederation	0
Laura Smith	Director of People	Executive Business Unit	Outside/Secondary Employment	01/04/2024	2024/25,2025/26	Board of Directors	I undertake some training & consultancy work on a self employed basis for the above organisation, as an Associate	Prospect Business Consulting and WellNorth Enterprises (also known as 360 Degree Sociey)	0
Laura Smith	Director of People	Executive Business Unit	Outside/Secondary Employment	01/04/2024	2024/25,2025/26	Board of Directors	Within my LCH role, I provide DoW support to the Leeds GP Confederation, which could at times represent a conflict of interest, eg if LCH and the Confed bid separately for the same contracts	Leeds GP Confederation	0
Khalil ur Rehman	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	01/04/2024	2024/25,2025/26	Board of Directors	NED role similar to LCH NED role & time committment	East Lancashire Hospitals NHS Trust Ltd	0
Khalil ur Rehman	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	01/05/2024	2024/25,2025/26	Board of Directors	Vice ChairSeacole is the NHS BAME NED network group	Seacole Group	0
Khalil ur Rehman	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	01/10/2024	2024/25,2025/26	Board of Directors	NED & Charity Trustee	Association of NHS Charities - NHS Charities Together	0
Khalil ur Rehman	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	04/08/2024	2024/25,2025/26	Board of Directors	part time IT & Digital consultant via TSI Caritas Ltd (see shareholding declaration)	Touchstone Leeds Ltd	0
Khalil ur Rehman	Non Executive Director	Executive Business Unit	Shareholdings and other ownership int	01/04/2024	2024/25,2025/26	Board of Directors	100-ordinary	TSI Caritas Ltd	0
Khalil ur Rehman	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	01/04/2024	2024/25,2025/26	Board of Directors	Board Member/NED on governing body.	University of Lancashire	0
Khalil ur Rehman	Non Executive Director	Executive Business Unit	Loyalty Interests	01/11/2025	2024/25,2025/26	Board of Directors	Consultant	The Human Digital Collaborative	0
Rachel Booth	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	22/10/2024	2024/25,2025/26	Board of Directors	Chief Risk Officer BUPA	BUPA UK	0
Rachel Booth	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	01/10/2025	2025/26	Board of Directors	Job title - General Counsel. Head of legal services for Bupa UK business units: dental practices, care homes, health clinics, hospitals and private medical insurance services.	Bupa	0
Lynne Mellor	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	18/09/2024	2024/25,2025/26	Board of Directors	Business Consultancy specialising in Cyber and AI	The Human Digital Collaborative Ltd	0
Helen Thomson	Non Executive Director	Executive Business Unit	Nil Declaration	15/08/2025	2025/26	Board of Directors			0
Ian John Lewis	Non Executive Director	Executive Business Unit	Nil Declaration	15/08/2025	2025/26	Board of Directors			0
Sara Munro	Interim Chief Executive	Non-Contracted Staff	Outside/Secondary Employment	01/04/2025	2025/26	Board of Directors	Trustee on the board of the WDT. This is a charitable trust and the role is not remunerated.	Workforce Development Trust	0
Sara Munro	Interim Chief Executive	Non-Contracted Staff	Outside/Secondary Employment	01/04/2025	2025/26	Board of Directors	substantive CEO of LYPFT NHS Trust	CEO of LYPFT	0
Andrea Osborne	Director of Finance and Resources	Executive Business Unit	Nil Declaration	17/11/2025	2025/26	Board of Directors			0

Item
2025-26
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Leeds Community Healthcare NHS Trust

Minutes Trust Board Meeting Held in Public On: 5 February 2026

Attendance

Present:	Helen Thomson Deputy Lieutenant	Acting Trust Chair
	Dr Sara Munro	Interim Chief Executive
	Jenny Allen	Director of People (JA)
	Hannah Beal	Deputy Director of AHP's and Clinical Education (Deputising for Lynsey Ure)
	Rachel Booth (RB)	Non-Executive Director
	Dr Ruth Burnett	Executive Medical Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Alison Lowe OBE (AL)	Non-Executive Director
	Lynne Mellor (LM)	Associate Non-Executive Director
	Andrea Osborne	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Khalil Rehman (KR)	Non-Executive Director
Apologies:	Laura Smith	Director of People (LS)
	Lynsey Ure	Executive Director of Nursing, Allied Health Professionals (AHPs), and Quality
In attendance:	Janet Addison	General Manager Children's Business Unit Leeds Community Healthcare NHS Trust (for Item 118)
	Chris Lake	Participation Lead, Child Health Management Leeds Community Healthcare NHS Trust (for Item 118)
	Three Members of the Leeds Community Healthcare NHS Trust Youth Board	For Item (118)
Minutes:	Liz Thornton	Corporate Governance Officer

One member of the public and two members of staff observed the meeting.

Item 2025-26 (114)

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 Executive Director of Nursing, Allied Health Professionals (AHPs), and Director of People (LS).

Item 2025-26 (115)

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 (116)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2025-26 (117)

Discussion points

Two sets of minutes were reviewed

ai) Minutes of the meeting held on 6 November 2025

The minutes were reviewed for accuracy and approved as a correct record of the meeting.
Subject to the following addition to the text in Item 88: Health Equity Annual Plan:
Non-Executive Director (LM) said that she thought that positive progress had been made to drive the plan forward but digital inclusion should feature more prominently.

aii) Minutes of the meeting held on 8 January 2026 (Extraordinary Meeting)

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

b) Action log

There was one action on the log to review:

2025-26 (66) - Health Equity Five Year Tactical Plan: ***Executive Medical Director/ Health Equity Lead to meet with Acting Trust Chair, Committee Chairs:*** The Executive Medical Director informed the Board that almost all the meetings had been completed. The remaining one was scheduled to take place shortly. **Action closed.**

There were no further actions or matters arising to address.

Item 2025-26 (118)

Discussion points:

Children's Takeover

Three members of the Trust's Youth Board were welcomed to the meeting. They each spoke about their individual role on the Youth Board, their particular areas of interest and posed the following questions to the Trust Board:

How will the proposed integration of Leeds Community Healthcare NHS Trust and Leeds and York Partnership NHS Foundation Trust improve the accessibility of services for young people with Special Educational Needs (SEND)?

The Interim Chief Executive said that a significant amount of work had already been done to review the services currently in place and bring them together where appropriate. One of the top priorities

for the new organisation would be to design a new pathway for SEND working in partnership with the Local Authority and other providers. As part of this work there would be the opportunity to work with children, young people, and their families to redesign services and develop a different and better offer. There would be a breadth of engagement across service users including with the Youth Board to ensure that the new services were designed around the wide spectrum of SEND needs.

The Board reflected on the planned changes in Neighbourhood Health which would mean that partners would work more closely to meet the needs of children, young people and families including with schools and other education providers.

Q. How can the Trust Board help to ensure that the connection between partners and providers improves the experience of young people facing mental health problems.

The Interim Chief Executive said the ambition was for a whole-life approach to mental health which addressed all aspects of an individual's life. Engagement would be a vital part of the journey to enable this ambition to be achieved. By 2028/29 the aim was to have mental health awareness support in every school to ensure there was timely access into mental health services for children and young people.

Non-Executive Director (LM) said that as part of this consideration must be given to the transition of children to adult mental health services which should be seamless, well planned, and not a sudden event.

Non-Executive Director (KR) observed that the individual's socio-economic background was also an important consideration to ensure equity in the delivery of services.

The Executive Director of Finance and Resources said that the proposed integration should offer the opportunity for greater financial collaboration, strengthen the investment in frontline services and offer more opportunities to work with the local authority and Third sector partners.

Members of the Youth Board said that they would like the Trust Board to make some pledges around the questions they had posed today and would like the opportunity to meet the Board again in six months' time to review what progress had been made against them.

Members of the Trust Board said they would like to the opportunity to attend a meeting of the Youth Board. It was agreed that a list of dates would be circulated.

Action: A list of Youth Board meeting dates to be circulated.
Responsible Officer: Participation Lead, Child Health Management

Board members thanked members of the Youth Board for attending the meeting and posing such challenging questions.

Item 2025-26 (119)

Discussion points: Interim Chief Executive's Report

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

Service Visits

She drew attention to the summary of the service visits she had undertaken over the past two months and highlighted some points from the summary reports.

Resident Doctors

Since the report had been written, Resident Doctors in England had voted overwhelmingly in favour of a mandate for industrial action for a further six months.

The Acting Chair asked about the level of demand on the health and care system which seemed to be less pressurised than in previous years.

The Executive Director of Operations said that in the past week there had been significant pressure in the integrated neighbourhood teams. Services had also had to deal with a significant spike in staff sickness over the past couple of months. Although the pressure was high this had been managed well with better communication with partners which had avoided the need for escalations.

West Yorkshire Integrated Care Board (ICB) Changes

There were some areas of function/activity which the ICB was asking provider trusts to host on their behalf and negotiations were ongoing. She highlighted recent developments in relation to leadership roles in the ICB. A further update would be provided when formal appointments were announced.

Non-Executive Director (IL) asked whether any decisions had been made on the resource implications following the conclusion of the Leeds Place Review.

The Interim Chief Executive said that negotiations were ongoing and at the moment the position remained uncertain.

Outcome: the Board

- Noted the report.

Item 2025-26 (120)

Discussion points: Medium Term Plan

The Executive Director of Finance and Resources presented the paper. All Trusts and ICBs were required to submit a 5-year strategic plan on 12 February 2026. The Trust Board had met in December to approve the draft submission to NHS England (NHSE) which was submitted on time. Since then, the Trust had received feedback on the draft submission and had been asked to submit additional information demonstrating further Board review and sign off.

She highlighted the following caveats in relation to the plan as currently drafted:

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

The narrative in the report reflected the discussions which had taken place at the Quality Committee meeting on 26 January 2026 and Business Committee on 27 January 2026, both were recommending Board approval of the Medium Term Plan.

Non-Executive Director (RB) asked about the portability of the 5-year plan into the integrated organisation.

The Interim Chief Executive said that the integration plans had been noted by NHSE and it was accepted that planning would change as the two organisations came together.

Non-Executive Director (LM) suggested that some sections of the plan could be strengthened by including:

- References to artificial intelligence (AI) in relation to increasing productivity and in the section related to the adoption of digital products.
- Strengthening references to equity throughout.
- Sustainability - more content on achievements and aspirations for the future.

The Board agreed that the plan as currently drafted was fit for purpose but acknowledged that there would be a chance for the Trust to review and refresh the plan when more clarity and information was available on the caveats set out above.

Non-Executive Director (KR) referred to statement 12 in the Board Assurance Statement '*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'* which was annotated as embedded.

He asked for assurance that indicative contract values within the plan aligned with the financial offer.
The Executive Director of Finance and Resources said that she did not anticipate any material changes.

Outcome: the Board

- Approved of the Trust's Medium Term Plan for submission to NHSE.

Item 2025-26 (121)

Discussion points: People Headlines and Strategy Update
The Director of People (JA) presented the update which provided information on the key headlines linked to the Trust's People Directorate portfolio. The paper had been reviewed and discussed by the People and Culture Committee prior to coming to Trust Board.

She highlighted the following:

- Progress on the People Strategic Plan
- Staff Survey – response rate 54%
- Mutually Agreed Resignation Scheme (MARS) – The scheme had now concluded, with 41 employees in total mutually agreeing their departures with the Trust.
- People and Culture Committee's support of the Trust's adoption of the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and the actions to reaffirm and cement the Trust's stance against all forms of hatred and discrimination.
- Leadership of Networks and Staff Side

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

The Acting Trust Chair noted the changes and gaps in the leadership of the Trust's Staff Networks and asked whether the underlying reason for this was the perception that staff would not be allowed enough time to undertake the additional duties required by taking on the role.

The Director of People (JA) agreed that they were not easy roles to fill but since the paper had been written a Chair of the Disability and Long Term Conditions Network had been appointed.

A review of how the posts were advertised to staff would be undertaken with the aim of making them more attractive.

Outcome: the Board

- Noted the Workforce Headlines presented in the report.
- Noted that in March 2026 a summary report from the Trust's Workforce Strategy 2021-
- 26; and a final draft of the new People Strategic Plan would be presented to the
- People and Culture Committee
- Noted the People and 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.
- Noted the position and progress in relation to the target measures set out in the current Trust Workforce Strategy.

Item 2025-26 (122)

Discussion points: Quality Committee Chair's Assurance Reports
Two reports were discussed: 25 November 2026 (included in the pack) and 27 January 2026 (tabled at the meeting).

Non-Executive Director (IL) Chair of the Committee presented the reports and focussed on the items in both reports which the Committee wished to alert to members of the Board.
Clinical Essential Skills Recording and Reporting
In November, the Committee received a paper which had summarised that there was no single system for recording clinical skills training, however, local systems were in place. In January, the

Committee received a report with an update on the progress to record and report on the clinical essential skills of staff. It was noted that the level of assurance remained limited with no material improvement despite the action plan. A progress update would be provided to the Committee in May, and an internal audit into the area was suggested.

HMYPI Wetherby Inspection by Chief Inspector of Prisons and Care Quality Commission
Overall, the report was a very positive one. There had been an indication that the Trust could receive a Regulation 12 notice about controlled drugs being issued by one person. The findings from the report had been reviewed and the processes were deemed safe and in line with the Trust's policies.

Patient Safety Incidents Metrics
The Committee received an update on the accuracy of the recording of Patient Safety Incidents. Issues had been identified in relation to how data was extracted from Datix by the Business Intelligence (BI) team. The Committee received assurance that the data in the six-monthly patient safety report was accurate, as this data had been taken directly from Datix without BI extraction. A further update on both correction of the data and the outcome of the investigation of the BI extraction failure would be reported to the Committee in March 2026.

Medical Devices Position Statement
The Committee received an update on medical devices compliance and asset management. It was reported that there remained a significant discrepancy between the number of devices recorded by the organisation and the number visible to Leeds Teaching Hospitals NHS Trust (LTHT) Medical Physics Department, who provided servicing. While a proportion of devices had been serviced within the last 18 months, a substantial number had not been serviced for more than three years. A 90 day improvement plan had been implemented The Committee received assurance that work was being aligned with LYPFT's systems and discussions were ongoing regarding alignment and shared learning. 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

Sudden and Unexpected Deaths in Childhood (SUDIC) Service Spotlight
The Committee received an excellent presentation from the SUDIC Team which highlighted the strong inter agency work involved.

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

Outcome: the Board
• Noted the assurance provided.

Item 2025-26 (123)

Discussion points: Business Committee Chair's Assurance Reports
Two reports were discussed: 27 November 2026 (included in the pack) and 28 January 2026 (tabled at the meeting).

Non-Executive Director (LM) Chair of the Committee presented the reports.

Alert: Strategic Estates Update
In November, the Committee received a report which summarised the improvements and progress on refreshing the strategy for 2026-2031, and a further draft of the strategy would be brought to Committee in February 2026. The Committee was not satisfied with the assurance provided on risk analysis and mitigation. The Chair of the Committee was concerned Estates risks had not been captured and asked for risks to be logged and assessed against the Trust's plan.

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.

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.

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, and this would be formalised via a service level agreement (SLA) with a plan for to 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 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.

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

Outcome: the Board
• Noted the assurance provided.

Item 2025-26 (124)
Discussion points: Audit Committee Chairs's Assurance Report
Non-Executive Director (KR) Chair of the Committee presented the report from the meeting on 9 December 2025.

Data Security and Protection Toolkit (DSPT) 2024-2025 Action Plan and 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

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. Four significant opinion internal audit reports were reviewed: eRostering, Well Led, Financial Sustainability and Medicines Management.

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

Outcome: the Board
• Noted the assurance provided.

Item 2025-26 (125):
Discussion points: Charitable Funds Committee Chair's Assurance Report
Non-Executive Director (AL) Chair of the Committee presented the report from the meeting on 16 December 2025.

Workforce Wellbeing Grant from NHS Charities Together
An application had been drafted for a Transformation Grant of £150,000. Some concerns had been raised regarding duplication of existing wellbeing offers, and the committee had discussed recruitment implications and longer term sustainability. Further information was requested before approving whether the application was to be submitted.

Charitable Funds Annual Report and Accounts
The final Charitable Funds and Related Charities Annual Report and Accounts 2024/25 were reviewed and approved and subsequently signed off by Trustees on 8 January 2026.

Fundraising Updates
- 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.

Outcome: the Board
• Noted the assurance provided.

Item 2025-26 (126)
Discussion points: Integrated Performance Report (IPR)
The Executive Director of Finance and Resources presented the report which provided an overview of performance across the Trust measured across the six domains that aligned to the NHS Oversight Framework.

She highlighted the key points in the report:
- Overall, the Trust's performance was improving. The National Oversight Framework (NOF) forecasting showed a possible move out of segment 4 in Quarter 3 reports. This was a tentative forecast that might change as more national data was published.
- Consistent improvements in relation to the non-reportable waiting times and indications were that the national target of 78% might be met.
- The target for 18 week waits could be met in the not-too-distant future alongside positive movements in relation to the equity of the waiting list processes.
- Statutory and mandatory training targets were being met for the first time in over 2 years.
- Waits for children needing a neurodevelopmental (ND) assessment continued to cause low performance in relation to 52 week waits (preschool) and ND waits for the Community Adolescent Mental Health Service (CAMHS). Work was underway to improve both. This is a nationwide issue due to the increased demand for ND assessments.

The Board commended the work to develop the format of the IPR which made the report much easier to read and data more visible and easier to understand. The layout of the NOF Performance Table was particularly clear.

The report had been scrutinised in detail by both the Quality and Business Committees in January 2026.

Outcome: the Board
• Received and noted the IPR report.

Item 2025-26 (127)

Discussion points: National Operating Framework

The Director of People (JA) presented the reports which updated the Board on progress in relation to improving NOF standards in two areas.

Sickness Absence

This report provided 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. She highlighted the key points:

- Sickness absence continued to rise, with a December spike to 8.2%, driven by an early flu season and increased stress-related absence.
- Trust remained in NOF Segment 4, performing above the sector benchmark and requiring sustained improvement to progress to Segment 3
- A new target-setting framework had been developed, balancing Trust-wide ambition with realistic business-unit-level accountability.

The Board discussed the management of long-term sickness absence and welcomed the review of long-term sickness cases and the identification of cases for targeted case-management intervention, the development of tailored action plans earlier Occupational Health input, more consistent follow-up, and clearer expectations for return-to-work planning. The Board also welcomed Audit Yorkshire's review of long-term sickness management which would provide further assurance and recommendations.

Non-Executive Director (LM) suggested that a visual perspective which mapped the management of cases across critical areas would be helpful in future reports.

Outcome: the Board

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

Staff Engagement Improvement Project Update

The report provided the Trust Board with an update on the implementation of the Staff Engagement Improvement Project, which has been established to address the current performance position in the NHS Oversight Framework 2025-26.

The Trust was 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 used the NHS Employers' Dozen Do's of Staff Engagement as a framework and was structured around three workstreams: Leadership and Culture; Staff Voice, Advocacy, and Involvement; Healthy Teams, Healthy Care.

The paper outlined the project scope, governance structures, key risks, and monitoring arrangements to provide confidence that the Trust was taking decisive action to improve staff engagement.

Outcome: The Board

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

Item 2025-26 (128)

Discussion points: People and Culture Committee Chair's Assurance Report 11 December 2025

Non-Executive Director (RB) presented the report.

Staff Story

Staff Side Chair Rezwana Malik told her staff story. 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.

Staff Safety and Support

The current climate and shifting attitudes to equality and diversity continued to be a theme which was discussed by the Committee. Executive leadership was encouraged to take every opportunity to listen to staff voices and to promote a positive culture where diversity is celebrated.

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.

Definition of Antisemitism

The Committee approved the adoption of the IHRA internationally recognised definition of antisemitism.

Network Spotlight

The Committee welcomed Ruth Salthouse, Chair of the Trust's Pride Network to present on the work and achievements of the network. 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.

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

Outcome: the Board

- Noted the assurance provided.

Item 2025-26 (129)

Discussion points: Freedom to Speak Up – Planning Toolkit

The Interim Chief Executive presented the report on behalf of the Freedom to Speak Up Guardian which provided an update on the Reflection and Planning Tool agreed with the Board in 2024.

It was recommended that Boards review the tool every 2 years, however it was proposed that the Board would not complete the tool again at this point in time. The Board was reassured that the priority actions agreed from the last assessment continued to be implemented with good progress being made. The Board would revisit the Board reflection tool as part of the establishment of the new Board and culture work for the organisational merger.

The Board discussed some ongoing actions from the original planning tool which were outlined in the paper.

The issue of mandating training had been raised in the audit of the Trust's freedom to speak up work. The Board discussed the options for mandating training for new starters and agreed that this should be considered in more detail by the People and Culture Committee and a proposal presented to the Board for approval.

Action: The options for mandating training for new starters to be considered by the People and Culture Committee and a proposal to be presented to the Board for approval.

Responsible Officer: Freedom to Speak Up Guardian

Non-Executive Director (AL) commented on the scores against two statements in ***Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture*** around confidence that there were clear processes in place for identifying and addressing detriment.

Senior leaders in the Trust had scored these as a 3: *generally applying this well, but aware of room for improvement or gaps in knowledge/approach*

She suggested that anecdotal evidence from her conversations with staff across the Trust suggested that their perception and experience of detriment through speaking up might be different.

The Board reflected on the use of the word detriment in this context and whether it was appropriate and clearly understood.

Outcome: the Board

- Supported the recommendation that the organisation continue to deliver on the priority actions from the previous self-assessment and do not revisit the Board reflection tool at this time.
- Agreed that the options for mandating training for new starters should be considered by the People and Culture Committee and a proposal to be presented to the Board for approval.

Item 2025-26 (130)

Discussion points: Guardian For Safe Working Hours - Quarterly Report

The Executive Medical Director presented the report on behalf of the Guardian of Safe Working Hours (GOSWH) which provided the Board with an update around national changes terms and conditions for resident doctors, exception reporting reforms, and local implementation.

She highlighted the key points:

- Implementation of the NHS England 10 point action plan, with the 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 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 January 2026.
- CAMHS Non-Resident On-Call (NROC) monitoring remains a concern due to low Resident doctor engagement, with the Medical Director offering to liaise with the CAMHS team to identify any additional support needed.

The Executive Medical Director informed the Board that she would be arranging to meet with Dr Elhag to discuss her role as LNC Resident Doctors' Representative.

Outcome: the Board

- Endorsed 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.
- Noted the introduction of the new MS Forms exception reporting system launching on 4 February 2026.
- Noted the appointment of Dr Salma Elhag as the LNC Resident Doctors' representative from January 2026.

Item 2025-26 (131)

Discussion points: Board Assurance Framework (BAF) Quarterly Update

The Interim Chief Executive Officer presented the quarterly update report.

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 had been reviewed.

The current scores for strategic risks 2 and 3 had both reduced during this quarterly review, and it was anticipated that the scores for strategic risks 1, 4, and 6 would reduce by the end of Quarter 4.

The outputs of all committees overseeing strategic risks during Quarter 3 resulted in reasonable assurance, but with comments added where individual items led to limited assurance.

Non-Executive Director (IL) suggested that the profile of digital strategic risks should be raised again in the BAF.

It was agreed that this would be considered when the BAF was reviewed at the Board workshop in March 2026.

Outcome: the Board

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

Item 2025-26 (132)

Discussion points: Significant Risks and Risk Assurance Report

The Company Secretary presented the report which provided 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 was based on information extracted from the Datix risk module on 12 January 2026.

She highlighted the following points:

- There were 117 open risks on the risk register, ten of which had been managed to the target level.
- Two risks scored 15 (extreme) and 20 risks scored 12 (high).
- The number of static risks scoring 12 or above had reduced from three in November 2025 to two. The Risk Management Group had 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**.**

Non-Executive Director (LM) said that she had suggested introducing a rolling 12 month risk trend chart in future reports.

The Company Secretary said that work was underway to develop this for inclusion in future reports.

Outcome: the Board

- Noted the changes to the significant risks since the last risk report was presented to the Board; and received assurance that planned mitigating actions would reduce the risks.

Item 2025-26 (133)

Discussion points: Updated Standing Orders (SOs), Reservation and Delegation of Powers and Standing Financial Instructions (SFIs)

The Interim Chief Executive Officer presented the paper which informed the Board of the review undertaken in updating the Trust's standing orders and standing financial instructions.

The SOs and SFIs had been updated to reflect:
- new regulations and legislation
- establishment of the People and Culture Committee
- changes to committee Terms of reference.

The Audit Committee had reviewed the changes at its meeting on 9 December 2025 and recommended that the Board approve them.

Outcome: the Board:

• Approved version 3.6 standing orders, reservation and delegation of powers and standing financial instructions in line with the summary of changes outlined in the paper.

Item 2025-26 (134)

Discussion points: Any other business Questions On Blue Box Items And Close

No matters of any other business were raised. Items in the Blue Box were noted. No questions were raised.

The Chair closed the meeting at 12.00 noon
Date and time of next meeting **Friday 27 March 2026 9.30am** **Wetherby Health Centre** **42 Hallfield Lane** **Wetherby** **LS22 6JT**

AGENDA ITEM 2025-26 (4b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) action log: 27 March 2026

Key		Key colour code
Total actions on action log	2	
Actions on log **completed** since last Board meeting on 5 February 2026 with a **proposal to close**		
Actions due for completion by 27 March 2026 – for update at the meeting	2	
Actions not due for completion before 27 March 2026		
Actions outstanding at 27 March 2026**: not having met agreed timescales and/or requirements**		

Agenda Item Number	Action Agreed	Lead	Timescale/ Deadline	Status
5 February 2026				
Item 2025-26 (118)	**Youth Board:** A list of Youth Board meeting dates to be circulated.	Participation Lead, Child Health Management	By email following meeting	Update on 27 March 2026
Item 2025-26 (129)	**Freedom to Speak Up – Planning Toolkit:** The options for mandating training for new starters to be considered by the People and Culture Committee and a proposal to be presented to the Board for approval.	Freedom to Speak Up Guardian	May 26	Update on 27 March 2026 – this was discussed at the March P&CC and a viability study on priority training is to be undertaken and discussed at the April P&CC.

ACTIONS CLOSED AT MEETING ON 5 FEBRUARY 2026				
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	**Action Closed:** The Executive Medical Director informed the Board that almost all the meetings had been completed. The remaining one was scheduled to take place shortly.

Leeds Community Healthcare NHS Trust

Agenda item:	
Title of report:	Interim Chief Executive's Report
Meeting:	Trust Board meeting - public
Date:	27 March 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

Since the last board meeting there has been a change in the Executive Nursing directorate, and the board is asked to welcome Heather McClelland to her first board meeting as our Executive Director of Nursing, Allied Health Professionals and Quality. Heather joined us on 16 March 2026 for a 12-month period and brings significant senior nursing leadership experience to the role.

The change follows the departure of Lynsey Ure at the end of February who is taking up a new role in the Royal College of Nursing. I would like to thank Lynsey for her contribution to the Trust over the previous 16 months and wish her all the best in her new role.

I have made some additional changes within the executive portfolios to strengthen our leadership and oversight arrangements. Heather will be supported by the addition of a deputy director of quality governance for a fixed period to provide additional capacity and expertise to the quality and professions directorate. This is in direct response to previous board workshops and the private board in February where we identified some gaps in governance and oversight arrangements and the team themselves reporting they were lacking capacity to make the progress they know needs to be made.

In addition, I have also changed line management arrangements and accountability for clinical leadership within the business units. Clinical leads previously reported into the quality and professional development directorate. Going forward these will now report to the Executive Medical Director, Dr Burnett. This will give Heather greater capacity to focus on the corporate professional and governance functions, create greater objectivity of oversight of business units and increase the clinical leadership oversight into the business units.

Review of Administration Services

As part of the trust's quality and value programme a review of how administration services are provided has been undertaken. This led to a new model being proposed which has been open to consultation with staff in February. There has been a significant amount of feedback provided on the proposed changes which many board members are aware of. As a result of this we have extended the timescales to ensure all feedback can be sufficiently analysed and responded to. I have raised it here as the administration services are fundamental to the effective working across all our teams and departments, and we want colleagues to know their feedback has been heard, we are grateful for the time people have given to share this feedback and we need to ensure we are thorough in our consideration of next steps.

Medium Term Planning

We submitted our medium-term plan and associated detailed financial, performance and workforce trajectories to NHS England (NHSE) by 12 February 2026. The regional team at NHSE have reviewed all submissions with the relevant ICB and now written to us to confirm our trust plan is classed as compliant.

We have been advised that the National Oversight Framework metrics will be changed for 2026/27 to align with the national priorities for NHS trusts set out in our medium-term plans - the proposals are going to NHSE National Board in March for sign off. Board oversight and capability to deliver will continue to be an area of assurance for NHSE.

➢ 3 Alignment with Leeds and York Partnership NHS Foundation Trust

Both boards formally approved our strategic outline case to merge the Trust with LYPFT. The case set out our preferred option of acquisition of LCH by LYPFT which provides the simplest route and retains Foundation Trust status for the new organisation.

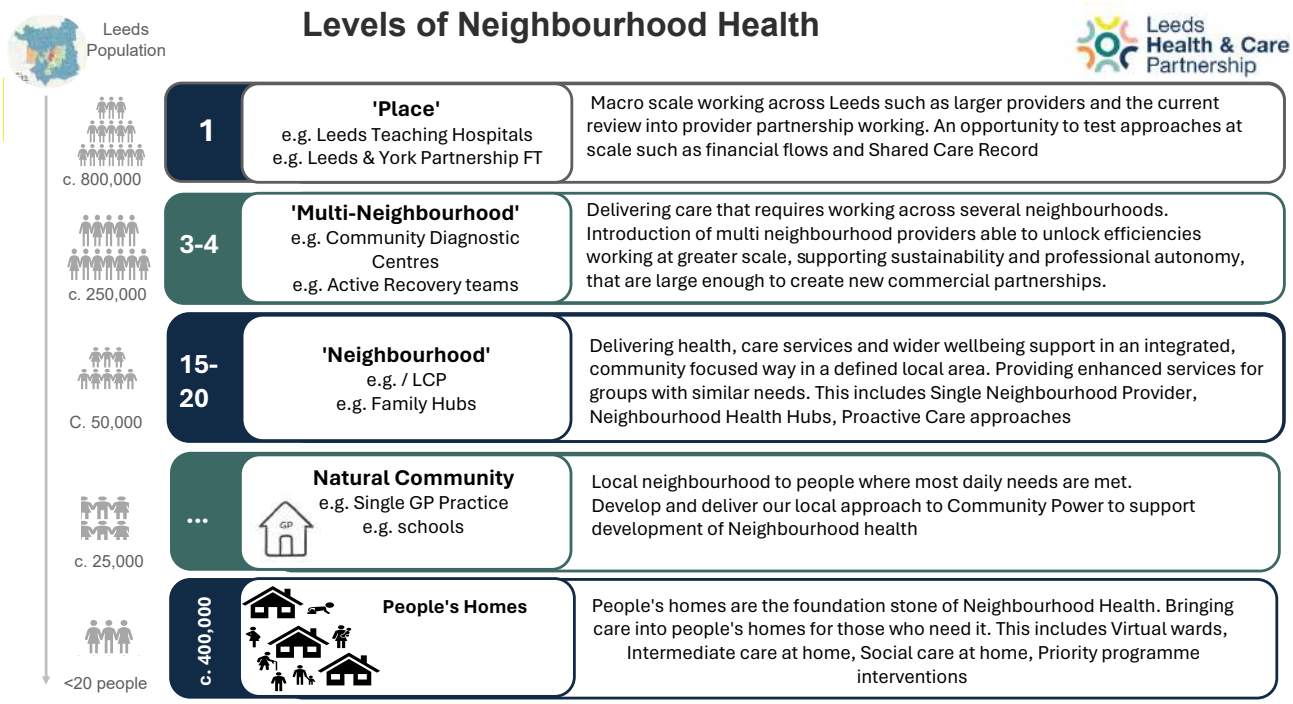
Following board approval, we submitted our strategic case to NHSE regional team on 12 February 2026. This is now being subject to review, and we have in place fortnightly meetings to discuss progress. At our initial meeting no risks, queries or issues were identified, and we were told the national transaction team may also have capacity to review earlier than previously indicated. Our concern of course is to maintain momentum with the overall transition programme, and more detail is included in the update paper to the private board.

We have sent out internal updates to staff and external updates to stakeholders. We have had no queries from external stakeholders. We have also briefed the council of governors at LYPFT and the Leeds overview and scrutiny committee of our strategic plans and rationale.

➢ 4 System Update

Neighbourhood Health in Leeds

Nationally the publication of a specification for neighbourhood health care models has been delayed. However, within the city we are continuing with the development of our models. The Health and Wellbeing Board held a workshop exploring the current proposals, with the aim to have a draft for sign off in May on how we will implement neighbourhood health – from the broadest sense of prevention and wider health and wellbeing in every community through to the health and social care offer for when people have greater needs for support, intervention and recovery.

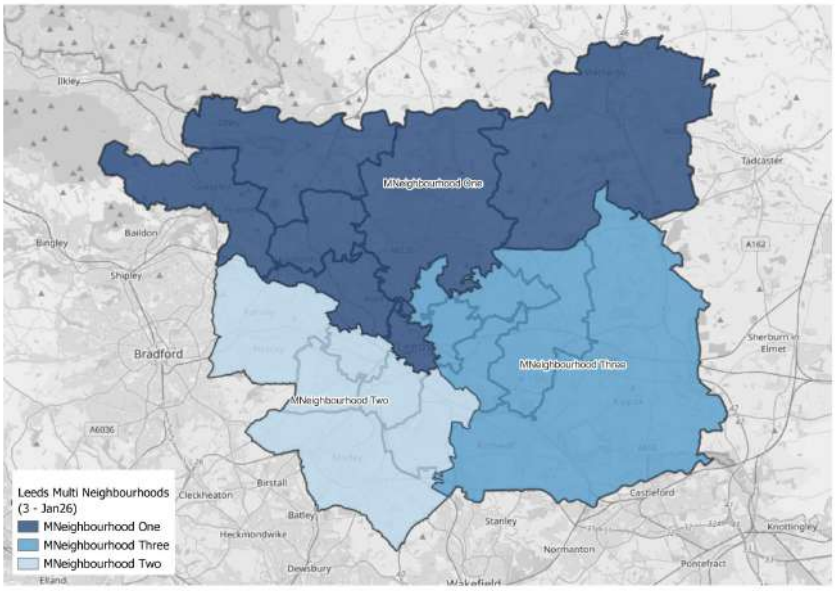


Neighbourhood footprints are matched to our primary care networks in the city and at the Leeds Partnership Leadership Team (PLT) this month we were asked to approve the footprints that will determine the multi neighbourhood level – the point at which we will 'cluster' services that are too niche, specialist or small to be delivered at every neighbourhood level. The following principles were discussed and PLT agreed to 3 multi neighbourhood footprints:

- Starting point is single neighbourhood footprints then group single neighbourhoods together
- Some single neighbourhoods already group together with shared workforce or geography – we have treated them as a single unit or building block
- Every option works well for some areas but creates challenges for others
- Many of the challenges across sectors are created at single neighbourhood level but may be amplified in some multi-neighbourhood options
- The multi-neighbourhood/multi-specialist delivery model is only just being developed – we will get things wrong, may need to adjust, but we do need some footprints to start testing things.

- Most planned health and care should be delivered at a single neighbourhood or community level and we have taken a portfolio approach to developing the detail.

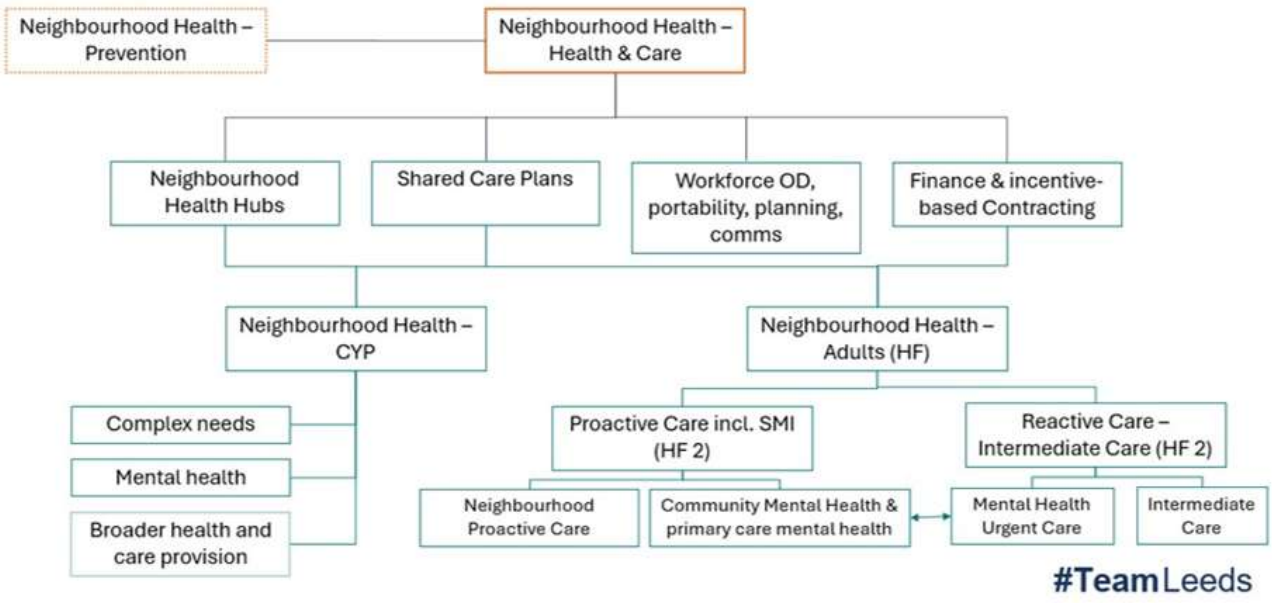
Preferred Option: 3 Multi -Neighbourhoods



Multi Neighbourhood	Primary Care Network Definition
MN One Total Population = 357,021 (38%)	Otley, Yeadon, Woodsley, Holt Park, Central North, Wetherby and LSMP and The Light
MN Two Total Population = 289,309 (32%)	West Leeds, Armley, Bramley, Wortley & MIddleton, Middleton & Hunslet, Morley and Beeston
MN Three Total Population = 297,319 (31%)	LS25/26, Seacroft, Cross Gates, York Rd, Chapeltown and Burmantofts, Harehills & Richmond Hill

January 2026

Proposed LHCP Portfolio Structure for 26/27:



Leeds Provider Partnership

Each Place within West Yorkshire is developing its own Place Provider Partnership (PPP). All places have been working with local partners to design their PPP and will shortly be working through membership of each PPP.

The ambition is that PPPs will have the ability to direct the resources across the partnership, to address the identified population health needs of local communities. This will result in making sure we can deliver smarter use of resources: targeted support where it's needed most, reducing duplication and delivering greater value for money.

In the future ICB operating model, at West Yorkshire level, the ICB strategic commissioning function will set an understanding of population need, based on qualitative and quantitative information. This will set a strategy, which in turn is translated into contractual form. Place Integrator Teams, working with emerging PPPs, will develop integrated services locally to respond to the strategy, outcomes and contracts set by the ICB strategic commissioning function. When PPPs are mature, integrator teams will then move into the host PPP. PPPs will be a formal partnership of providers at Place level. They will have joint responsibility for planning and delivery across health, care and VCSE sector. Membership will reflect the breadth of local expertise including NHS providers, general practice, social care, public health, VSCE and citizen voice and this will be specific to each place. In terms of governance and decision making, it is proposed that a joint committee will operate in shadow form, alongside existing NHS West Yorkshire ICB Place Committees in 2026-27. This is a transitional year, from April 2026.

For the Leeds Place Provider Partnership, we are working through our proposed memorandum of understating and terms of reference for our joint committee. Due to the timing of the ICB consultation and need for greater clarity on the place-based integrator function we have decided to extend this phase. Therefore, we are now aiming to have an agreed MoU, terms of reference and membership to set up a shadow joint committee from May 2026 – subject to trust board approval/sign up.

The joint committee in the transitional period will ‘build the decisions’ about how to deliver: local priorities, service models, resource allocation. It will then recommend these to the existing Place committee. The Place committee then ‘takes the decision’ during the transitional period We are working on the assumption that the joint committee will be fully operational in all five Places as we mobilise formal contracting arrangements by April 2027.

Leeds GP Confederation CEO Update

Following the announcement by Jim Barwick that he is retiring in May 2026 the GP Confederation have now recruited a new CEO. I was on the final interview panel and colleagues were involved in the stakeholder process. At the time of writing, I cannot confirm who the successful candidate is due to pre-employment checks being underway.

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 and completed a formal consultation on the new structures for the ICB in line with the national blueprint published in 2025. Feedback on the consultation was provided directly by organisations, the collaborative and the Leeds place provider partnership. A key theme in the feedback was the need for greater clarity on how the new structure would work with providers and with place-based partnerships given the significant reduction in capacity.

Final structures will be shared with staff on Monday 23 March, with the appointments to posts process starting immediately after. Most of the appointments process is expected to complete in June 2026, with movement to the new model by 1 July. The transitional period will be difficult and disrupted by these changes; the ICB are ensuring business continuity processes are in place. Place Accountable Officers will continue to speak with partners to capture feedback at high level relating to key elements of the consultation and proposed structures.

Transitional arrangements are being enacted to current operating arrangements as some teams and functions will see much bigger resource gaps following voluntary redundancy. These changes are to ensure delivery of the core business of the ICB

and continue to support transitional arrangements as some areas of work and responsibilities transfer to Place Provider Partnerships.

Following Rob Webster's announcement in January that he will be stepping down as ICB Chief Executive, Acting Chair, Professor Nadira Mirza, has confirmed that Rob will leave the organisation on 15 April 2026.

Jonathan Webb, the ICB's Director of Finance, has agreed to be Interim Chief Executive for the period between Rob leaving and a substantive Chief Executive starting in post. Ian Holmes will continue in his role as Deputy Chief Executive during this period.

NHSE will also begin their consultation with regional staff shortly on changes to the regional structures.

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
17 March 2026

Item
2025-26
8

Leeds Community Healthcare NHS Trust

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 27 March 2026
Date of Meeting:	25 February 2026	**Date of next meeting:**	25 March 2026

Introduction

Quorate meeting. The Committee sought assurance with robust discussions across all key agenda items. The Committee welcomed representatives from Leeds Sexual Health Service and learnt about the service's positive achievements in its first year. The Committee discussed and noted the updates on the AI current position, Quality and Value Programme, the Neighbourhood Model, National Cost Collection Report and Waiting lists. Reports were received on the NHS Provider Partnership review, Estates and facilities performance management report, initial draft of the strategic estates plan and updates on the Digital Strategy.

Alert

A live estates asset register for plant and equipment on Micad was just being established and requested assurance for management of risk. Action: The Committee Chair requested that the establishment of an estates asset register logged as a risk and assurance is given that a plan is in place to resolve.	The establishment of an estates asset register logged as a risk and assurance is given that a plan is in place to resolve.

Advise

- Neighbourhood Model Update (Key Priority) – the Committee learnt that progress was being made against each of the core components and a paper had been submitted to the Home Fist Programme Board which was expected to approve a proactive care approach which would commence with high-risk populations before being rolled out to the remaining Leeds population.
- NHS Provider Partnership Review (Key Priority) – the Committee noted the programme's progress on developing the different workstreams. The West Yorkshire ICB was undertaking much of the commissioning work before delegating to NHS organisations. The challenge was considered to be delegation to Primary Care organisations. However, the correct set up and governance of provider collaboratives was felt to be key.
- Waiting List Update (Key Priority) – The Committee were advised that the improvement trajectory was progressing well, although there was some concern around paediatric neuro disability.
- EPR Contract Procurement proposal, the WAN extension and LMWS CBT business case papers were approved.

Committee Escalation and Assurance Report

- The anticipated surplus information was welcomed in the Monthly Financial Dashboard and that the NCC index had improved since the end of 2025 but had not affected the ranking and segmentation.

Assurance

- The Estates & Facilities Quarterly Update was received. In addition, a development update on the Strategic Estates Plan was also provided.
- The Quarterly update on the Digital Strategy was welcomed and the anticipation that all services would have progressed to digital letters by March 2026.
- Service Spotlight – presentation received from the Leeds Sexual Health Service and their achievements in their first year. It was still to be identified how the success of the service would be measured.

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.
- The risk that Estates did not have a live asset register was identified.

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	16 (extreme)	Reasonable	Noted risk in Estates Strategy re asset register

Committee Escalation and Assurance Report

spending does not exceed available funding, then this could jeopardise delivery of our strategic goals and priorities.			
Risk 5 Failure to maintain business continuity: If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.	12 (high)	Reasonable	
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	Felt assured the risk was being managed.

Author:	Sue Grahamslaw / Helen Robinson / Lynne Mellor
Role:	Corporate Governance
Date:	3 March 2026

Committee Escalation and Assurance Report

Name of Committee:	Audit Committee	**Report to:**	Trust Board 27 March 2026
Date of Meeting:	10 March 2026	**Date of next meeting:**	7 April 2026

Introduction

Quorate meeting with a full agenda and good debate on key topics – good challenging conversations, would have benefitted from exec lead in relation to the two limited assurance internal audit reports (Management of Waiting Lists and EPRR).

Alert	Action
• EPRR Internal Audit Report – limited assurance. Areas for improvement focussed on testing and reporting against the improvement plan.	Business Committee to discuss the limited assurance report, prior to further discussion with Exec sponsor at Audit Committee on 7 April.
• Management of Waiting Lists Internal Audit Report – questions raised around data validation and improving efficiencies, as Quality and Business Committees had been reassured there had been reductions in waiting lists.	Quality Committee to discuss the limited assurance report, prior to further discussion with Exec sponsor at Audit Committee on 7 April.

Advise

- Internal Audit Progress Report – two limited assurance reports and one significant assurance report (BAF and Risk Management Framework) issued since the last meeting, with another report in draft stages awaiting management response. Further work to be done on root cause analysis in order to be meaningful. Noted that the EQIA audit scope was now agreed with the final report expected in June 2026.
- Internal Audit Follow up of overdue audit recommendations – the number of re-opened recommendations was disappointing, the processes to monitor audit recommendations and provide oversight will continue to be strengthened.
- Draft Head of Internal Audit Opinion 2025-26 – Outstanding recommendations were being pursued to enable a final Head of Internal Audit Opinion to be provided by year end.
- Draft Internal Audit Annual Plan – the flexibility of the proposed plan was welcomed and the plan was approved.
- External Audit – the progress update was received and the engagement letter and fee accepted.
- Going Concern Consideration – agreed to recommend to Board that the accounts were being prepared on a going concern basis.
- Progress noted on the Data Security and Protection Toolkit Baseline Assessment, on track for a “standards met” submission by 30 June 2026.

Committee Escalation and Assurance Report

- Contracts Register would be received in full at the next meeting (instead of an extract)

Assurance

- Update on the PSIRF Internal Audit - progress on the follow up recommendations
- Internal Audit – Board Assurance Framework and Risk Management Framework Internal Audit Report was received with significant assurance
- Annual Report and Accounts - preparations in place and timetable noted in conjunction with changes to accounting policies.
- Information Governance Annual Report – received and noted.
- Financial Controls – updates on Losses and Compensation, Tender and Quotation Waivers, Procurement and Working Capital received.
- Board Assurance Framework activity report received providing a six monthly summary of the sources of assurance provided to the Committee. Q4 BAF review currently underway.
- Summary of the HFMA Improving NHS financial sustainability Checklist and NHSE Well Led Finance Toolkit noted.

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	Reasonable assurance overall but concerns raised regarding the Internal Audit EPRR report.

Author:	Helen Robinson / Khalil Rehman

Leeds Community Healthcare NHS Trust

Committee Escalation and Assurance Report

Role:	Company Secretary/Committee Chair
Date:	18 March 2026

Committee Escalation and Assurance Report

Name of Committee:	Charitable Funds Committee	**Report to:**	Trust Board 27th March 2026
Date of Meeting:	19/3/2026	**Date of next meeting:**	7 July 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 19 March 2026. Quorate meeting with good debate on key topics.

Alert	Action
No alerts	

Advise

- Workforce wellbeing grant from NHS Charities Together – application for a Transformation Grant of £150,000 was unsuccessful.
- Giving Voice Choir – to be supported to set up as an independent charity.
- Charitable Fundraising Events and Engagement – Committee received an update on planned fundraising events such as the London Marathon, half marathon, 10K, and corporate partnerships, as well as strategies to increase staff and public engagement. Some concerns raised regarding engaging participants in some events. To use existing communications channels to extend reach rather than creating a specific newsletter.
- Charitable Funds Officer scoping grant opportunities.
- Consideration to be given to using the Board meeting to spotlight charitable fund activities and impact.
-

Assurance

- Integration with LYPFT – Committee discussed the implications of merging with LYPFT, including differences in committee structures, the need for charity registration, and collaboration on volunteering and fundraising. To be picked up through Integration Workstreams.
- Finance report covering April 25 – February 2026 received and accepted.
- Committee agreed to renew the NHS Charities Together annual membership.
- Committee annual report received and approved. The effectiveness review and achievements over the past year were considered and no major concerns raised, and minor changes agreed to Terms of Reference prior to Board approval in May.
- Steering Group Terms of reference also approved.

Committee Escalation and Assurance Report

Risks Discussed and New Risks Identified
No new risks identified

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

Author:	Helen Robinson
Role:	Company Secretary
Date:	19 March 2026

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 11
Title of report:	Integrated Performance Report
Meeting:	Trust Board
Date:	27th March 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 provides: 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:

It has been confirmed that the Trust will be in segment 3 of the NHS Oversight Framework in Q3 2025/26. This is a great achievement. Contributing to this are the significant improvements that are being reported over a number of the waiting list measures. This is indicative of the ongoing hard work and focus on waiting times across a number of services. Most notably for the first time since the COVID Pandemic, consultant led waits are now showing statistically significant rates of improvement.

Improvements in NHS Talking Therapy 6 weeks waits and CAMHS routine waits for eating disorder services are required. Additional capacity has been put in place to manage this.

Unfortunately, we have seen a deterioration in the equity of our consultant led waits with people living in IMD1 more likely to experience 52 week waits. This is an area of focus for the Access LCH steering group.

Statutory and mandatory training has seen a sustained period during which performance has remained around the 90% target. This is an achievement considering the Trust's current high levels of sickness; despite reduced capacity, compliance has been maintained.

High levels of sickness are also contributing to a lack of capacity to manage patient safety incident investigations. None have been closed this month due to investigations not consistently meeting the required timescales.

Previously considered by:	
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:	Appendix 1 – MDC Methodology Appendix 2 - National Oversight Framework (NOF) Improvements Project Update – Update for People and Culture Committee



Integrated Performance Report

NHS
Leeds Community Healthcare
NHS Trust

March 2026

Reporting on: January 2026 & February 2026



Executive Summary

NHS Leeds Community Healthcare NHS Trust

Summary

It has been confirmed that the Trust will be in segment 3 of the NHS Oversight Framework in Q3 2025/26. This is a great achievement. Contributing to this are the significant improvements that are being reported over a number of the waiting list measures. This is indicative of the ongoing hard work and focus on waiting times across a number of services. Most notably for the first time since the COVID Pandemic, consultant led waits are now showing statistically significant rates of improvement.

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Summary Performance

Data Quality : **Medium Assurance** Performance: **Improving**

Top Highlights

Domain	KPI	Target	Actual	Performance	Assurance
Responsive	% Patients waiting under 18 weeks (non reportable)	>=95%	79%	H	F
Responsive	Number of patients waiting more than 52 Weeks (Consultant-Led)	0	704	L	F
Responsive	Percentage of patients currently waiting under 18 weeks (Consultant-Led)	>=92%	27%	H	F
Well Led	Statutory and Mandatory Training Compliance	>=90%	90%		?

Top Concerns

Domain	KPI	Target	Actual	Performance	Assurance
Responsive	IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	>=75%	87%	L	P
Effective	Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 52 week standard	<=1.00	1.26		F
Well Led	Total sickness absence rate (Monthly) (%)	<=6.5%	7.5%	H	F
Safe	Number of Patient Safety Incident Investigations (PSII)	No Target	0	↘	
Responsive	% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	>=95%	71%		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

- **It has been confirmed that LCH is in segment 3 in Q3 reporting**. A refresh of the national dashboard is expected in the next week. The table below shows our forecasted position. **Our actual overall metric score for Q3 is 2.58. As forecast and we are ranking 43 out of 61.**
- The improvement is primarily driven by stronger CYP access to mental health services and reduced waiting times.
- The Q4 forecast draws on all available national datasets, with the exception of sickness absence, which had not been released at the time of writing. NHS Staff Survey results have delivered a net improvement of 0.4 in our NOF performance, in contrast to many providers who have experienced a decline.
- Further improvements in CYP access to MH services are anticipated, as indirect activity from Infant Mental Health and Primary Care Mental Health begins to flow into national reporting.
- The 2026/27 NOF measures are expected to be published in the NHS England Board papers on 23 March, with a member briefing likely to follow shortly thereafter.

		Q2				Q3 (forecast)				Q4 (forecast)			
Domain	**Metric**	Value	Score	Rank	Segment	Value	Score	Rank	Segment	Value	Score	Rank	Segment
Overall		-	**2.71**	47 of 61	4	-	**2.56**	43 of 61	3	-	**2.45**	41 of 61	3
Access to Services	Percentage of patients waiting over 52 weeks	7.82%	3.32	32 of 41	3	5.72%	3.18	31 of 41	3	2.37%	2.95	29 of 41	3
	Annual change in the number of CYP accessing MH services	-6.98%	3.65	45 of 49	4	4.64%	2.7	29 of 46	3	8.55%	2.03	17 of 46	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	7.01	1.4	9 of 61	1	7.01	1.4	9 of 61	1
People & Workforce	NHS Staff Survey - Engagement theme sub-score	6.95	3.25	46 of 61	3	6.92	2.85	38 of 61	3	6.92	2.85	38 of 61	3
	Sickness Absence Rate	5.80%	3.51	46 of 61	4	***6.79%***	***3.54***	***46 of 61***	4	***6.79%***	***3.54***	***46 of 61***	4

Summary

NHS Staff Survey – Engagement Theme

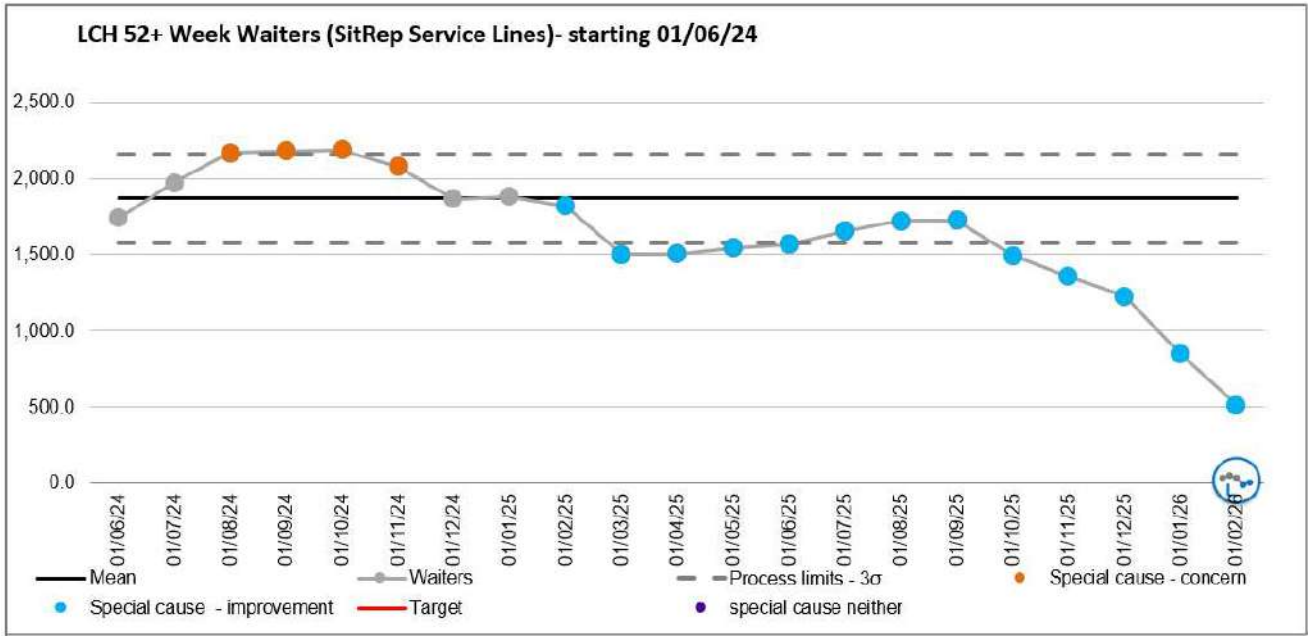
- The Trust's engagement score is 6.92 and we have achieved this years' target of maintaining our score. This is in comparison to other trusts 75% of which have seen lower scores.
- While the headline score has been maintained, there is not yet evidence of upward movement. In the context of organisational change and service transformation, continued focus will be required to strengthen trajectory.
- Emerging themes align with sickness absence data, particularly around pressure of work and reduction in ability to make improvements
- An Intention Plan framework has been introduced, with Business Units asked to complete plans aligned to four Staff Survey themes.
- Engagement and other data is being used to identify priority teams, aligned with sickness absence project. The two projects are distinct, with different aims, but are both addressing interconnected aspects of organisational health. Engagement measures staff perception and experience, whereas the sickness absence management measures behavioural and operational impact.

Sickness Absence

- Long term sickness absence case views have been completed
- Managing Absence with Confidence Training has been piloted and currently in place from March
- Occupational Health are providing additional support and guidance for Managers in ensuring appropriate referrals
- Organisational Health work is in early stages, with initial pilot currently underway in Police Custody services
- Organisational and Business Unit sickness absence targets have been created and supporting dashboards built

Percentage of Patients Waiting More than 52 Weeks

- Very positive reduction in 52+ week waits across the Trust influencing this metric. The SPC shows the significant downward trend.
- Podiatry, Diabetes and MSK have now eliminated all 52+ week waits.
- Performance in other services continues to improve, with Adult SLT and CUCS each having only one patient remaining waiting over 52 weeks.
- Significant strides being made in PND and there are now 459 children waiting over 52 weeks, a reduction of over 400 from 868 reported in January. The service (subject to Business Case approval) anticipates clearing all 52 week waits by June.
- Trust still likely to move into segment 3 for this metric.



Safe Domain Summary

Accountable Exec: Heather McClelland

NHS Leeds Community Healthcare NHS Trust

Summary

There were no Patient Safety Incident Investigations (PSII) which concluded in January and February 2026. PSII reports are not consistently completed within the initially agreed timescales, this is held under Risk ID 1357 with actions in progress to mitigate the risk.

There are 9 overdue PSII actions which remain a risk to patient safety until recommendations and actions have been implemented and embedded. Overdue PSII actions are held on the Trust Risk Register under Risk ID 1359. The process for extension of these actions has been reviewed and updated with an additional process developed for actions assigned to the Corporate Business Unit.

Eight incidents met the criteria for Statutory Duty of Candour during the reporting period, all were compliant. Five were completed within the LCH-defined timescales. The remaining three were completed outside of the LCH timeframe however, this was led by patient and family preferences for communication so was appropriate to ensure effective engagement with those affected.

There were no Never Events recorded by LCH. However, a partner led Never Event (retained foreign object post-procedure) remains under investigation, and the final PSII will determine where accountability for the Never Event should sit.

Domain Summary Performance

Data Quality : **Medium Assurance**

Performance: **Off Track**

KPI	Reporting Month	Target	Actual	Performance	Assurance
Clostridium Difficule - infection rate**	Feb-26	3	0		P
Compliance with statutory Duty of Candour	Feb-26	100%	100%		P
Attributed MRSA Bacteraemia - infection rate**	Feb-26	0	0		P
Number of overdue PSII actions	Feb-26	No Target	9	↘	
Never Event Incidence**	Feb-26	0	0		P
Compliance in Level 1 and 2 Patient Safety Training	Feb-26	95%	89%	H	F
Number of Patient Safety Incident Investigations (PSII)	Feb-26	No Target	0	↘	
CAS Alerts Outstanding**	Feb-26	0	1		F
Data Quality Maturity Index (DQMI) - MHSDS dataset score**	Nov-25	>=95%	88%		F
Data Quality Maturity Index (DQMI) - IAPT dataset score**	Nov-25	>=95%	98%	H	P
Data Quality Maturity Index (DQMI) - CSDS dataset score**	Nov-25	No Target	91%	H	

Compliance In Level 1 and 2 Patient Safety Training

Domain: Patient Safety Accountable Exec: Heather McClelland Author: Shelia Sorby

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

What is the trend we see?

Currently, patient safety training compliance for level 1 & 2 is 89%, 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?

The Trust has taken a proactive approach by mandating this training, despite it not yet being a national requirement. Current performance shows that several areas remain below the agreed compliance threshold. Targeted improvement work is underway to close this gap, with focused support being provided to teams with lower completion rates and to any areas where compliance concerns have been identified. This includes direct engagement with managers, monitoring progress through performance reporting processes, and ensuring that appropriate actions are in place to achieve the required standard.

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?

There is a risk that the Trust will not achieve the 95% compliance target due to increased operational pressures on services. There is also a risk of reduced engagement and limited follow-up in some areas, which may further impact performance. This risk is being actively mitigated through strengthened monitoring and oversight via QAIG and the Performance Panel, with targeted actions in place to support areas of low compliance.

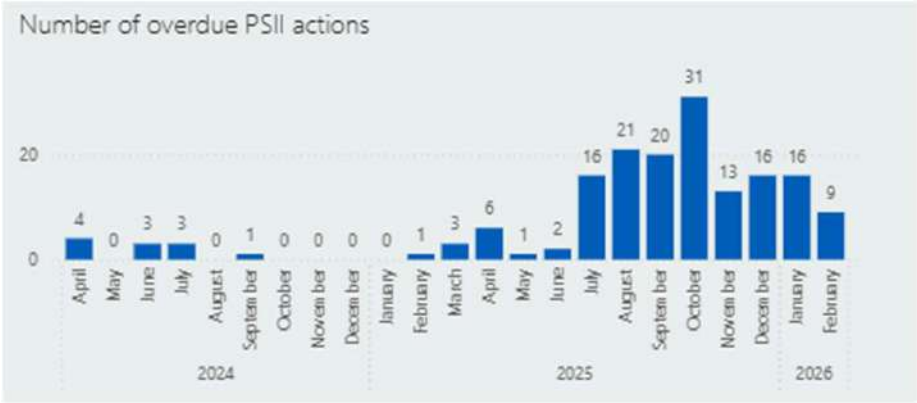
Number of Overdue PSII Actions

Leeds Community Healthcare NHS Trust

Domain: Patient Safety	Accountable Exec: Heather McClelland	Author: Sarah Yeomans
Target: No Target	Actual: 9	Data Quality: High Assurance

What is the trend we see?

There are nine overdue PSII actions in the incident reporting system. Whilst the aim is for no PSII actions to be overdue, it should be noted that this is a significant improvement when compared with the last eight months. Of the nine actions four are for the Corporate Business Units, three for Adult Business Unit and two for the Specialist Business Unit. Some of these actions are significantly past the due date and were due for completion in March (1), October (1), December (4), January (1) and February (2).



What is being done about it?

This is an ongoing risk which is held on the trust Risk Register ID 1359 assessed as moderate, as incomplete PSII actions remain a risk to patient safety until implemented and embedded.
The process for managing Overdue Patient Safety Incident Investigation (PSII) and Patient Safety Learning Response (PSLR) actions has been reviewed and updated, clearly outlining responsibilities across Clinical Governance and Business Units. A further process has been developed for PSII actions assigned to responsible leads within the Corporate Business Unit, this is awaiting feedback prior to finalisation.
All current overdue PSII actions have been shared with a request they are reviewed in line with the above processes.

When do we expect to see improvement

When the Overdue Patient Safety Incident Investigation (PSII) and Patient Safety Learning Response (PSLR) actions is shared and embedded.

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.

Number of Patient Safety Incident Investigations (PSII)

Leeds Community Healthcare NHS Trust

Domain: Patient Safety | Accountable Exec: Heather McClelland | Author: Sarah Yeomans

Target: No Target | Actual: 0 | Data Quality: High Assurance

What is the trend we see?

There have been no Patient Safety Incident Investigations concluded and approved by an Executive Director in January or February 2026.

Patient Safety Incident Investigation reports are not consistently meeting the timescale agreed for completion at the initial terms of reference meeting . Ongoing operational pressures continue to affect the timely completion of Patient Safety Incident Investigations including:

- Current demand exceeding the capacity of lead investigators
- Unplanned workforce absence
- Delays in receiving information from external providers as well as extended sign off processes for multi organisational PSIIs.

What is being done about it?

A risk is held on the Risk Register ID 1357 assessed as 12 – Moderate.

The following actions are in progress to strengthen governance and improve timeliness:

- A formalised extension process has been developed and is pending approval to ensure consistent oversight and escalation of delays.
- Investigator roles will be reviewed as part of the Quality and Value work within the Clinical Governance Team, with the aim of improving capacity and resilience in the investigation function.

All current overdue PSII have had an extension date agreed and eight are due within the next reporting period.

When do we expect to see improvement

Improvement in the timeliness of PSIIs is dependent on a review of the current capacity constraints for Lead Investigators. A review of Lead Investigator roles is needed to understand whether sufficient time is built into these roles to meet the demands of the PSII process and if not, an action plan for how this can be met.

What are the risks to delivery?

The risk is that without sufficient capacity within Lead Investigator roles, PSII reports will not meet the agreed timescales for completion.

CAS Alerts Outstanding

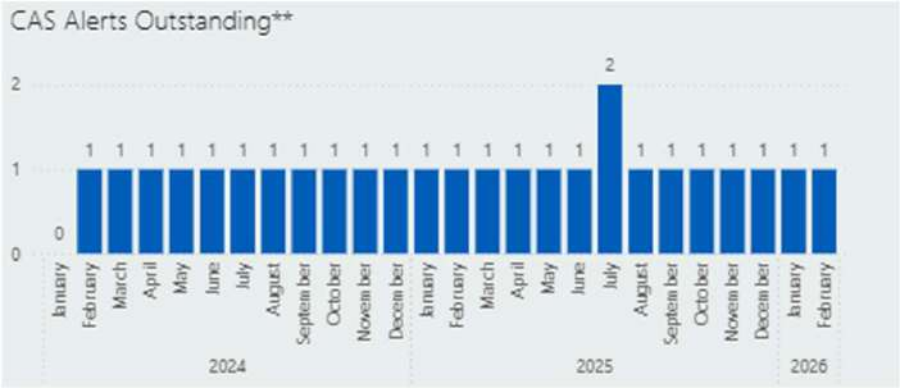
Leeds Community Healthcare NHS Trust

Domain: Patient Safety | Accountable Exec: Heather McClelland | Author: Delphine Arinze

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

What is the trend we see

The outstanding CAS Alert relates to the **National Health Service National Patient Safety Alert**: *Medical beds, trolleys, bed rails, grab handles and lateral turning devices – risk of death from entrapment or falls*.
Risk assessments for discharged patients remain a challenge due to limited resources. These patients were originally risk assessed prior to the Medicines and Healthcare products Regulatory Agency guidance issued on 31 August 2023.
The Equipment Portfolio and Clinical Lead has calculated that approximately **10 full-time staff** would be required to meet the patient risk-assessment compliance requirements for **7,000 patients**, as set out in the MHRA guidance. This situation has remained unresolved for several months.
Patients currently on active equipment loan have been assessed in line with the updated guidance since **January 2024**.



What is being done about it?

There is plan to present 4 proposed plans to QAIG Iin April in order to bring this to a resolution.

When do we expect to see improvement

The timeframe for improvement will be dependent on the options appraisal and resulting action.

What are the risks to delivery?

The risk to delivery remains; however, it has been **significantly reduced** due to the completion or progress of several actions.

- **Action 1:** Policy **LP270** on bed rails, sticks, and grab handles has been completed.
- **Action 2:** Training has been completed by all **CBU prescribers** and **76% of ABU prescribers**, exceeding the acceptable compliance standard of **75%**.
- **Actions 2 & 3:** These remain under **LCES**, with all issued equipment now carrying an **in-date service sticker** and a **unique equipment identifier**.
- **Action 5:** Assessment of **atypical anatomy** has been completed within CBU and SBU. Work is ongoing in ABU. The **Medicines and Healthcare products Regulatory Agency** has allowed flexibility due to financial constraints, provided the risk remains on the risk register until full compliance is achieved.
- **Action 6:** All patients currently on caseload have been assessed in line with guidance since **January 2024** and documentation is in place. Assessment of discharged patients remains challenging due to resource limitations; however, patients are normally provided with **Patient Information and Follow-Up (PIFU)** at the point of equipment issue.

Data Quality Maturity Index (DQMI) - MHDS Dataset Score

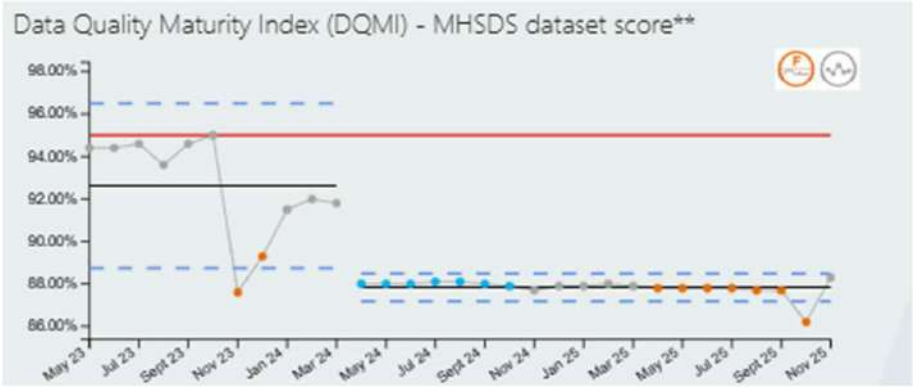
Domain: Patient Safety | Accountable Exec: Andrea Osborne | Author: Victoria Douglas-McTurk

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 (November 2025) score is 88.3%. This is against a national average of only 41.5%.



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

Typically, responses from NHS England are slow. We will report back in the July report unless there is significant movement in this matter before then.

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: Heather McClelland

The number of complaints to the Trust show a fluctuating pattern, with the trend showing no sustained upwards or downwards trend. The data is within the upper and lower controlled limits. Since June it is noted a lower number of complaints received, though the variation remains consistent. It should be noted that this likely reflects a pilot of responding to complaints in line with the Parliamentary Health Service Ombudsman standards.

For Friends and Family Test data there is currently no significant change within the data. The data continues to remain within the upper and lower control limits showing common cause variations. There has been a reduction noted in the last months data documented.

Sub Domain Summary Performance

Data Quality : **Low Assurance**

Performance: **Off Track**

KPI	Reporting Month	Target	Actual	Performance	Assurance
Total Number of Formal Complaints Received	Feb-26	No Target	6		
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	Feb-26	>=95%	93%		

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

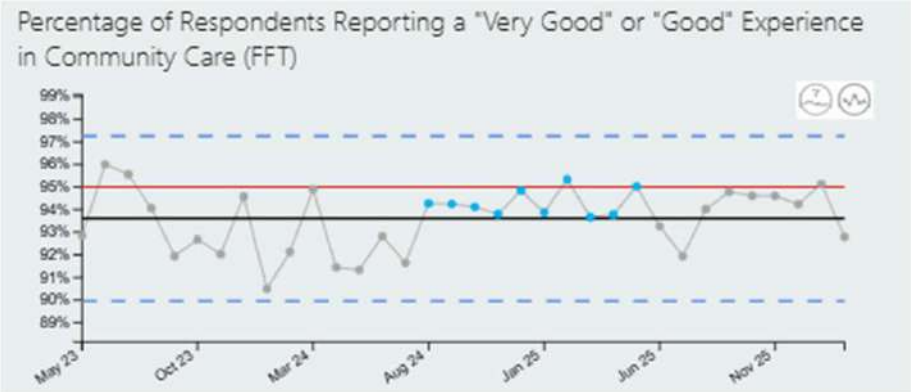
Leeds Community Healthcare NHS Trust

Domain: Caring | Accountable Exec: Heather McClelland | Author: Hayley Barker

Target: 95% | Actual: 93% | SPC Variation: | SPC Assurance: | Data Quality: **Low 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 showing common cause variations. There has been a reduction noted in the last months data documented.



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.
CIVICA, the external provider for FFT, has been notified of the variation in data between the FFT score and Trust Wide Satisfaction score and is investigating the causation.
The Patient Engagement Manager is undergoing work to standardise the FFTs for all services and move towards bespoke surveys for service specific feedback. This will provide increased data quality assurance if confirmation is received by CIVICA as the causation.

When do we expect to see improvement

The aim for completion on standardisation of FFT is by end Quarter 1 2026/7.

What are the risks to delivery?

Analysis of January and February's data shows inconsistencies between FFT score and Trust Wide satisfaction score (with Trust Wide satisfaction score for January 2026 – 97%). There is potential for lack of completeness in data however there is accuracy in the overall SPC chart as data is consistently provided from the same report mechanism. Initial feedback from CIVICA in the disparity could be due to the number of bespoke FFTs used by services within the Trust.

Total Number of Formal Complaints Received

Leeds Community Healthcare NHS Trust

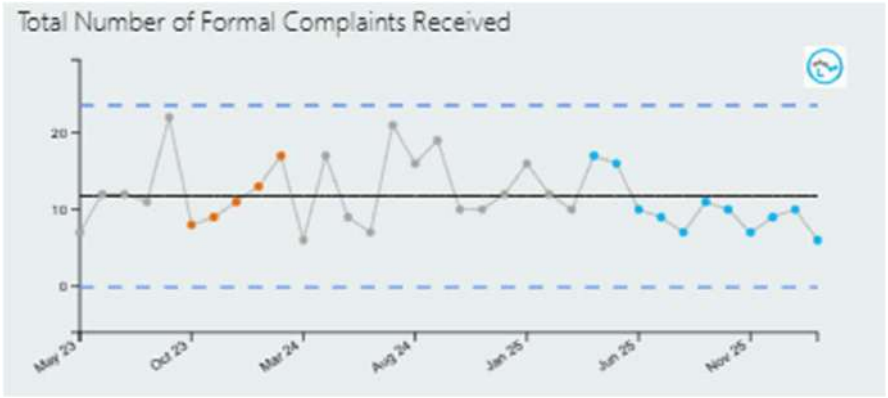
Domain: Caring	Accountable Exec: Heather McClelland	Author: Ioney Chattoo

Target: N/A	Actual: 6	SPC Variation:	SPC Assurance:	Data Quality: **Low Assurance**

What is the trend we see?

The number of complaints show a fluctuating pattern, with the trend showing no sustained upwards or downwards trend. The data is within the upper and lower controlled limits. Since June it is noted a lower number of complaints received, though the variation remains consistent.

The decline in June relates to the Parliamentary Health Service Ombudsman (PHSO) pilot. The pilot involved two services, CYMPHS and MSK. In December, a further four services were added to the pilot. The services are ICAN, Neighbourhood Teams North, LMWS and Leeds Sexual Health.



What is being done about it?

Complaints are continuing to be reviewed by services, investigated and responses provided, in line with the current complaints process. The current PHSO pilot allows for early resolution for complainants in line with PHSO and the NHS complaints standards. If a complaint requires a closer look, the services continue to manage these in line with our complaints policy.

What are the risks to delivery?

We will be making some changes to our Datix system where we record all complaints. This may impact the data, as the PHSO pilot complaints are recorded in a separate module to our current complaints.

When do we expect to see improvement

- We will continue to see an improvement longer term, as we will be involving further services within the pilot in the next quarter. Though we may see a significant rise within the number of complaints, as we will be logging all feedback where complainants are dissatisfied of an experience of care. Previously feedback has been separated from concerns.

Effective Domain Summary

Accountable Exec: Ruth Burnett

NHS Leeds Community Healthcare NHS Trust

Summary

The Effective measures are reported quarterly therefore are not included in this report.

Equity in waiting list data is included with a detailed narrative for each section: the difference in waiting list time has not sustained early signs of an improvement. A focussed Access LCH workshop looking at equity and access was held earlier in March to focus on improving this trajectory.

Domain Summary Performance

Data Quality : Medium Assurance

Performance: Off Track

KPI	Reporting Month	Target	Actual	Performance	Assurance
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 18 week standard	Feb-26	<=1.00	1.26		F
Difference in access to services for patients living in IMD1 vs IMD2-10 - Non-Consultant 18 week standard	Feb-26	<=1.00	1.23	H	F
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 52 week standard	Feb-26	<=1.00	1.26	H	F

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

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

Target: 1.0 | Actual: 1.30 | SPC Variation: | SPC Assurance: | Data Quality: High Assurance

What is the trend we see?

The difference in odds ratio for consultant-led 18 week standard waits has returned to above 1. While still within process limits, this indicates patients in our most deprived areas (IMD1) are waiting longer in these services than the rest of the population.

What is being done about it?

Longer waiting times for people in IMD1 are part of monthly Access LCH meetings, identifying which individual services with long waits are contributing to this aggregated position. Further work is being undertaken to understand the causes and solutions to the difference between services. This includes analysis of intersectional data between IMD, ethnicity and interpreter requirements so that solutions can be identified that are tailored to the needs of the groups waiting longest, in addition to the existing improvement projects that are being delivered to reduce missed appointments in IMD1 across the trust. The new interpreter contract has been rolled out in Q4, with delivery of an associated communication and training plan. This new provision is expected to improve access to interpreters and so contribute to a reduction in missed appointments and longer waiting times.

When do we expect to see improvement

The About Me template to record reasonable adjustments and other needs e.g. language and carers was launched in January 2026, with associated improvements to the delivery of those adjustments expected to align with use of the template for all new referrals in Q1 2026/7. In Quarter 4, the Access policy review will be completed and thematic analysis available on the admin phone calls with people in IMD1 who have missed appointments. This will be supplemented in Q1 2026/7 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?

Services do not yet have access to reporting on completion of the About Me template so support is unable to be targeted to those services with lowest rates. Reporting will be available in Q1 2026/7 and proposed to be included in performance reporting. Until this is available, we are unable to compare interpreter usage to interpreter requirements, and so unable to triangulate this data with missed appointments to understand any associated causes and implement targeted improvements.

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 52 week standard

Leeds Community Healthcare NHS Trust

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

Target: 1.0 | Actual: 1.23 | SPC Variation: H | SPC Assurance: F | 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 increased and is now outside process limits, indicating patients in our most deprived areas (IMD1) are waiting longer in these services than the rest of the population.

What is being done about it?

Longer waiting times for people in IMD1 are part of monthly Access LCH meetings, identifying which individual services with long waits are contributing to this aggregated position. Further work is being undertaken to understand the causes and solutions to the difference between services. This includes analysis of intersectional data between IMD, ethnicity and interpreter requirements so that solutions can be identified that are tailored to the needs of the groups waiting longest, in addition to the existing improvement projects that are being delivered to reduce missed appointments in IMD1 across the trust. The new interpreter contract has been rolled out in Q4, with delivery of an associated communication and training plan. This new provision is expected to improve access to interpreters and so contribute to a reduction in missed appointments and longer waiting times.

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What are the risks to delivery?

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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 Non – Consultant 18 week standard

NHS Leeds Community Healthcare NHS Trust

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

Target: 1.0 | Actual: 1.22 | SPC Variation: H | SPC Assurance: F | 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 and above target.

What is being done about it?

Longer waiting times for people in IMD1 are part of monthly Access LCH meetings, identifying which individual services with long waits are contributing to this aggregated position. Further work is being undertaken to understand the causes and solutions to the difference between services. This includes analysis of intersectional data between IMD, ethnicity and interpreter requirements so that solutions can be identified that are tailored to the needs of the groups waiting longest, in addition to the existing improvement projects that are being delivered to reduce missed appointments in IMD1 across the trust. The new interpreter contract has been rolled out in Q4, with delivery of an associated communication and training plan. This new provision is expected to improve access to interpreters and so contribute to a reduction in missed appointments and longer waiting times.

When do we expect to see improvement

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What are the risks to delivery?

Services do not yet have access to reporting on completion of the About Me template so support is unable to be targeted to those services with lowest rates. Reporting will be available in Q1 2026/7 and proposed to be included in performance reporting. Until this is available, we are unable to compare interpreter usage to interpreter requirements, and so unable to triangulate this data with missed appointments to understand any associated causes and implement targeted improvements.

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 Community Dental in 2026. 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, Diabetes and CUCS.

The total number of people waiting for care has fallen to 22,973 patients awaiting the start of care at the end of February 2026, compared to 27,933 at the start of the financial year. The number of patients waiting more than 52 weeks continues to decrease, falling to 1,159 at the end of February 2026, down from 1,647 at the end of December 2025 and 3,430 at the end of August 2025, largely driven by significant reductions in PND waits.

The number of patients seen within 18 weeks continues to rise and now sits at 78.7% for February, up from a low of 67% in March 2023, and currently meets the national target. This improvement has largely been driven by the triage of the Tier 3 Weight Management waiting list, where 942 patients were identified as no longer meeting the service criteria, alongside a number of targeted waiting list initiatives. In addition, six-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 to support continued improvement in access performance.

Further improvement have been seen in the Trust's performance against the Urgent Community Response Standard, with performance sitting at 89% for January.
Our Children's Audiology Service had 0 breaches with 100% of patients seen within 6-weeks in February 2026.

Domain Summary Performance

Data Quality : Medium Assurance

Performance: Off Track

KPI	Reporting Month	Target	Actual	Performance	Assurance
% Patients waiting under 18 weeks (non reportable)	Feb-26	>=95%	79%		
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	Feb-26	>=95%	99%		
Available virtual ward capacity per 100k head of population	Feb-26	No Target	7.7		
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	Feb-26	No Target	63%		
Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care	Feb-26	0	2		
LMWS – Access Target; Local Measure (including PCMH)	Feb-26	24456 by year end	1789		
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	Feb-26	>=75%	87%		
Community health services two-hour urgent response standard	Feb-26	>=70%	84%		
Number of patients waiting more than 52 Weeks (Consultant-Led)	Feb-26	0	704		
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	Feb-26	>=99%	100%		
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	Feb-26	>=92%	26.9%		
% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	Feb-26	>=95%	71%		
Number of Patients Accessing CAMHS	Feb-26	No Target	1174		
Percentage of Children over 5 currently waiting more than 18 weeks for a Neurodevelopmental Assessment	Feb-26	5%	96%		
NOF - Annual change in the number of children and young people accessing NHS-funded MH services	Dec-25	No Target	5%		

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

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

Target: 92% and 0 | Actual: 25% and 781 | SPC Variation: | SPC Assurance: | Data Quality: High Assurance

What is the trend we see?

For the first time since the COVID Pandemic, both indicators are now showing statistically significant rates of improvement. This reflects the significant amount of work being undertaken in services to improve waiting times for patients.

The primary influence on this trend continues to be children awaiting autism assessment within the Paediatric Neuro Disability (PND) service. However, due to targeted waiting list initiatives, progress in reducing 52+ week waits for this cohort is now improving at pace, with over 400 children seen and removed from the waiting list in the last month alone. This progress is expected to continue and will likely begin to positively impact the Trust's 18-week performance in the coming months.

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, alongside a broader capacity and demand review. In addition, a business case has been developed and is awaiting approval to recruit substantive Paediatricians, which would support reducing the waiting list to within 18 weeks.

When do we expect to see improvement

Subject to approval for substantive staffing it is anticipated that all 52 week waits will be cleared by June and that the service will be able to get the waiting list down to 18 weeks. Without this approximately 240 children will remain waiting over 52 weeks from April and the list will begin to grow again.

What are the risks to delivery?

The key risk is that without additional substantive staffing, the waiting list cannot be fully cleared and will begin to grow again.

Non-consultant led 18 week waits

Leeds Community Healthcare NHS Trust

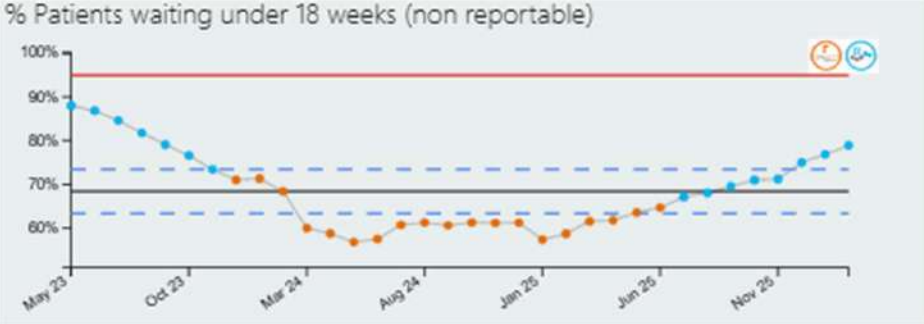
Domain: Responsive | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: 95% | Actual: 79% | SPC Variation: | SPC Assurance: | Data Quality: **Medium Assurance**

What is the trend we see?

The Trust is seeing statistically significant growth in the number of patients waiting under 18 weeks and is currently meeting the national 18-week standard, with 78.7% of patients seen within 18 weeks across Community Sit Rep services. However, the Trust is still significantly under the 95% target. We continue to see overall reductions in the number of people waiting more than52 weeks, as can be seen in the table. A number of services have cleared 52 week waits altogether since the last report (Podiatry, MSK and Diabetes) and CUCS and Adult SLT now having only 1 patient each waiting over 52 weeks.

52+ week waits	Oct 25	Mar 26
CYMPHS	743	594
PND	1269	459
Adult SLT	88	1
CUCS	30	1
Diabetes	2	0
MSK	2	0
Podiatry	28	0
Dental	367	70



What is being done about it?

Trajectories continue to be used and closely monitored. PND, CYPMHS ADHD pathway, Dental, Podiatry, Adult SLT and CUCS have all made significant progress in reducing their longest waits. Access LCH has now shifted focus from the longest waits to 18-week performance, with services across the Trust developing plans to ensure the 18-week target can be sustained. The majority of non-consultant led longest waits now sit within CYPMHS on the Neurodevelopmental pathway, and long-term plans for this pathway are currently in development.

When do we expect to see improvement

Expecting a potential dip as highlighted in the risks to delivery section.

What are the risks to delivery?

Whilst the current position is positive, modelling suggests it may not be sustainable once this non-recurrent funding ends. Both short-term predictive modelling and the Trust's Medium Term Planning submission indicate that performance may fall below the national standard without additional recurrent capacity.

CAMHS Eating Disorder

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

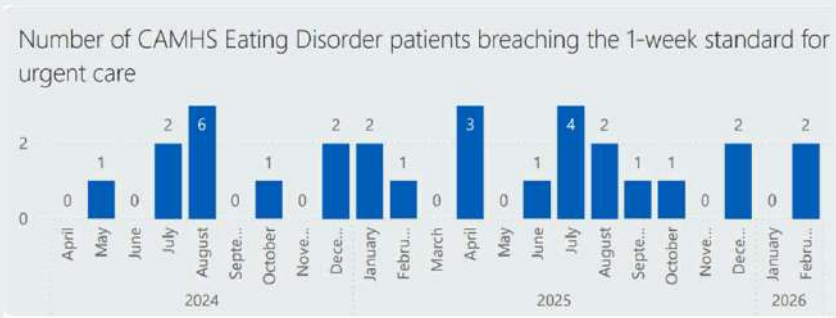
Target: 0 and 95% | Actual: 2 and 71% | SPC Variation: | SPC Assurance: | Data Quality: **Medium Assurance**

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 has risen since Nov-25 but is still 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. 3 out of the 4 posts have now successfully been recruited to and one is already in post in the service.

When do we expect to see improvement

The team are now able to offer 5 assessments per week in order to meet demand. As soon as the remaining staff are through recruitment the team should be able to further increase slots and reduce breaches.

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: 96% | SPC Variation: | SPC Assurance: | Data Quality: **Medium Assurance**

What is the trend we see?

Due to limited capacity the service prioritises waits based on clinical need. This prioritisation is consistent with the West Yorkshire criteria. 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 March Business Committee, with a focus on securing substantive and fixed term increases in staffing.

20 of the longest waiters are being transferred to new ICB approved providers. It is expected that as of 01 April 2026 additional new provider capacity will be released to increase the number of longest waiters that are being transferred.

When do we expect to see improvement

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

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.

Leeds Mental Wellbeing Service

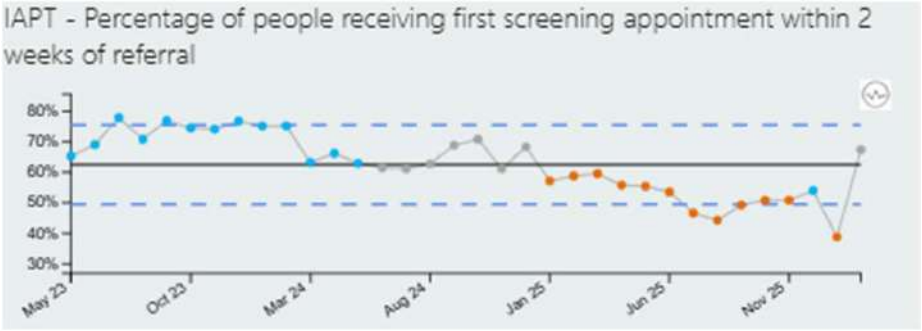
Domain: Responsive | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: N/A and 75% | Actual: 67% and 87% | SPC Variation: | SPC Assurance: | Data Quality: **Low Assurance**

What is the trend we see?

This indicator is reported as a Data Quality and Performance Concern but also from a deteriorating access position perspective. The 'Screening' element is reported as a data quality issue. The pattern is that the most recent month (Feb 26) shows improvement, but when the data for Feb-26 is refreshed, this month will show a different figure. The pattern is that this figure reverts to a lower percentage value once additional data is added.

There is also now a statistically significant (over 5 months recurrent) drop in the percentage of people referred beginning treatment within 6 weeks of referral, reflecting operational challenges in the Hub. Despite this numbers remains higher than the same period last year, despite a growing waiting list following the absence of a significant digital offer since September.



What is being done about it?

The Service is implementing plans through the Step 2 Workforce review to increase screening capacity, alongside work to reduce cancellations and rescheduled appointments and to increase productivity. Non-recurrent funding has also been secured to direct approximately 25% of the waiting list (around 500 patients) to the remote digital provider Xyla, alongside plans to invest in additional screening hours and expand digital therapy provision.
A meeting is scheduled in March with the Service to investigate the recurrent data quality issue.

When do we expect to see improvement

The Service has already seen higher numbers entering first screening appointments in February and increased productivity, with total contacts in January rising by 20% compared to September. Further improvement is expected as the current cohort of 10 trainees move into qualified roles from April and reach full caseloads within three months, with digital therapy initiatives expected to reduce waiting times by approximately 10–15 weeks within three months.

What are the risks to delivery?

The Service remains aware of ongoing pressure on timely screenings due to staff moving into developmental roles and increased case complexity requiring more follow-up appointments. There is also a risk that waiting lists will continue to grow if digital therapy capacity and workforce expansion are not sustained beyond the current non-recurrent funding.

Well-Led Domain Summary

Accountable Exec: Laura Smith and Jenny Allen

Overall performance within the People & Workforce Domain continues to demonstrate sustained improvements in compliance and data quality. Sickness absence, however, remains a challenge.

Over the last 4 months, we have continued to see an upward trend as high as 8.5%. The latest month looks reasonably promising at 7.5%, which whilst this is above the 6.5% target, it is hoped that we are starting to see the results of the significant and intense range of pro-active and preventative measures that have been put into place (further details within the sickness section).

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, hovering on or around the Trust target of 90%. Managers can easily view the new statutory and mandatory dashboard, to get granular detail for their service which helps them to maintain compliance.

The 15% percentage of staff identifying as BME has exceeded the 14% target, which could in part be due to the proactive engagement with staff to complete declarations on the ESR system, as well as actions within our Inclusion Plan to support and develop BME staff and the active REN staff network that is in place.

Domain Summary Performance

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

KPI	Reporting Month	Target	Actual	Performance	Assurance
'RIDDOR' incidents reported to Health and Safety Executive	Feb-26	No Target	2		
AfC Staff Appraisal Rate	Feb-26	>=90%	81%		F
Total sickness absence rate (Monthly) (%)	Feb-26	<=6.5%	7.5%	H	F
The overall percentage of staff who have identified as BME (including exec. board members)	Feb-26	14%	15%	H	P
Starters / leavers net movement	Feb-26	>=0 in favour of starters	31		?
Statutory and Mandatory Training Compliance	Feb-26	>=90%	89.9%		?
Staff Turnover	Feb-26	<=14.5%	0		P
Total agency cap (£k)	Feb-26	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: Katie Wilson

Target: 6.5% | Actual: 7.5% | SPC Variation: | SPC Assurance: | Data Quality: High Assurance

What is the trend we see?

February saw the absence rates reduce by a full percentage point, reflecting ongoing improvement work and seasonal sickness trends. This downward trend is expected to continue over the next few months. For now though, total sickness absence remains above target, following sharp increases in December and January. This has been driven mainly by long-term stress, anxiety and depression, with seasonal illness adding short-term pressure. Hotspot services continue to experience sustained high absence, contributing to operational strain, workload pressure and increased reliance on temporary staffing.

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.

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. This includes manager training on Managing Absence with Confidence, which has been fully developed and is being delivered currently, with the first sessions running through March. Occupational Health are also providing additional training for managers, offering support and guidance to ensure appropriate referrals.

When do we expect to see improvement

The reduction in absence rates seen in February is expected to continue across the spring and into summer. Based on previous years' trends and supported by the proactive interventions and preventative measures currently taking place, further reductions in both long-term and short-term sickness are anticipated.

For additional assurance, appendix 2 includes our NOF Sick Absence and Engagement Project slides, which were presented to the People & Culture Committee in March 2026

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.

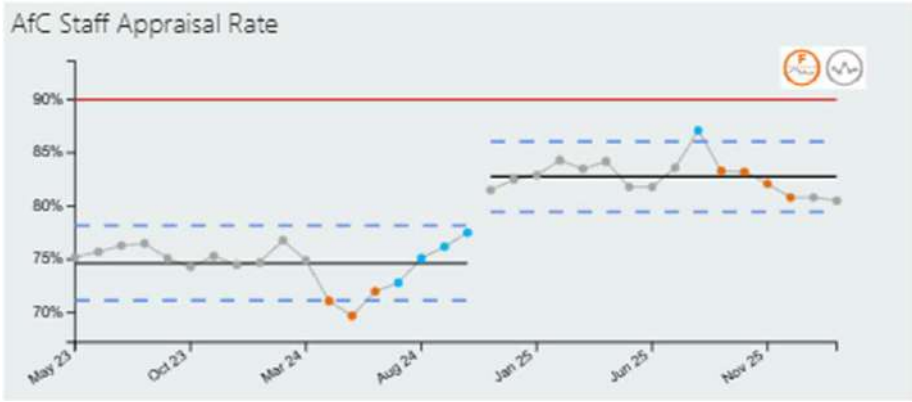
AfC Staff Appraisal Rate

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. Current data indicates that the rates have not fallen further significantly in January and February



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 has been formally addressed at performance panels, ensuring accountability and targeted action and rates have not fallen further significantly in January and February

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 and staff survey action planning 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: | SPC Assurance: | Data Quality: **Medium Assurance**

What is the trend we see?

The compliance figure has continued to increase since June 2024. It is currently on 89.9% and therefore continuing to remain on or around the Trust target figure of 90%, which it hit in October last year.

What is being done about it?

A 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 the compliance figure will continue to trend close to or 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.

‘RIDDOR’ Incidents Reported to Health and Safety Executive

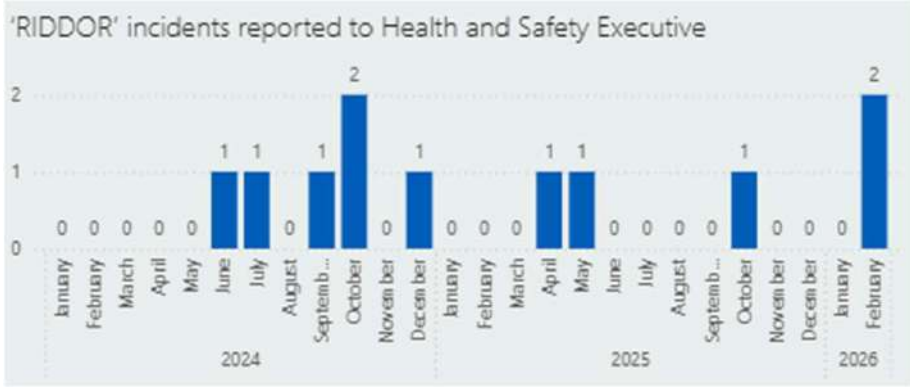
Leeds Community Healthcare NHS Trust

Domain: Well-Led | Accountable Exec: Sam Prince | Author: Diane Allison

Target: 0 | Actual: 2 | Data Quality: **Medium Assurance**

What is the trend we see?

Two RIDDORs were reported to the Health and Safety Executive in February 2026. Both involved staff members receiving back injuries. One was whilst moving a patient, the other was moving a heavy load.



What is being done about it?

The Safety Team is currently investigating these incidents.

What are the risks to delivery?

No risks to note.

When do we expect to see improvement

The services involved are involved in the investigation and will identify and share learning as part of that process.
The investigation report including recommendations and corrective action will be presented at a future Health and Safety Group meeting for wider learning.

Finance Domain Summary

Accountable Exec: Andrea Osborne

NHS Leeds Community Healthcare NHS Trust

Income & Expenditure: As at the end of February 2026, the Trust reported a year-to-date (YTD) surplus of £0.876m, compared to its break-even plan. The Trust remains on track to achieve its stretch target of £0.900m surplus by year end. The current financial position is being supported by a combination of one-off measures, such as releasing historic accruals no longer required and pay budget underspends. After accounting for the full-year impact of savings already delivered, the forecast underlying position at Month 11 is a £1.4m 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 £50.4m, higher than the planned figure by £6.9m, this was due higher than planned NHS receivables and the timing of capital payments due to the accelerated capital programme. The cash operating days, which is to pay short-term liabilities, is 73 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 97.1% by both number and value of invoices.

Capital Expenditure: At the end of February 2026, the Trust has reported a spend of £6.4m on owned assets and £1.84m on ROU assets. The Trusts capital limits in future years remain challenging, and so a number of operational capital schemes have been approved to bring forward from future years to offset the underspend. As a result, spend is broadly on plan year-to-date and forecast however there are some risks to achieving this, most notably around the timing of planned lease renewals.

Quality & Value Programme: Identified CIP has remained unchanged in February, maintaining the forecast total at £11.8m, a full-year effect of £12.566m (90% of target). Year to date, the Trust is delivering the plan in full, comprising £10.758m of recurrent savings, with the remaining savings delivered through non-recurrent measures. Work continues to achieve the full recurrent target although it is likely that full delivery will now be in 26/27.

Temporary Staffing: Year-to-date performance shows an underspend of £0.559m, with year-to-date temporary staffing expenditure representing 4.5% of gross staff costs, which is 0.3% favourable to plan. Month-on-month temporary staffing spend has increased slightly, from £0.717m in Month 10 to £0.827m in Month 11, with most of the temporary staffing expenditure continuing to support winter pressures and waiting list initiatives, staffing vacancies within the police custody service and neighbourhood teams. Costs associated with waiting list initiatives are not expected to continue beyond the 2025/26 financial year.

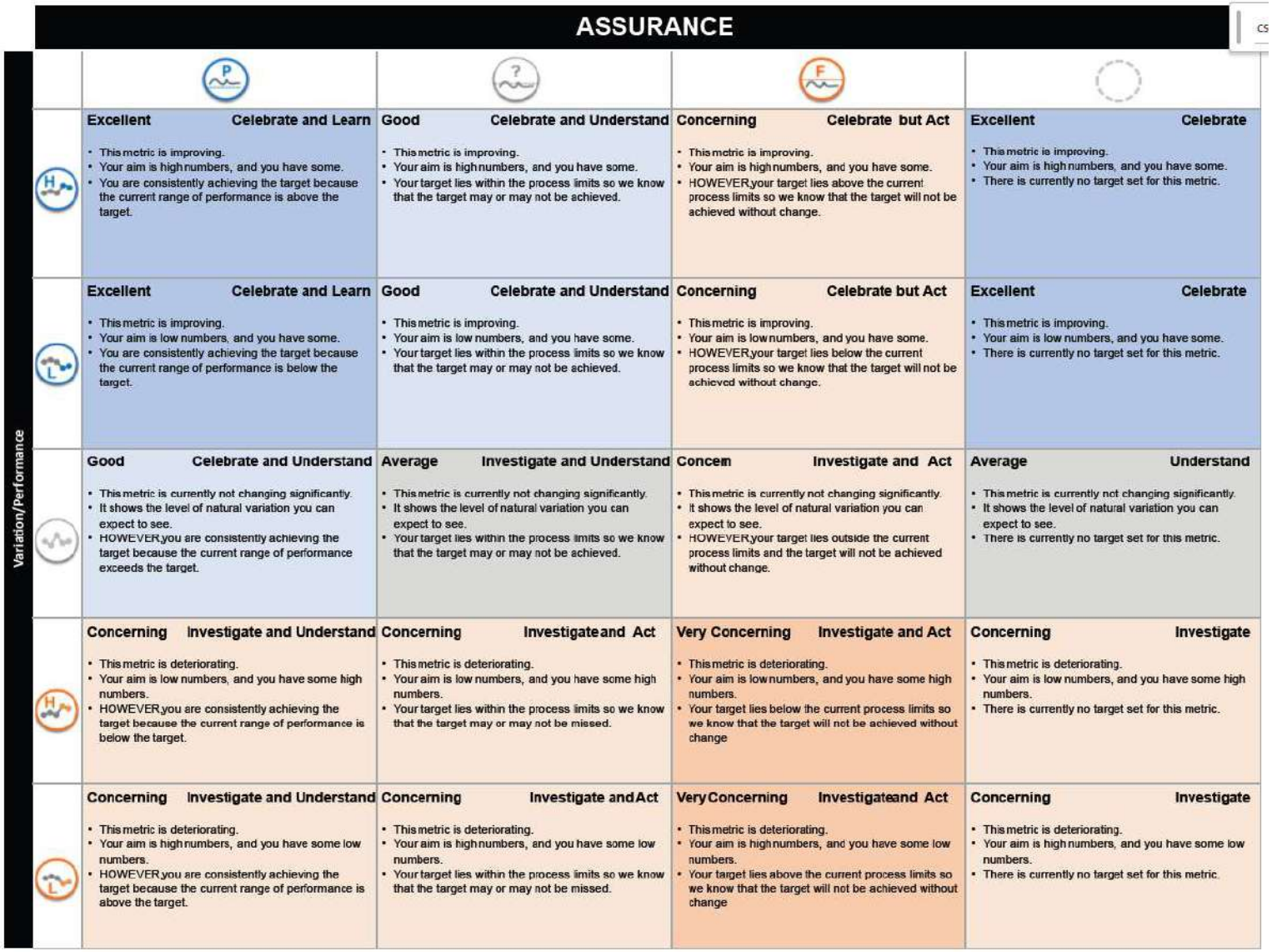
Domain Summary Performance

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	-	(876)	**(876)**	-	(900)	**(900)**
3,600	Underlying (Surplus)/Deficit	-	956	**956**		1,434	**1,434**
50,908	Closing Cash Balance	43,526	50,394	**(6,868)**	43,426	51,387	**(7,961)**
(7,628)	Capital Expenditure (CDEL)	8,426	8,172	**(254)**	9,711	9,836	**125**
	Quality & Value Programme						
9,130	Recurrent Savings	12,834	10,757	**2,077**	14,000	11,818	**2,182**
6,648	Non Recurrent Savings	-	2,077	**(2,077)**	-	2,182	**(2,182)**
15,778	**Total Savings**	**12,834**	**12,834**	**-**	**14,000**	**14,000**	**-**
	Temporary Staffing						
2,408	Agency	2,507	1,838	**(669)**	2,859	2,179	**(680)**
5,334	Bank	4,959	5,069	**110**	5,419	5,612	**193**
7,742	**Total Temporary Staffing**	**7,466**	**6,907**	**(559)**	**8,278**	**7,791**	**(487)**
168,716	**Total Gross staff Costs**	**154,653**	**152,223**	**(2,430)**	**169,061**	**166,578**	**(2,483)**
4.6%	**Temp Staffing Costs as a % of gross staff costs**	**4.8%**	**4.5%**	**(0.3%)**	**4.9%**	**4.7%**	**(0.2%)**

	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 ( )
High	**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.
Low	**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.
Common	**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.
High	**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.
Low	**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.

Leeds Community Healthcare
NHS Trust

National Oversight Framework (NOF) Improvement Projects Update

Update for People and Culture Committee

17th March 2026

Presented by: Alan Sewell – Associate Director, People Operations and Catherine Hall – Associate Director, People Solutions

Created by: Elfie Astbury – People Projects Manager

Leeds Community Healthcare
NHS Trust

Sickness Absence Update

Presented by: Alan Sewell – Associate Director, People Operations

Current Position & Trajectory

NHS
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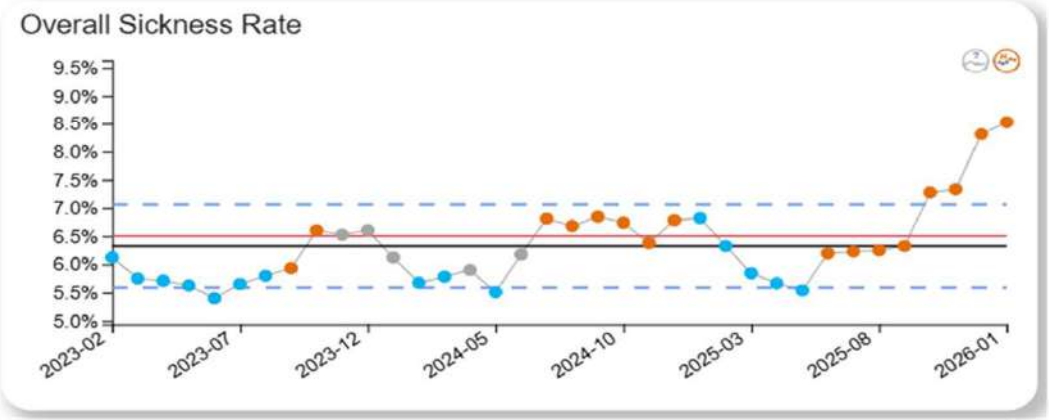
NHS Trust

Where we are now

- LCH remains in NOF segment 4 for sickness absence.
- Sickness absence peaked at 8.5% in January (target being 6.2%, following sustained deterioration over the winter period.



What the data is telling us

- The leading cause of absence is anxiety/stress/depression, predominately long term (5.5%). Seasonal cold and flu is the next most significant contributor, spiking at 3%, a 0.2% rise since December 2025.
- The current position is not explained by seasonal illness alone. Stress-related absence is persistent and largely long term and continues to drive the overall rate even as short term illness fluctuates.
- There is marked variation across service. Higher episode volumes and sustained absence are concentrated in several hotspot areas previously identified, including Neighbourhood Nights, 0-19, Dental, Police Custody and Wetherby YOI & Adel Beck.
- Whilst seasonal illness contributes to the recent increase, deep-dive diagnostic work and case review themes suggest that sustained stress-related absence in some services may be associated with wider organisational factors including workload and leadership capacity.

Why it matters

- Operational resilience – sustained absence across services increases workload pressure and reduces capacity to respond to demand
- Workforce sustainability – cumulative strain on high-attending staff and leaders, increasing the risk of both further stress-related absenteeism and presenteeism, with potential impact on retention and performance.
- Financial pressure – increased reliance on bank and temporary staffing to maintain services, alongside wider productivity, efficiency & quality impacts arising from service disruption and fragmented cover.
- Organisational integration – this is a significant period of change, and high sickness absence limits the resilience and leadership capacity needed to support teams through it.

Key Developments

NHS
Leeds Community Healthcare
NHS Trust

- The improvement project aims to reduce sickness absence by implementing a systematic improvement programme that integrates policy clarification, clear accountability, capability development, and cultural change to achieve measurable and sustainable improvements in organisational health and absence rates.
- The programme operates across five integrated workstreams with defined outcomes and accountable leads. Progress is monitored through monthly reporting to the Project Steering Group and Senior People Leadership Team.

Guidance, policy and process	• Manager training programme developed, with delivery dates scheduled through July 2026 to strengthen capability in managing short- and long-term absence. • Wellness at Work toolkit refreshed, including updated sickness notification form and pre-panel checklist; operational testing sessions planned to support consistent application. • Sickness panel improvement work initiated following Chair session; Task & Finish group formally established (meeting 25th Feb) to address reporting standards, panel consistency, chair engagement and trade union capacity. • Structured 6-month review of 27 long-term sickness cases under active management by a dedicated People Partner, with tailored action plans developed alongside line managers and structured oversight through panels. • Work underway to strengthen engagement with training uptake and embed consistent policy adherence standards.
Occupational Health	• SLA reviewed and currently with Procurement for final sign-off; revised arrangements will run through to March 2027, aligned to forthcoming LYPFT integration. • KPIs clarified, with quarterly reporting to the Health and Safety Committee; regular contract management meetings being formalised with SWYFT to address responsiveness, report quality and workforce changes within the provider. • Focus on improving referral quality and timeliness through monthly manager training and clearer escalation routes via People Business Partners to support earlier intervention in long-term cases. • OH service offer and referral guidance being prepared for publication on the intranet to improve clarity and access.
Employee Assistance Programme	• Current EAP provision (Health Assured) will align with the outcome of the LYPFT procurement process; LCH will transition to the successful provider when the existing contract concluded in December. • Promotional materials available via the intranet; webinars delivered (December 2025) and February 2026 to promote awareness. • Utilisation data obtained to inform understanding of uptake and effectiveness of promotion.
Organisational Health	• A qualitative, diagnostic review has been undertaken in the Police Custody service, an identified 'hotspot', with a series of suggestions made and follow up work planned. • Further deep-dives scheduled in additional high-absence areas (Dental, YOI) to inform targeted action and learning. • NHS Charities bid submitted to support development of a coordinated Health and Wellbeing Network (including Mental Health First Aiders and Health and Wellbeing Champions). Outcome expected by the end of March. This work is aligned to both 'NOF' improvement projects.
Data, reporting & intelligence (new)	• Workstream established with named lead and agreed scope to strengthen performance oversight and direction setting. • Monthly reporting being enhanced to provide clearer visibility of hotspots and trajectory against Trust and business unit targets. • Revised target-setting framework in development to support accountability and earlier identification of risk. • A standardised monthly business report has been introduced to consolidate workstream deliverables, risks and progress into a single governance view, strengthening oversight and continuity.

Forward Focus

Leeds Community Healthcare NHS Trust

Reporting, Intelligence and Governance: *getting consistent insight and programme control*

- Strengthen monthly reporting to give clearer visibility of stress-related long-term absence, hotspot services and progress against revised Trust and BU targets.
- Roll out absence dashboards incorporating BU-level targets and develop a simple early-warning indicator for services where risk is increasing.
- Integrate Audit Yorkshire findings into the oversight and reporting framework once available.

Case Management and Sickness Processes: *quality, timeliness, long-term case control and process clarity*

- Continue structured review of long-term cases, with emphasis on stress-related absence, ensuring timely progression and earlier intervention.
- Embed improvements to sickness panel processes (standards, reporting, chair engagement) and ensure consistency of application across BUs.
- Reinforce expectations for timely referrals, quality of referral information and adherence to policy across all services.
- Strengthen performance management of the Occupational Health provider.

Leadership Capability and Workforce Culture: *leadership behaviours, consistency and organisational health themes*

- Apply organisational health diagnostic learning to high-absence services, starting with Police Custody actions on rota stability, fairness, leadership support and safety.
- Maintain deep-dives in hotspot areas, ensuring Business Units own delivery and follow-through of agreed actions.
- Continue building management capability and consistency through targeted training and clearer expectations for case ownership and earlier intervention.

Leeds Community Healthcare
NHS Trust

Staff Engagement Update

Presented by: Catherine Hall – Associate Director, People Solutions

Current Position

Leeds Community Healthcare NHS Trust

Where we are now

- According to the 2025 NHS Staff Survey results, the Trust's engagement score is 6.9, consistent with 2024 performance.
- While the headline score has been maintained, there is not yet evidence of upward movement. In the context of organisational change and service transformation, continued focus will be required to strengthen trajectory.

What the data is telling us

- Movement within the underlying engagement questions is mixed.
- Scores have increased slightly in areas linked to pride in care, and day-to-day engagement, suggesting that staff remain committed to delivering high standards of care and continue to feel connected to their roles.
- Slight reduction in scores relating to enthusiasm and ability to influence or make improvements.
- Overall, engagement has been maintained, but the data highlights specific themes around energy, empowerment and influence which require attention to support improvement toward the 7.2 ambition.
- Emerging themes align with sickness absence data, particularly around pressure and reduced agency

Why it matters

- Staff engagement is a key indicator within the NHS Staff Survey and NHS Oversight Framework, reflecting organisational health, leadership effectiveness and culture.
- High engagement is associated with improved quality of care, stronger safety culture and positive patient experience and is therefore relevant to clinical performance and regulatory assurance.
- Engagement themes relating to motivation, involvement and advocacy are all relevant to workforce sustainability, national commentary highlights that burnout and engagement represent opposing workforce states, reinforcing the importance of creating conditions that support energy, purpose and connection.
- Themes emerging within engagement data (particularly enthusiasm and perceived influence) align with areas of focus within the sickness absence programme, where stress-related absence remains significant.

Key Developments

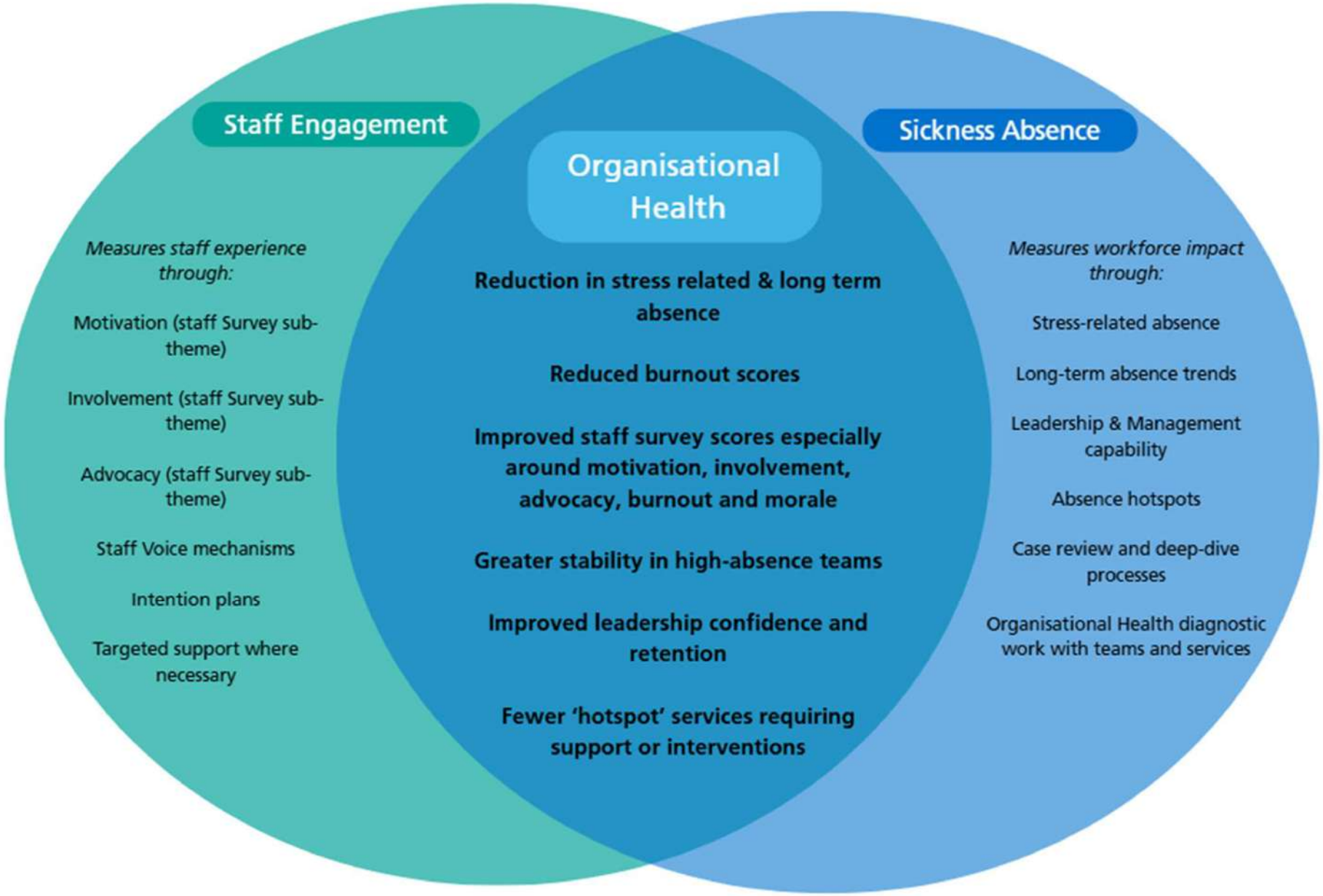
NHS
Leeds Community Healthcare
NHS Trust

- The Staff Engagement Improvement Project aims to strengthen organisational culture and workforce experience by implementing a systematic programme that integrates leadership visibility, staff voice mechanisms, wellbeing support and recognition to achieve measurable and sustainable improvements in engagement.
- The programme operates across three integrated workstreams with defined outcomes and accountable leads. Progress is monitored through monthly reporting to the Project Steering Group and Senior People Leadership Team.

Leadership and Culture	• Engagement toolkit (based on Dozen Do's framework) in final development, targeted for launch end of March; designed as a tool to support structured team discussions whilst supporting managers. • We are exploring different mechanisms to evaluate the uptake and impact of the toolkit. • Continued focus of visible senior leadership engagement – opportunity identified to improve transparency of service visits and sharing of good practice across services. • Initial discussions held with LYPFT engagement leads; future work likely to be progressed through the Trust Integration Programme People and Culture Workstream
Staff Voice, Advocacy and Improvement	• Engagement data from the NHS Staff Survey results informs identification of 'red and amber' teams, which informs targeted support and interventions. Work has been initiated in Dental and WYOI and will be started within the coming weeks. This work aligns with the sickness absence review work also (using organisational health diagnostic methodology), in particular the work done in the Police Custody service. • Clarification of accountability for supporting 'amber' teams, with an expectation that General Managers lead local improvement activity. Further consideration required on how to prevent those teams from deteriorating in their engagement scores. • Intention plan framework introduced, with Business Units asked to complete plans aligned to four Staff Survey themes • Activity underway to drive completion and oversight of local intention/action plans (including weekly reporting and escalation via GMs) • Engagement data used to identify priority teams, aligned with sickness absence review also; targeted engagement support initiated in Dental and WYOI
Healthy Teams, Healthy Care	• NHS Charities bid submitted to support development of a coordinated Health and Wellbeing Network (including Mental Health First Aiders and Health and Wellbeing Champions). Outcome expected by the end of March. This work is aligned to both 'NOF' improvement projects.

Forward Focus

- Strengthen targeted and proactive engagement support with Business Units, including continued application of the organisational health diagnostic approach in priority services, aligned with sickness absence deep-dive activity
- Continue working on introducing a visible reward and recognition approach for high-performing teams in the Staff Survey, including certificates and wider promotion of good practice.


Staff Engagement
Measures staff experience through:
Motivation (staff Survey sub-theme)
Involvement (staff Survey sub-theme)
Advocacy (staff Survey sub-theme)
Staff Voice mechanisms
Intention plans
Targeted support where necessary
Organisational Health
Reduction in stress related & long term absence
Reduced burnout scores
Improved staff survey scores especially around motivation, involvement, advocacy, burnout and morale
Greater stability in high-absence teams
Improved leadership confidence and retention
Fewer 'hotspot' services requiring support or interventions
Sickness Absence
Measures workforce impact through:
Stress-related absence
Long-term absence trends
Leadership & Management capability
Absence hotspots
Case review and deep-dive processes
Organisational Health diagnostic work with teams and services

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 12
Title of report:	Strategic Estates Plan
Meeting:	Trust Board
Date:	27 March 2026

Presented by:	Andrea Osborne, Executive Director of Finance
Prepared by:	Louise English, Associate Director of Estates - Operational

Purpose of the report:		
This report provides Board with the Strategic Estates Plan (SEP) to cover the period between 2026-2028 (the transition period to a new organisation) for sign off.	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		**Partial Assurance** Some confidence in delivery of existing objectives		**No assurance** No confidence in delivery	

Summary of Key Issues:
The SEP covers: • An assessment of the current position of the Trust, including data analysis, key themes, population growth and service mapping • Strategic principles for delivery of estates in the medium term, linked to national and regional policy/guidance and to meet the organisational principles • A framework for delivering those principles, including investment, defining the estate in line with NHS categorisation, and constraints and dependencies • High-level overview of LCH and LYPFT coming together as a new organisation, including where there are similarities, existing partnership working, risks and opportunities

Previously considered by:	Business Committee, 25th February and 25th March
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?	
	No	X	Why not/what future plans are there to include this information?	Service-dependent

Recommendation(s)	Board is asked to sign off the SEP.

List of Appendices:	Strategic Estates Plan v2

LEEDS COMMUNITY HEALTHCARE TRUST

STRATEGIC ESTATES PLAN

2026-2028

Sewell Advisory | COMMUNITY VENTURES LEEDS

NHS Leeds Community Healthcare NHS Trust

CONTENTS

VERSION CONTROL

VERSION	AUTHOR	DATE	DESCRIPTION
V1	CVL / Sewell Advisory	February 2026	First draft
V2	CVL / Sewell Advisory	March 2026	Second draft

EXECUTIVE SUMMARY

NHS
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NHS Trust

EXECUTIVE SUMMARY

Leeds Community Healthcare Trust (LCH) has commissioned Community Ventures Leeds (CVL) to refresh our Strategic Estate Plan (SEP) to ensure it remains fit for purpose in a rapidly evolving healthcare landscape.

Over the past year, significant change across the NHS, including the publication of the NHS 10 Year Plan and its three shifts- from treatment to prevention, from hospital to community, and from analogue to digital- has reinforced the need for a clear, forward-looking estates strategy.

Internally, we are progressing the development of our Medium Term Plan, preparing for a merger with Leeds & Yorks Partnership NHS Foundation Trust (LYPFT) and driving efficiency improvements through our Quality & Value Programme. The transition towards integrated Neighbourhood Health Models (all ages) across health and social care providers will inevitably influence how and where community services are delivered. While the full implications of these changes continue to emerge, a strengthened and aligned estates approach is essential to ensure readiness for future delivery models.

This SEP assumes a two-year horizon to reflect the Trust's transition toward the Provider Partnership. Over this period, we will strengthen our core assets, address essential risks and prepare for the integration of both estate functions, ensuring a smooth and aligned approach to a future combined estate model.

This plan takes a whole-system perspective, ensuring our estate supports current and future models of care, clinical service priorities and system-wide infrastructure developments. It focuses on providing safe, compliant and high-quality environments whilst improving estate efficiency, mitigating risks associated with the built environment and targeting investment to deliver best value for money.

The SEP will be underpinned by a clear implementation plan and a comprehensive sustainability roadmap, setting out how we will progress towards net-zero carbon commitments and wider environmental objectives. Together, these documents will provide a robust framework to guide decision-making, enable measurable progress, support service transformation and ensure the estate contributes positively to patient outcomes, staff experience and long-term organisational sustainability.

The SEP is structured around three key areas:

Our present position

A clear baseline assessment of the current estate, including condition, compliance, suitability and challenges.

Our aspirational future

A defined future-state vision for the estate that supports clinical and service strategies and delivers safe, high-quality, efficient and sustainable healthcare environments.

Delivering our vision

A prioritised and deliverable programme of change, a phased Implementation Plan and a Sustainability Roadmap, supported by clear governance and performance measures.

OUR PRESENT POSITION

Our estate plays a vital role in delivering high-quality community healthcare across Leeds. We operate a geographically dispersed and diverse portfolio that supports neighbourhood-based models of care to remain accessible to the communities we serve.

However, our current estate configuration and condition limit our ability to respond effectively to rising demand, evolving models of care and long-term strategic priorities.

- **Estate Profile:** Over half of the freehold estate is now over 40 years old. This has a direct impact on the level of investment required for repairs and maintenance and many of the buildings are configured around outdated service delivery models.
- **Estate Condition:** The presence of backlog maintenance, combined with an ageing estate, means that condition-related risk is likely to escalate over time, without a robust estate investment and lifecycle replacement programme to safeguard service continuity and long-term sustainability.
- **Estates Cost:** The estate is a high operational cost for the Trust, and therefore ensuring the estate is optimised and using financial resources wisely is essential to ensure value for money.

While the Trust maintains an important local presence across Leeds, service leads have identified a number of thematic challenges that need to be addressed to provide a fit-for-purpose estate that supports the delivery of a modern health service, as detailed on the right.

Over the next two years, as LCH progresses towards the Provider Partnership with LYPFT, there will be opportunities to review how estate resources across both organisations can better support collaboration, service integration and the more effective use of space across the system.

THEMATIC CHALLENGES	
Evolving Neighbourhood Health Model (all ages)	Accessibility variations across the portfolio
Digital readiness and infrastructure limitations	Transport constraints
Poor space utilisation (driven by process and behaviours)	Clinical capacity constraints
Inconsistent inclusion and wellbeing facilities	Safety and security concerns
Funding constraints	Deteriorating building condition
Patients' perspective not consistently embedded	Misalignment of hard and soft clinical space

OUR ASPIRATIONAL FUTURE

Our aspirational future sets out a clear, forward-looking vision for how our Trust will evolve to enable neighbourhood-based, inclusive, digitally-enabled and sustainable models of care, forming a crucial part of ***the golden thread*** that connects national priorities, system ambitions and our organisational strategy.

It describes the future estate we need to deliver high-quality care, support our workforce, reduce inequalities and maximise value across Leeds.

ENABLE NEIGHBOURHOOD-BASED INTEGRATED CARE

The estate will shift towards flexible, integrated, neighbourhood hubs, supporting co-location with partners, joined-up pathways and prevention-focused care models. This includes developing environments that facilitate multidisciplinary working and reflect the evolving Neighbourhood Health Model (all ages)

PROVIDE SAFE, HIGH-QUALITY, INCLUSIVE ENVIRONMENTS

Buildings will be designed around staff wellbeing, patient experience and accessibility, providing modern, adaptable spaces that support clinical excellence, hybrid working and improved workflow. Features such as confidential spaces, gender-neutral toilets, inclusive prayer rooms, ergonomic workspaces and sensory-sensitive environments will become standard.

SUPPORT DIGITAL TRANSFORMATION

Our future estate will embed digital capability, enabling virtual care, smarter building controls, interoperable systems and more efficient use of space. This accelerates the move from analogue to digital and reduces reliance on physical administrative footprints.

DRIVE SUSTAINABILITY AND PROGRESS TO NET ZERO

A phased, fabric-first sustainability programme will reduce carbon, improve energy efficiency and prepare sites for low-carbon technologies. This ensures alignment with NHS Net Zero standards and the Trust's sustainability commitments.

OPTIMISE AND MODERNISE THE ESTATE TO MAXIMISE VALUE

The estate will be reshaped to prioritise high-quality core assets, enable rationalisation where appropriate, improve utilisation and support flexible, long-term service delivery. This approach ensures affordability, resilience and best use of the existing portfolio.

DELIVERING OUR VISION

This SEP provides the framework for estate planning, investment and decision-making in the medium term, by:

- Categorising the freehold, leasehold and LIFT estate in line with NHS England's definitions of 'core', 'flex' and 'tail' to guide investment and future service provision.
- Development of a framework to support future estate decision-making, to ensure the estate continues to provide safe, accessible and compliant premises while working towards the strategic goals.
- Consideration of the constraints and dependencies of estate matters.

Delivery of the SEP will be monitored by the Trust's Estates Strategy Implementation Board, with bi-annual updates to the Business Committee.

ESTATE BLUEPRINT

We are committed to improving our estate by including the features that deliver on our strategic estates plan principles and provide the foundations for improved staff and patient experiences using our estate, further introduction of measures to ensure we keep our building users safe, and sustainability initiatives and digital capabilities to ensure our buildings work intuitively.

Those features include:

- **Digital Capabilities -** smart building controls, standardised IT
- **Staff Wellbeing –** inclusive of suitable rest facilities and private spaces, gender-neutral WCs, prayer rooms, height-adjustable desks, ergonomic chairs
- **Safety & Security -** sufficient external lighting, intruder barrier measures and PA system
- **Environment -** child and family-friendly spaces, appropriate wayfinding/signage

CASE FOR INVESTMENT

While the Neighbourhood Health Model continues to mature, estates matters should be subject to a case for investment, to ensure resources are focused on delivering safe and compliant buildings, investment is proven to be value for money and support the medium to long term strategic direction.

The basis of this investment framework could confirm:

- **Strategic importance and policy alignment -** criticality for core services and alignment with long-term priorities
- **Building condition and compliance -** physical state, maintenance backlog, safety and statutory compliance and resilience to prevent operational disruption.
- **Affordability and value -** capital and running costs, efficiency gains and rationalisation for the best long-term value.
- **Risk -** operational, clinical, compliance and environmental risks of delayed or missed investment.
- **Deliverability -** planning, funding, workforce and stakeholder readiness for on-time, cost-effective delivery.

INTRODUCTION

NHS
Leeds Community Healthcare
NHS Trust

SCENE SETTING

Community healthcare is undergoing a significant transformation. The publication of the NHS 10 Year Plan, alongside demographic changes, increasing demand, workforce pressures, digital innovation and the national shift towards neighbourhood-based, multidisciplinary and integrated care, is reshaping how and where services are delivered.

The estate is increasingly recognised as a critical enabler for new models of care. High-quality, adaptable and sustainable environments are essential to support prevention-focused services, multidisciplinary working and care delivered closer to home. This evolving landscape provides a pivotal opportunity to make better use of existing assets and improve the quality, flexibility and sustainability of the environments in which care is provided.

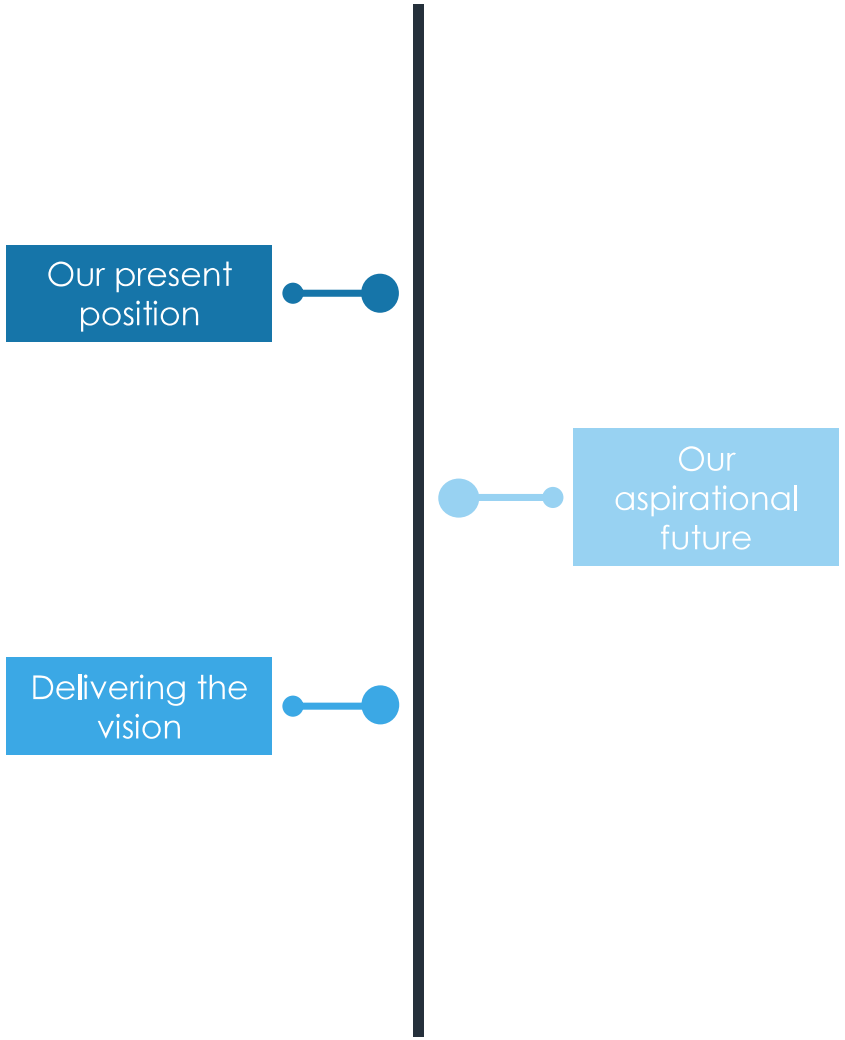
This SEP provides a clear and practical framework to support the future provision of community health care services across Leeds Community Healthcare NHS Trust (LCH).

It sets out a shared understanding of the current estate, defines a future vision grounded in local need and establishes a strategic approach to estate optimisation and investment that supports emerging models of care.

Reflecting the Trust's transition towards the Provider Partnership, the plan focuses on the next two years as a period of transition. During this time, it will support immediate estate priorities while laying foundations for closer alignment between the two organisations' estate functions and future integrated strategy.

Informed by engagement with LCH teams, data analysis, and local system insights, this plan articulates the Trust's priorities, challenges, and constraints. It provides a clear basis for informed decision-making, ensuring the estate is safe, compliant, financially sustainable and environmentally responsible, while enabling high-quality, person-centred care across the communities of Leeds.

The strategy is structured around three interrelated considerations, providing a clear and logical progression from evidence to ambition and delivery:



OUR APPROACH/METHODOLOGY

The methodology used to develop the SEP provides a clear and structured pathway from understanding our current position, through data analysis, strategic review and stakeholder engagement, to defining our future estate model and the activities required to deliver it.

Each stage builds logically on the previous one, ensuring our SEP is evidence-based, aligned to national, regional, local and organisational priorities, and underpinned by a robust Implementation Plan and a Roadmap to Net Zero*.

DATA COLLECTION

Gathering all current estate-related data

Development of a baseline data report

STRATEGIC REVIEW AND ENGAGEMENT

Review of key strategic drivers

Stakeholder engagement

STRATEGIC MODEL AND ASPIRATION

Articulation of updated strategic model and aspirations

Development of the Strategic Estates Plan

IMPLEMENTATION PLAN

Translating the strategy into a deliverable action plan

ROADMAP TO NET ZERO

Assessment and mapping of sustainability and net-zero requirements

Roadmap to Net Zero development

*to follow

STAKEHOLDER ENGAGEMENT

Focus sessions and workshops were held using a collaborative approach to gather operational insight, clinical priorities and corporate objectives. Participants were invited to share their experiences, challenges and aspirations for the estate. This engagement captured current pressures, opportunities for improvement and future requirements, ensuring an understanding of how the estate can further support service delivery, workforce needs, including wellbeing and inclusivity, financial sustainability and system-wide priorities.

Feedback has been collated into key themes to inform the SEP, including opportunities for partnership working and colocation.

This engagement complements the organisational review with Healthwatch that heard from communities, patients and carers as to how the wanted to access their services.

Why we engaged

- To understand how the estate currently supports (or constrains) service delivery
- To identify future service and capacity requirements
- To set key principles of the strategic estate plan and preferred ways of working
- To assess the impact of medium to long-term needs for the estate
- To ensure alignment between estates, clinical services and overall organisational strategy
- To build shared ownership and confidence in the proposed strategic direction

Who we engaged with

1:1 Focus Sessions:

Estates
Facilities Management
Sustainability
Strategy, Change and Improvement
Finance
Admin

Workshops:

Trust Leadership Team
Children Business Unit
Adult Business Unit
Specialist Business Unit

How we used feedback

- Confirmed 'the good and the challenging'- feedback confirmed areas for improvement
- Identified opportunities for flexible space, capacity planning and integrated care
- Informed the strategic direction for improving working environments to support staff morale, wellbeing, inclusion, retention and operational efficiency
- Guided the priority action to be included in the Implementation Plan

OUR PRESENT POSITION

Leeds Community Healthcare
NHS Trust

OUR TRUST OVERVIEW

We play a central role in delivering care closer to home in Leeds, supporting people to stay well, independent, and connected to their communities. As a community-based trust, we provide a wide range of services that sit at the interface between primary care, acute hospital, mental health services and local authority provision.

Our collaborative approach with partners enables services to be designed around local need and delivered through neighbourhood-based models of care, helping reduce inequalities and improve access for communities across the city.

We operate from a diverse and geographically dispersed estate that reflects our commitment to local, accessible provision. Our footprint brings clear benefits in terms of reach and visibility within communities. However, it also presents challenges, with a mix of ageing buildings, varying levels of utilisation, and differing suitability for modern models of care.

As services continue to evolve in response to neighbourhood health ambitions, workforce needs, and system integration, our estate has an increasingly important role to play. Buildings are not only places where care is delivered, but also the environments that shape staff experience, service flexibility, and our Trust's ability to respond to change.

We are therefore focused on ensuring that our estates is well utilised, safe and adaptable, supporting both current service delivery and future transformation. This includes aligning estate decisions with wider system priorities, sustainability ambitions, and the longer-term direction of travel for integrated care across Leeds.

Serving a population of over 845,000 people	Over 70 community clinic sites across Leeds	Support over 1.6 million patients each year
Employ over 3,400 people	Part of WY ICB and Leeds HCP	£5.45m Annual Estates Budget
Over 2,000 people have participated in research	Provides services through 13 NT	54% of estate located in deprived areas
Works collaboratively with Leeds City Council, PCNs, VCSE partners and wider ICS	One of only 20 distinct NHS Community Care provider Trusts in England	Good CQC rating

THE CHANGING LANDSCAPE

UNDERSTANDING OUR ESTATE TODAY

The current estate position provides a clear and shared understanding of our Trust's baseline, from which future estate decisions and priorities will be shaped. It brings together a comprehensive view of the estate (with all buildings categorised as *core*, *flex* and *tail*) and describes how our buildings and spaces are currently used to support service delivery.

EMERGING CHANGES

The planned merger of LCH with Leeds and York Partnership Foundation Trust (LYPFT) may present future estate opportunities in terms of optimisation, rationalisation and realignment of services into different locations. However, the implications for future estate requirements are not yet defined.

Similarly, the discussions relating to the practicalities of delivering a Neighbourhood Health Model (all ages) are ongoing and not yet sufficiently mature to determine how services will be delivered and the full impact on the estate. Notwithstanding this, the estate is increasingly viewed as a strategic enabler, supporting the positioning of LCH buildings and services as neighbourhood health hubs aligned to place-based care.

In parallel, a review of the current business unit structure (adult, children and specialist services) will lead to new organisational arrangements. The estate will play a critical role in enabling this transition, ensuring that building configuration, space utilisation and location are aligned with revised models, operational structures and future ways of working.

An administrative accommodation review is underway. Early indications suggest that consolidating and releasing non-clinical space could create opportunities to increase clinical capacity. This includes quantifying rooms that could be vacated, identifying services within the tail estate that could be relocated and exploring opportunities to release or repurpose surplus assets.

These changes mean the estate must adapt in the short to medium term to meet the evolving needs.

WHAT THIS MEANS FOR OUR ESTATE

There is a clear and realistic picture of how our estate currently operates, highlighting both existing constraints and emerging opportunities and reinforcing its role as a key enabler of organisational change and future service transformation. The evolving landscape presents further opportunities for partnership, integration, repurposing of space and the foundations needed to align with new ways of working.

KEY ESTATE DATA

Our estate underpins the delivery of services across multiple communities and neighbourhoods and has evolved in response to changing clinical and operational requirements. These metrics provide an overview of our current estate baseline to understand how the estate is performing today.

We currently operate a mixed estate model, comprising freehold, leasehold and Local Improvement Finance Trust (LIFT) premises.

32
Total number of sites

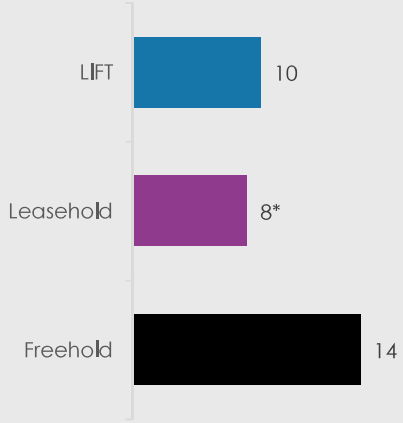
28,842M²
Total Gross Internal Area

83% VS 17%
Clinical vs non-clinical split

£21.9M
Total estate operating costs per annum

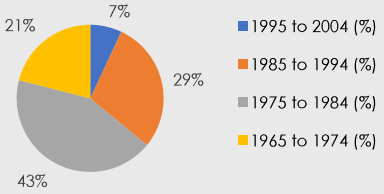
£820
Operating cost per sqm per annum

TENURE BREAKDOWN

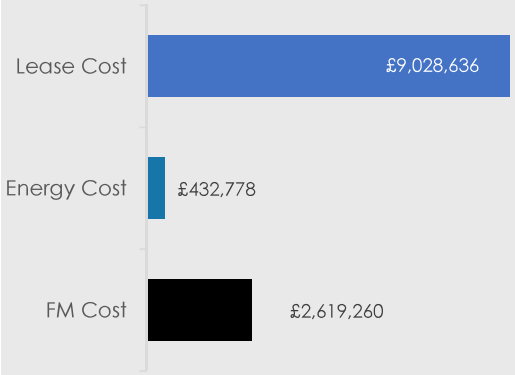


0.9%
Underused/Empty - 255m²

AGE PROFILE (FREEHOLD ESTATE)

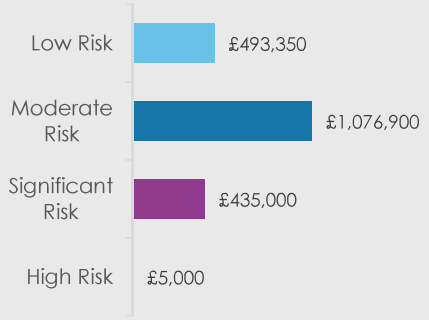


COSTS BREAKDOWN



BACKLOG MAINTENANCE**

68% of BLM split across Significant and Moderate Risk



** WROP includes the car park*
*** excludes Horsforth Clinic and Otley Clinic (under offer)*

OUR ESTATE LOCATIONS

A mixed estates model directly influences our level of control, flexibility and financial exposure, and therefore shapes how we approach optimisation, investment and future service alignment.

Viewing our estate through a tenure lens provides essential context for strategic decision-making, particularly as service models evolve and opportunities for partnership and neighbourhood-based delivery continue to develop.

KEY INSIGHTS

- The estate has a diverse tenure profile with no single dominant ownership type
- Freehold sites represent the largest proportion (44%) and form the backbone of the Trust's directly controlled estate. They offer the greatest opportunity for redevelopment, reconfiguration and longer-term optimisation
- Around one third of sites operate within LIFT arrangements, reflecting strong integration with primary care settings and providing an established platform for collaborative, place-based working
- A quarter of the estate is leasehold, carrying associated contractual and financial commitments that can limit flexibility
- The scope to consolidate, repurpose or rationalise space will vary significantly by tenure type and the level of control each arrangement allows

OUR SERVICES

Building on the overview of the Trust's geographically spread estate, the map below illustrates how services are distributed across Leeds. It evidences how accessible care is to local communities, with a wide range of adult, children and specialist clinical services delivered from community health centres across the city.

This footprint demonstrates both the breadth of provision and our commitment to delivering care closer to home through neighbourhood-based models. More detailed service maps are included at Appendix 2.

This delivery model is flexible and aligned to neighbourhood hubs, enabling services to be adapted to local need and supporting integrated working with primary care, local authority, and voluntary sector partners.

Strong universal coverage of services. High-frequency services like PHINS 0–19, Podiatry, MSK, Neighbourhood Teams and LMWS have excellent citywide reach, supporting consistent, accessible community care.

Well distributed children's services. A broad footprint of SLT, and paediatric ophthalmology strengthens early intervention and ensures good access across diverse neighbourhoods.

Opportunity to build stronger hubs. Co-locating complementary services (e.g. MSK + Podiatry + Physio) would improve MDT working, streamline pathways and enhance patient experience.

Admin space to support clinical service delivery across many sites is limited. This can constrain workflow efficiency. Prioritising the need for admin space is key for LCH.

CURRENT STATE OF THE ESTATE

To give us a better understanding of what the data tells us, we have analysed this information to look beyond the headline figures and understand what it tells us about the scale, cost, utilisation, condition and risk profile of our buildings.

At a high level, it shows us how our estate is configured, where our expenditure is concentrated, how effectively space is being used, and the level of maintenance risk we are carrying.

Estate profile

Over half of the freehold estate is now over 40 years old. This has a direct impact on the level of investment required for repairs and maintenance and many of the buildings are configured around outdated service delivery models.

From a space allocation perspective, the estate appears to be intensively utilised, with 83% of space dedicated to clinical activities and 17% to non-clinical functions. However, utilisation of the space is not routinely or robustly monitored. Feedback from stakeholder workshops indicated accommodation is not consistently used extensively or optimised.

Less than 1% of the estate is currently reported as underutilised. This limited flexibility significantly constrains the Trust's ability to accommodate service expansion or new models of care without significant reconfiguration.

In addition, the Trust has a relatively small non-clinical estate, restricting the availability of appropriate administrative and support space.

Estate condition & backlog risk

Backlog maintenance is concentrated in moderate and significant risk categories, accounting for over two-thirds of the total backlog value.

While the level of immediate high-risk issues is currently limited, the overall profile indicates a growing medium-term compliance and operational resilience risk if investment is deferred.

The concentration of backlog maintenance in these categories, combined with an ageing estate, means that condition-related risk is likely to escalate over time, without a robust estate investment and lifecycle replacement programme to safeguard service continuity and long-term sustainability.

The age and condition of the buildings will affect both the cost and feasibility of decarbonising the estate in line with the 2040 net zero targets.

Estate cost

Total annual operating costs are £21.9m (£820 per sqm). Lease costs represent the single largest pressure. LCH occupy a significant proportion of LIFT buildings through under-lease plus agreements (ULPAs) as unitary payments. These payments incorporate rent, lifecycle replacement, facilities management (FM) and service charges. As a result, LIFT properties are among the best-performing buildings within the estate in terms of condition and lifecycle compliance.

FM represents a meaningful, though not dominant, component of the overall cost base. However, within LIFT buildings, FM and lifecycle services are embedded within the uLPA costs. As a result, the standalone £2.62m reported FM spend is likely to understate the true scale of FM activity and cost across the estate.

Energy cost represents a significant element of operating expenditure. While overall energy performance is relatively strong, cost exposure is uneven across the estate, with higher intensity assets driving disproportionate spend. The portfolio remains heavily reliant on gas.

HOW DOES LCH ESTATE COMPARE?

LCH has been benchmarked with two comparable organisations: North East London NHS Foundation Trust (NELFT), which has a similar LIFT portfolio, and Birmingham Community Healthcare NHS Foundation Trust (BCHFT), a comparable community trust operating in a large urban city.

This comparison has illustrated:

- LCH has lower total operating costs, with a median cost per square meter below the benchmark
- LCH serves only a marginally smaller patient population than BCHFT within a much smaller building footprint (despite a comparable number of buildings)
- LCH LIFT estate has lower operating costs per square metre when compared to the other Trusts (noting NELFT may be subject to London weighting)
- LCH has lower energy costs per square metre
- NELFT and BCHFT report fewer under-utilised or void estates than LCH*

Site	Leeds Community Healthcare Trust	North East London NHS FT	Birmingham Community Healthcare Trust
Population (catchment)	0.8m	4.3m	1.1m – 1.2m
Geographic spread	Leeds	Barking & Dagenham, Havering, Redbridge, Waltham Forest (also parts of Essex, Kent and Medway)	Birmingham (some regional specialist services across the West Midlands)
Number of sites	31	44	32
Overall GIA	28,627 m²	188,193 m²	76,969 m²
Freehold Estate (No of sites/GIA)	14 / 8641 m²	12 / 24,577 m²	17 / 40,801 m²
LIFT Estate (No of sites/GIA)	10 / 14,528 m²	12 / 14,766 m²	4 / 17,789 m²
Lease Estate (No of sites/GIA)	7 / 5,458 m²	20 / 148, 850 m²	11 / 18,379 m²
Total Operating Cost (£)	£23,187, 804	£94,647,193	£68,568,947
Operating Cost per m² (£)	£810.00	£502.93	£890.86

** Analysis has been undertaken using 2024/25 ERIC submissions. Data has not been verified with individual trusts; therefore, accuracy is dependent on the quality of input.*

THEMATIC CHALLENGES

Following a review of information gathered and insights gained during engagement sessions with services, it is clear that our estate faces a set of consistent challenges limiting our ability to adapt to evolving service models, financial pressure and our neighbourhood healthcare ambitions.

Although these issues appear differently across sites, they stem from common structural factors- an ageing estate, limited capital and inconsistent utilisation across our footprint. The key challenges are outlined below:

EVOLVING NEIGHBOURHOOD HEALTH MODEL

As the Neighbourhood Health Model (all ages) continues to develop, service reconfiguration and integration plans remain fluid.

Estate decisions must therefore be flexible to accommodate future changes in footprint and operating hours. This is especially critical for sites under consideration for rationalisation or redevelopment, as current choices limit estate adaptability in the future.

POOR SPACE UTILISATION (DRIVEN BY PROCESS AND BEHAVIOURS)

Despite ongoing pressure and space needs, underutilisation was noted across clinical and non-clinical sites.

Unused bookings, inconsistent check-ins and reluctance to share rooms mean recorded demand often overstates actual occupancy.

ACCESSIBILITY AND TRANSPORT CONSTRAINTS

Car parking remains a challenge across multiple sites, affecting both patient and staff access. Limited spaces, restrictions, and peak time congestion particularly impact wheelchair users and those with mobility or sensory needs.

While active travel is encouraged, inadequate public transport and cycling infrastructure at some sites increase car dependency, affecting service delivery.

INSUFFICIENT STAFF WELLBEING FACILITIES

Most of our sites lack private, flexible spaces for supervision, safeguarding discussions, sensitive calls, and staff wellbeing.

Older buildings with constrained layouts and limited informal areas often force staff into unsuitable environments, impacting experience, safety and retention.

Inclusive facilities, such as gender-neutral WCs and prayer rooms, are also needed.

SAFETY AND SECURITY CONCERNS

In some sites, particularly those operating into evenings or weekends, staff often feel unsafe due to inappropriate lighting, antisocial behaviour (within those communities), or isolated car parks. This impacts staff confidence and can limit the ability to deliver extended hours service.

FUNDING CONSTRAINTS

LIFT buildings, inflation-linked contracts and IFRS 16 pressures makes some sites significantly more expensive to run. With limited capital overall, it is difficult to tackle condition, utilisation and decarbonisation needs at the same time.

Delayed investment risks higher costs later and ongoing pressure on revenue budgets.

CLINICAL CAPACITY CONSTRAINTS

Growing clinical services cannot consistently access the right rooms, while admin functions have expanded into clinical areas over time. This reduces clinical capacity, increases inefficiency and weakens our ability to prioritise patient-facing activity.

DIGITAL AND TECHNOLOGY LIMITATIONS

Connectivity is inconsistent across parts of the estate, with mobile blackspots, unreliable meeting room technology and limited electrical sockets. These issues disrupt clinics, collaboration and hybrid working, especially in older or multi-storey buildings.

MISALIGNMENT OF HARD AND SOFT CLINICAL SPACE

Some hard clinical rooms are not always used for clinical purposes, and services that need them struggle to find appropriate space. Some of our specialist services require adjacent rooms, which the estate does not always provide, constraining service delivery.

PATIENTS' PERSPECTIVE NOT CONSISTENTLY EMBEDDED

Changes that are beneficial operationally can still feel like reduced access for patients, especially in deprived communities where local provision is critical. Without embedding patients' perspectives, decisions may risk challenge, poorer perception of equity and reduced trust.

DETERIORATING BUILDING CONDITIONS

Several buildings have ageing fabric, overheating, poor ventilation, inadequate lightning or historic maintenance issues. These environments can impact staff wellbeing and productivity, and the gap between older and improved or newer buildings is becoming more noticeable.

OUR POPULATION

Leeds Community Healthcare
NHS Trust

POPULATION OVERVIEW

As care models change and neighbourhood health plans continue to develop, our estate must reflect the needs of the Leeds population and align with national, regional and local strategic priorities.

Nationally, the NHS continues to shift towards care closer to home, prevention, digitally enabled delivery and reducing inequalities, all of which influence how clinical and non-clinical estate should be configured and used.

Locally, Leeds is a growing, diverse city with demand drivers that are both demographic and socioeconomic in nature. Between the 2011 and 2021 censuses, the population grew by 8% (from approximately 751,500 to 812,000), which is faster growth than the Yorkshire and Humber region as a whole.

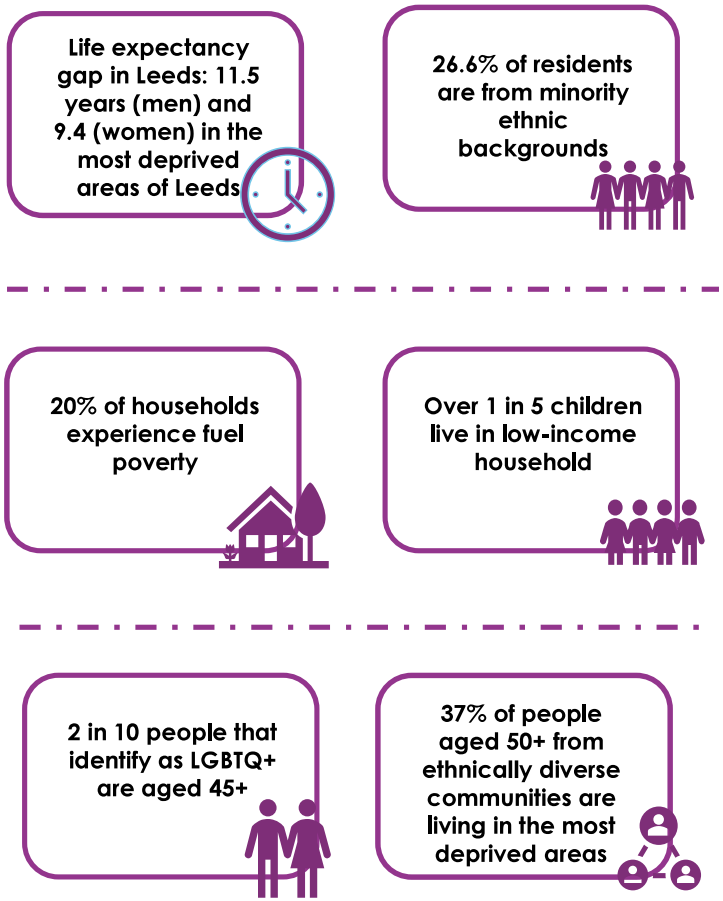
The population in Leeds continues to expand, and according to ONS (2021) is projected to rise towards around 864,000 by 2040, with a notable increase particularly in older age groups. Population ageing is correlated with higher prevalence of long-term conditions, frailty and increasing demand for community services such as community nursing, therapy and multidisciplinary care.

Leeds has a more diverse ethnic profile than the regional average, with a higher proportion of Black (5.6%) and Asian (9.7%) populations.

Health inequalities in Leeds remain significant; 24% of the population live in the most deprived decile nationally, and many children live within these areas. Life expectancy varies across the city, with people in the most deprived areas living 9 to 11 years less than those in the least deprived.

These patterns contribute to uneven and complex health needs ranging from long-term conditions, mental health, to lower healthy life expectancy and create operational pressures at sites serving high-need populations.

A breakdown of deprivation levels for each of our sites is provided in Appendix 1.

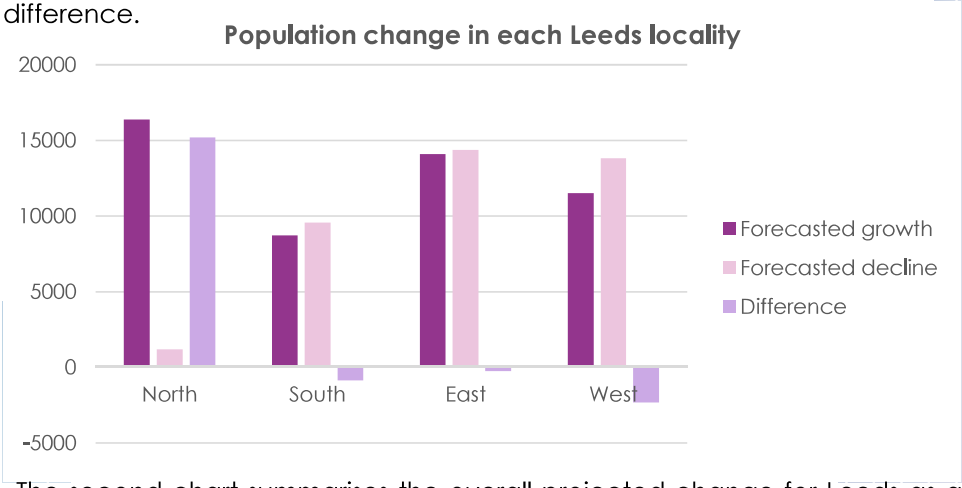


Source: ONS (2021), Leeds Observatory.

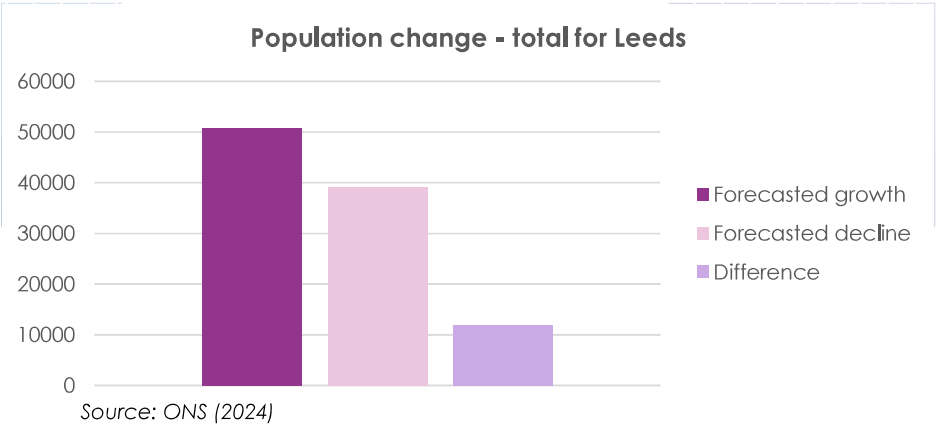
PROJECTED POPULATION GROWTH

To give us a better understanding of the projected population growth across Leeds, the two charts break the data down both by locality and at a total city level.

The first chart shows the projected population change in each of Leeds localities. It compares forecasted growth against forecasted decline and the resulting net difference.



The second chart summarises the overall projected change for Leeds as a whole. This allows us to clearly see where growth is strongest, where decline is more prominent, and how these trends balance out across different parts of the city.



Source: ONS (2024)

KEY OBSERVATIONS:

- As a whole, by 2033, Leeds will see a total population growth of 50,719 (6%) and further increase to 926,487 by 2047
- However, the total forecasted decline is 38,964 (4.6%). Therefore, the forecasted population change is 11,755 (1.4%)
- Despite areas of decline, the net position for Leeds is positive and growing
- The biggest growth is predicted for the North Locality (16,389 - 32% of the total growth)
- Considering the decline in population numbers, Leeds North is the only locality with population growth
- Leeds East will see the second highest population growth of 14,105 (27.8%) but also the biggest decline (14,361- 36.8%)
- All localities apart from Leeds North see a greater decline than growth

Note: the population growth and decline have been calculated by using the total growth/decline as a baseline

- Since 2016, Leeds has seen a fairly consistent population growth
- Between 2016 and 2021, the growth remained below 1%, with a sharp increase and staying above 1.3% from 2022
- Considering the last 8 years, the total population growth was 7.2%. Therefore, it can be assumed that the total increase expected by 2033 will be higher than the forecasted 1.36%

DEMAND DRIVERS AND HEALTH NEEDS

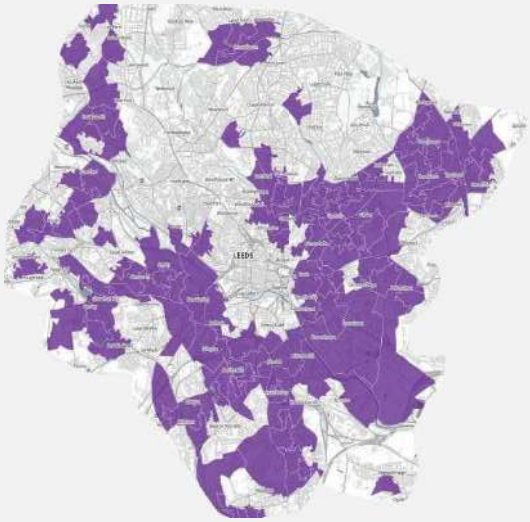
Demand across Leeds is shaped by demographic change, increasing diversity, high levels of deprivation and varying accessibility needs. Areas with the highest deprivation also experience morbidity and long-term condition burdens, which directly influence where neighbourhood teams and care closer to home models will be needed the most.

Some of the prominent demand drivers for our Trust include:

- A significant increase in ethnic diversity, 26.6% of the population is from minority ethnic backgrounds, and school-age diversity has almost doubled since 2005.
- 17% of people report disability related limitations to daily activity.
- 4.3% identify as LGBTQ+, including 4,754 people whose gender identity differs from their sex at birth.
- Over 1 in 2 people aged 50+ are living with 2+ long term conditions.
- Approximately 1,346 people aged 50+ are living with a learning disability.
- A changing social profile, with fewer people identifying as religious, alongside continued growth in the Muslim population.
- Leeds has 114 neighbourhoods (24%) in the most deprived 10% nationally and ranks 4th in England for income deprivation and 3rd for employment deprivation.
- Areas located in close proximity to acute hospitals experience higher unplanned demand as residents often choose to attend nearby hospital sites when seeking urgent or unscheduled care. This creates increased pressure on acute services and influences patterns across community provision.

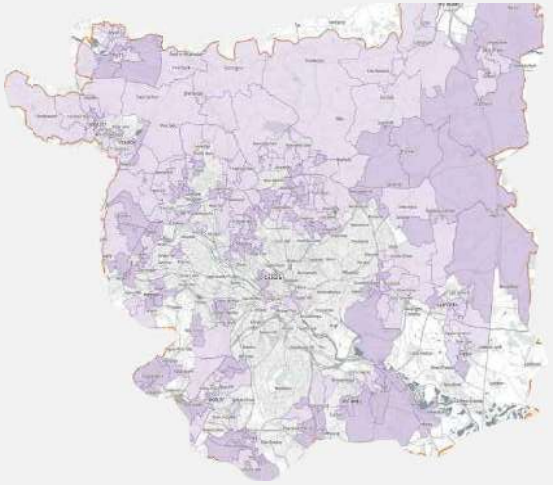
These combined factors drive higher demand for our services, including community health, prevention, early intervention, estate interventions and integrated neighbourhood models of care (for all ages), particularly in areas identified that face the greatest socioeconomic challenge.

Most Deprived Areas



The map above shows that 136 areas in Leeds fall within the most deprived quintile.
13 of our estates' locations are situated in these areas, with Seacroft Clinic located in the highest scoring LSO (Indices of Multiple Deprivation (IMD) score: 68.66), significantly above the national average of 21.67.

Least Deprived Areas

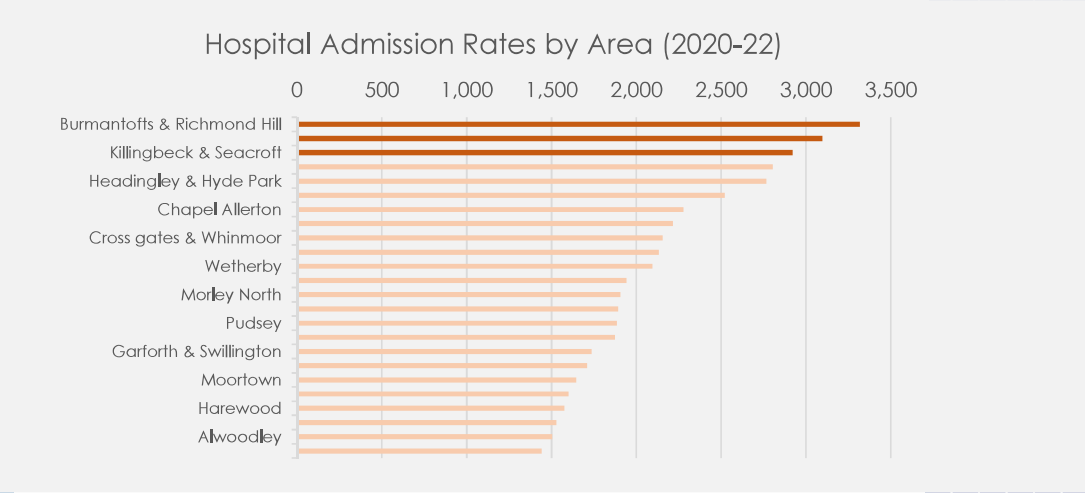


The map above shows that 214 areas in Leeds fall within the least deprived quintile, with an average IMD score of 24.11.
11 of our estates' locations are situated in these areas. Kippax Health Centre has the lowest IMD score at 5.20, significantly below the national average of 21.67, noting IMD reflects the site's local LSOA.

Source: SHAPE Atlas; ONS (2024), Leeds Observatory 2025

IMD scores reflect the LSOA in which each estate site is located

Hospital Admission Rates



Hospital admission rates show the highest concentrations of acute activity in East and South Leeds, particularly within Burmantofts & Richmond Hill, Killingbeck & Seacroft, Hunslet & Riverside. These areas record significantly higher admissions volumes (over 3,000 admissions) than other parts of the city, and a large proportion of our Trust's estate is located within or adjacent to these high-need neighbourhoods.

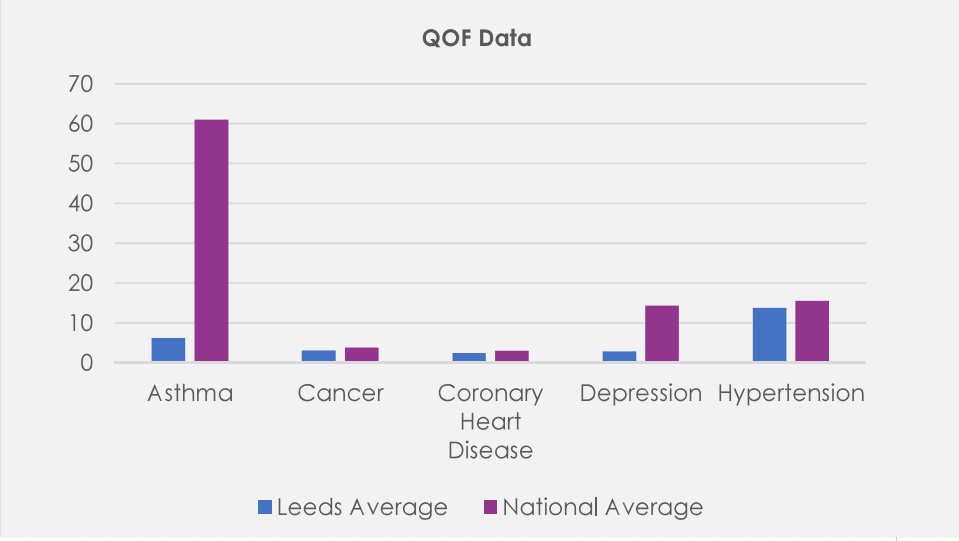
In comparison, areas with lower admission rates, including Pudsey, Moortown, Harewood, Garforth and Alwoodley are served by sites such as Pudsey, Holt Park and Wetherby Health Centre, aligning with comparatively lower levels of acute activity.

A review by Ageing Well Leed (2024) shows that 21% of professionals identify mental health and wellbeing as a priority for ageing populations, including concerns around social isolation, equitable access to services, and community provision. Additionally, 6% of older people highlight the importance of public spaces in supporting health and happiness, reinforcing the need for accessible, community-based support.

Quality and Outcome Framework

Quality and Outcome Framework (QOF) data indicate that prevalence rates for key long-term conditions in Leeds are broadly in line with national averages.

However, due to the city's population size, the absolute number of people living with long-term conditions is high, and these cases are geographically concentrated in the same East and South Leeds neighbourhoods with the highest admission activity. This reflects a consistent overlap between high deprivation, higher multimorbidity and the locations of community service delivery sites. QOF also highlights where the region is in comparison with the national average in terms of the prevalence of key health indicators and this includes:



Source: ONS (2024), Ageing Well Leeds (2024), Leeds Observatory 2025

OUR ASPIRATIONAL FUTURE

NHS
Leeds Community Healthcare
NHS Trust

OUR VISION AND VALUES

Our vision and values define who we are, what we stand for and the impact we aim to have on the communities we serve. They guide every decision, from how we deliver care to how we work together as a team. Understanding them provides a foundation for everything that follows, ensuring our strategies, services and plans are anchored in shared purpose and consistent principles.

Our Vision

'We provide the best possible care in every community'

- To work with communities to deliver personalised care
- Collaborate with partners to enable people to live better lives
- Enable workforce to thrive and deliver the best possible care
- To embed equity in all that we do
- To use our resources wisely and efficiently both in the short and long term

Our Values

- We are open and honest and do what we say we will
- We treat everyone as an individual
- We are continuously listening, learning and improving

How We Work:

- Caring for our patients
- Making the best decisions
- Leading by example
- Caring for one another
- Finding solutions
- Working together
- Adapting to change and delivering improvements

Our estate will enable compassionate, accessible, high-quality care in community settings and provide safe, inclusive environments for our workforce and our patients.

NATIONAL STRATEGIC CONTEXT

Our SEP is directly shaped by and responsive to national priorities, creating a clear ***'golden thread'*** from policy intent to place-based delivery across the LCH estate. It shows how key priorities translate into tangible requirements for the estate.

The estate is therefore a crucial strategic enabler of patient outcomes, workforce effectiveness and system-wide goals.

Fit for the Future - 10 Year Health Plan for England

hospital to community ♦ treatment to prevention ♦ earlier intervention and reduced avoidable admissions ♦ analogue to digital ♦ reducing health inequalities ♦ workforce wellbeing, growth and development ♦ financial sustainability

Care Closer to Home - National Neighbourhood Health Implementation Programme (NNHIP)

place-based neighbourhood-led care model ♦ integrated one-stop health and wellbeing hubs ♦ improved access in underserved communities ♦ reduction in health inequalities ♦ co-located multidisciplinary teams delivering joined-up care ♦ local data-based population health management ♦ improved access, prevention and early intervention ♦ flexible, multi-use community assets

Digitally Enabled Estate - National Data and Digital Transformation

digital-first service models ♦ enhanced system Interoperability ♦ technology-enabled productivity ♦ reduced estate footprint through smarter use of space ♦ eliminating paper records ♦ improved digital inclusion ♦ improved patient and staff experience

The NHS's Net Zero Building Standard

net zero carbon in operation ♦ low energy, climate-resilient and adaptable buildings ♦ low-carbon facilities with efficient structural design ♦ material-efficient healthcare buildings reducing waste and enabling flexibility ♦ improved indoor environments supporting health and wellbeing

NHS Capital Regime and Value for Money Guidance

prioritisation of investment ♦ best use of existing assets ♦ disposals and reinvestment ♦ affordability and long -term sustainability

SYSTEM STRATEGIC CONTEXT

At a regional level, the SEP responds to the Integrated Care System priorities and place-based plans, focusing on collaboration, neighbourhood delivery and more effective use of assets. The Trust is taking a significant step towards closer collaboration, supported by the West Yorkshire Integrated Care System (WY ICS), as part of the wider review of how local organisations work together to plan and deliver integrated care services.

By aligning with the ICS ambitions, the LCH estate can support system working and regional transformation ambitions.

West Yorkshire ICS Integrated Care Strategy

improving population health and reducing inequalities ♦ joined-up care across health, social care and voluntary sectors ♦ neighbourhood-based, community-focused delivery ♦ prevention and early intervention ♦ supporting children, families and vulnerable groups ♦ enabling efficient and effective use of resources

West Yorkshire ICS Infrastructure Strategy

providing the physical and digital infrastructure to support equitable, community-based care ♦ prioritising facilities and technology that enable prevention, early help and seamless collaboration across places and partners ♦ tailored support for children, families and vulnerable groups

West Yorkshire Joint Forward Plan 2024

integrated planning across the ICS ♦ aligning health, social care and community services ♦ improving access and outcomes for local populations ♦ supporting neighbourhood-based delivery ♦ addressing health inequalities ♦ enabling system-wide transformation and sustainability

West Yorkshire ICS Digital and Data Strategy

safe, secure and seamless information flow ♦ digital tools enabling efficient and effective working regardless of the location ♦ population empowerment to access and contribute to their own records ♦ maximising the benefit of data to support decision-making, design services and improve population health

West Yorkshire ICS Sustainability and Net Zero Strategy

low-carbon, energy efficient buildings ♦ sustainable estate ♦ reducing travel emissions ♦ climate-resilient infrastructure ♦ supporting broader ICS environmental targets

OUR ORGANISATIONAL RESPONSE

At an organisational level, our SEP reflects the organisational strategic priorities, supporting neighbourhood-based and integrated care, workforce development, wellbeing and inclusivity, and the delivery of services in line with clinical strategy and local population needs.

By aligning our organisational strategies with the wider system ambitions, our SEP ensures that our estate actively enables high-quality service delivery, supports our workforce, strengthens neighbourhood-based care and embeds sustainability and inclusivity at the heart of how we operate.

Medium Term Plan

bring care closer to home ♦ improve quality and patient experience ♦ embrace and embed digital innovation in service delivery ♦ provide flexible clinical and staff spaces ♦ strengthen place-based partnerships ♦ increase local retention and recruitment ♦ align capital investment to neighbourhood model requirements

Health Equity

greater fairness in access to services ♦ best possible care in every community ♦ knowing and working with communities ♦ different support depending on different needs ♦ communities of interest ♦ working to identify and address inequity in health ♦ working with the third sector and statutory partners

Workforce Strategy

attract, develop and keep the best people ♦ maximise workforce capacity for the delivery of best possible care ♦ reduce disparities in employee experience ♦ improve psychological, physical and financial wellbeing ♦ best ever attendance, capability & satisfaction ♦ further successful integration and joint working

Quality and Value Programme

deliver person-centred, high-quality care ♦ reduce health inequalities ♦ work in partnership with patients, families and communities ♦ efficient use of resources to improve value and outcomes ♦ create a supportive, inclusive and learning-focused workforce culture ♦ improve patient safety and strengthen learning systems

LCH Cultural Context

people before process ♦ equality and inclusivity ♦ organisational development and culture ♦ integrated working ♦ partnership & collaboration ♦ employee voice and speaking up ♦ health & wellbeing ♦ employer of choice

Sustainability

achieve net zero by 2040 ♦ Decarbonise buildings through LED, smart controls and solar panels ♦ Reduce travel emissions and promote EVs/active travel ♦ Strengthen waste reduction and recycling system ♦ Improve green spaces and biodiversity

PATIENT VOICE

We engaged with our patient community through a series of interconnected engagement sessions, led by Healthwatch. The engagement sought the views and experiences of a diagonal slice of the patient population, including adults, children and young people, parents and carers, unpaid carers, those with and without health conditions and disabilities. While the outputs related to patient experiences, some of the themes that emerged from the engagement have direct implications for where healthcare is delivered and need to be considered as part of both the emerging Neighbourhood Health Model (for all ages) and the estate in which it is delivered.

Integration of services – the need for flexible, coordinated estate design

A successful neighbourhood health model relies on flexible space that allows different services to work together and support complex needs. Therefore, buildings need to accommodate:

- Multidisciplinary teams
- Easier access for people with mobility difficulties or who struggle to leave their home

Use of Community Spaces

Much of the community who were engaged with are either hesitant or do not currently use community spaces (for example BAME, people in poverty, housebound people). Any care delivered from community spaces needs to be carefully considered, from a confidentiality, accessibility and Infection Prevention & Control (IPC) perspective, and a recognition not all care can be delivered from those kind of community settings.

Self-Management and GP Reliance

Patients see primary (and by extension community) care as the 'gold standard health professional' and the estate needs to enable this through adequate clinical space, and high-quality spaces for confidential/private conversations.

Digital Access

A significant cohort of the population cannot. or do not want to use digital services to access care. This has a direct impact on estates, to ensure adequate provision is designed into the estate to ensure equity of access.

Prevention and Lifestyle Support

The 45-66 age group and young people were receptive and motivated to lifestyle change to prevent further health issues. The estate could support prevention through group rooms.

#TEAMLEEDS

LCH are an active member in the Leeds Strategic Estates Board (SEB), a collective of public and voluntary sector organisations working collaboratively to support and deliver a 'one public estate' ethos, as Leeds Health and Care Partnership (LCHP).

The Leeds SEB vision is:

"Through collaboration and informed decision-making, we will create one high-quality health and care public estate in Leeds.

By working together, we will develop a seamless, efficient environment that supports the needs of communities, enhances public services, and delivers long-term value and environmental sustainability, advancing the Leeds Health and Care Partnership's priorities for a better future."

To enable achieving the vision, the following principles have been agreed by all SEB members:

1. The land and buildings used to deliver health & care services by LHCP to be viewed as 'one Leeds health & care estate' by all SEB members.

2. SEB will adopt a transparent, open-book, collaborative approach to estates data, decision-making and delivery.

3. SEB will actively consider risk appetite of partners when progressing the delivery of shared priorities and within the context of the overall estate's strategy.

4. SEB will seek to optimise the use of the health & care estate and Leeds £, while being cognisant of the need for organisations to sustainably manage their budgets, maximising opportunities within the wider 'one public estate'.

5. As a critical Enabler within the LHCP, members of SEB will:

- Ensure the insights and experience of services users, their carers/families, health & care services, staff and other stakeholders have been fully considered when delivering the SEB priorities.
- Take responsibility for 'following through' on recommendations, identifying and securing additional resources where possible or adjusting plans as required to achieve the best outcomes for service users
- Lean into, support and champion partnership working and the agreed vision, principles and priorities in their own organisations and with other stakeholders.
- Work with other Enablers to address digital, financial, communication, workforce and cultural barriers.

There are a number of active workstreams to deliver the vision.
LCH lead the 'Seamless Estate' workstream, looking at how partners can lift the barriers to facilitate more shared use of estate, specifically in terms of finance, access, connectivity, flexibility and availability.

EMERGING NEIGHBOURHOOD HEALTH MODEL

The principles for Neighbourhood Health delivery for all ages across Leeds are beginning to take shape, through the first wave of the National Neighbourhood Health Implementation Plan (NNHIP).

This is creating the framework in which Leeds system partners will come together to develop models of proactive care and prevention through partnership transformation programmes.

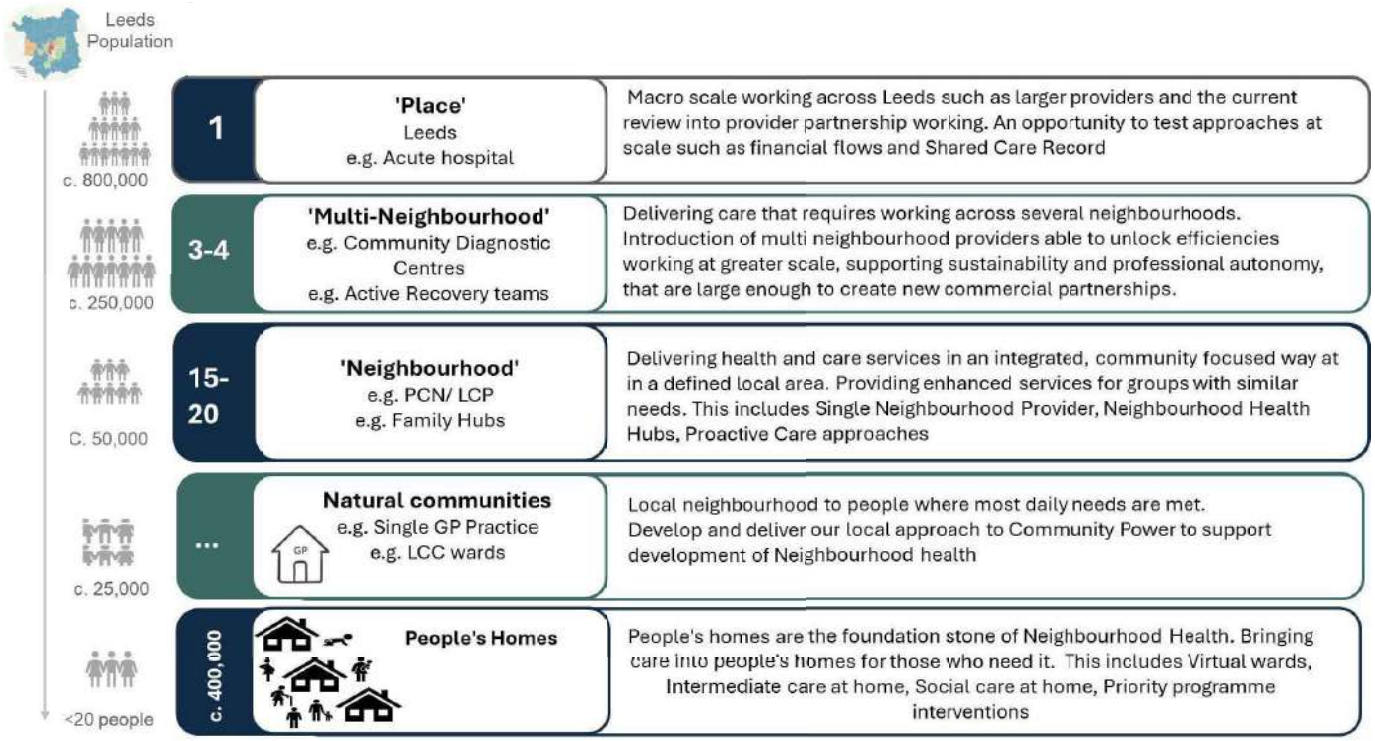
Early identified estates opportunities of these new models of care include:

- Development of standardised Neighbourhood Hubs
- Deployment of hub and spoke or campus style models
- Flexible, adaptable, bookable space
- One reception and a warm welcome

At present, the impact on service delivery models within LCH is under review and therefore the impact on the estate is not yet understood – both from an organisation and a system perspective.

However, the guiding principles for the SEP have been developed with neighbourhood health in mind and to support the three shifts of the NHS 10 Year Plan.

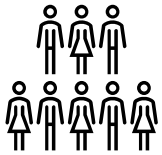
The requirements of the estate and the basis of decision making and investment in the short to medium term will have to meet with this model as it continues to mature.



STAFF WELLBEING

Alongside our evolving Neighbourhood Health (all ages) delivery model, the way our staff and patients use our spaces is evolving. A key component of the engagement sessions has been to hear directly from stakeholders what staff wellbeing and inclusivity features our buildings need as we move towards more integrated working.

A working environment that celebrates equality, diversity and inclusivity has several key benefits, including improved wellbeing for building users, lower stress, a stronger sense of belonging and creates a sense of cohesion and mutual respect among cohorts.



Warm, welcoming spaces including reception areas, waiting rooms, child- and family-friendly spaces	Adequate meeting space
Confidential/private spaces – for supervision, break out, private phone calls, etc.	Comfortable surroundings, including acoustics, dimmable lighting, temperature controls
Good accessibility and parking provision, particularly for peripatetic staff	All desk set ups incorporate adjustable height desks and ergonomic chairs
Adequate security features – external lighting, car parking provision on site	Adequate car parking, good bus routes
IT capacity – adequate electricity sockets, 'plug in and play' uniform desk set up	Adequate space for staff – both in terms of sufficient meeting rooms and clinical spaces, as well as "not cramming people in"
More flexibility in terms of room bookings and sharing space	Open plan offices to support collaboration (with private spaces, good acoustics)
Safe, accessible storage	For children's services: sensory spaces and soft therapy rooms
Cycle storage and shower facilities	A positive environment: inspiring and sensitive décor

There are some features which were not raised as part of the engagement session, that would elevate the equality and inclusivity plans for the organisation, including: good quality rest spaces for staff (both indoor and outdoor, where space allows), gender-neutral WCs at each site, neuro-sensitive design of workspaces, prayer rooms and quiet, non-stimulating workspaces.

SUSTAINABILITY

OUR POSITION

Our estate presents both challenge and opportunity. While meaningful progress has been made in improving energy performance, such as LED rollout and smarter controls, much of the estate is ageing, reliant on gas and not yet equipped to meet long-term NHS Net Zero targets for 2040 (direct emissions) and 2045 (indirect emissions). Older buildings in particular require substantial fabric improvements to support decarbonisation, reliance and affordability.

The 'priority and hierarchy of work' graphic, from the 2025-2028 Green Plan, illustrates our approach to investing in renewable energy as a priority, with investment and improvements into the fabric and fenestration over a longer period of time.

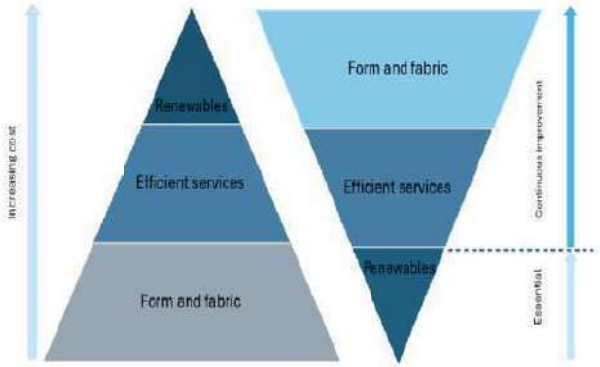
The SEP will be underpinned by a sustainability roadmap, which will outline the phased journey required to strengthen environmental performance, reduce carbon emissions and ensure the estate becomes future-proof, affordable and aligned with the Trust's long-term vision.

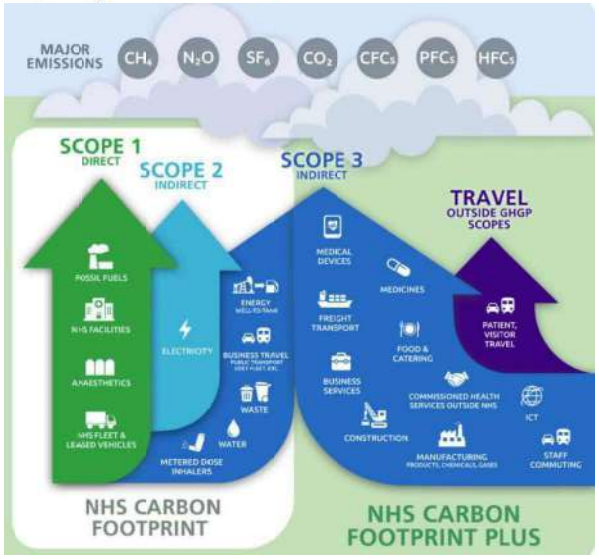
ENERGY PERFORMANCE OVERVIEW

Energy efficiency varies considerably across the estate. Some modern or recently refurbished buildings perform well, while older sites with outdated construction and plant consume disproportionately more energy.

This variation influences operating costs, carbon emissions and the feasibility of introducing low-carbon technologies.

PRIORITY AND HIERARCHY OF WORK





KEY INSIGHTS

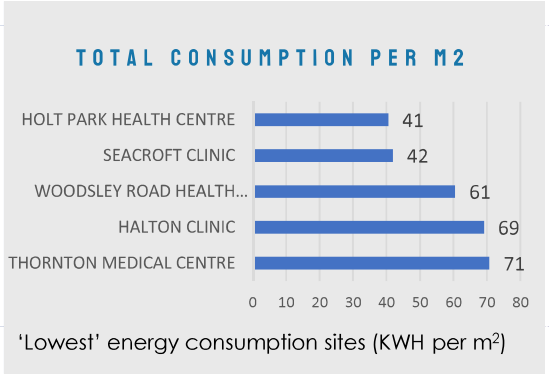
- The Trust has made strong progress in LED coverage, delivering immediate reductions in energy use
- Several sites show good energy performance, providing a solid baseline for further decarbonisation work
- Many buildings still rely on gas heating and fabric condition limits the feasibility of heat pumps without significant enabling works
- No buildings have solar PV, presenting a future opportunity (subject to structural and grid feasibility)
- The greatest carbon reduction potential lies in targeted upgrades at ageing sites with high consumption patterns

WHAT DOES IT MEAN FOR OUR ESTATE?

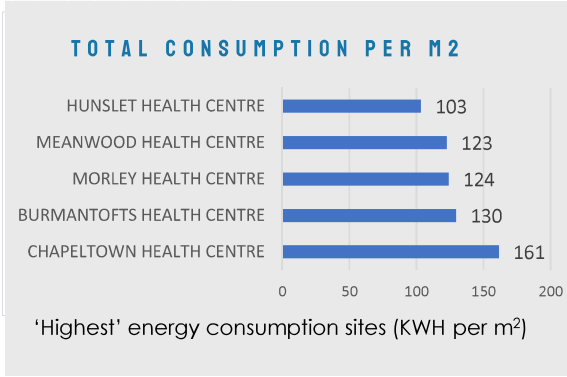
A phased, fabric-first estate approach is required to bring the estate in line with national net-zero expectations. Investment decisions will need to balance:

- Condition-led risks
- Sustainability gains
- Operational impact
- Financial constraints

This will form the foundation of the Sustainability Roadmap, guiding how we reduce emissions, improve efficiency and strengthen building resilience across the next decade.



'Lowest' energy consumption sites (KWH per m^2)



'Highest' energy consumption sites (KWH per m^2)

2,547,741

Total Gas consumption (kwh)

985,154

Total Electric consumption (kwh)

70%

Average LED coverage

1. BEESTON HILL HC
2. PARKSIDE HC
3. MORLEY HC
4. PUDSEY HC
5. ROTHWELL HC

'Top' performing sites according to DEC ratings

1. MIDDLETON HC
2. WOODSLEY ROAD
3. REGINALD CENTRE
4. BURMANTOFTS HC
5. HALTON CLINIC

'Worst' performing sites according to DEC ratings

TRAVEL AND TRANSPORT

Travel and transport play a critical role in how effectively our estate supports service delivery across Leeds.

As a community-based provider with a geographically-dispersed footprint, we want patients, staff and partners to reach our buildings safely, reliably and sustainably, meeting both operational needs and our wider environmental commitments.

Looking ahead, our goal is to embed travel and transport firmly within our sustainability agenda, taking a whole-scale approach to how we enable movement across the estate. This includes reviewing and facilitating access by public transport, walking, cycling and car, with a focus on reducing unnecessary car journeys and supporting the NHS's net zero ambitions.

We recognise that car parking across the estate is often constrained and future solutions will need to balance the needs of staff and patients with the imperative to encourage sustainable travel.

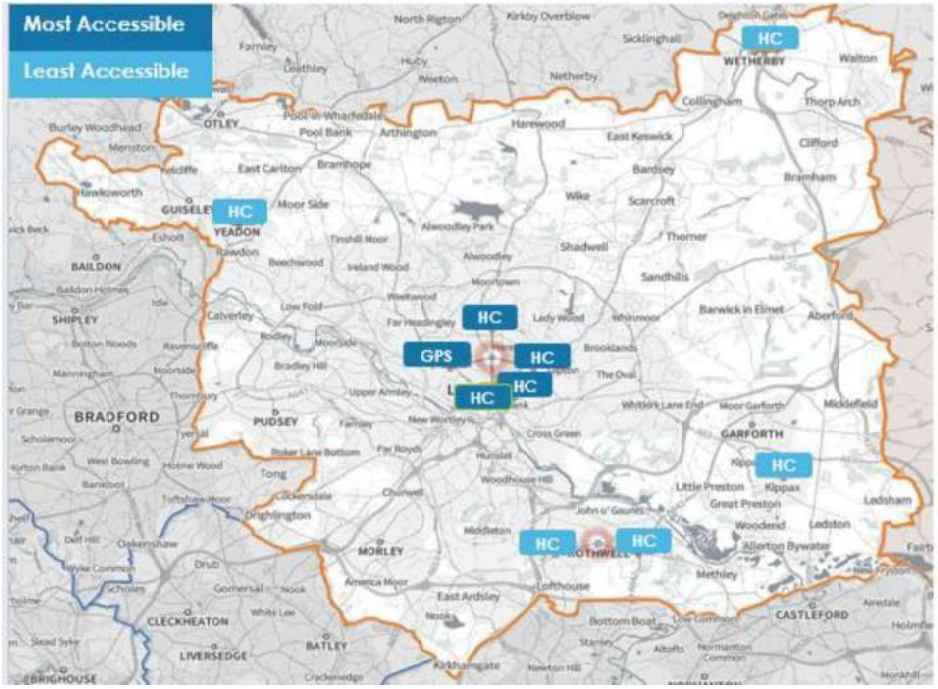
For staff, predictable travel times, reliable access and safe facilities remain crucial to delivering timely, place-based care and maintaining productivity.

For patients, especially those living in deprived or poorly connected neighbourhoods, enhanced transport options will reduce barriers to attendance, improve health equity and make our services more accessible.

The development of a coherent Travel and Transport Plan will therefore be a key enabler of the SEP. This includes an understanding of transport access across all sites, improving wayfinding and safety, supporting multimodal travel options and aligning future estate decisions with public transport corridors and sustainable travel infrastructure.

Integrating transport considerations into estate planning will strengthen accessibility, support decarbonisation and ensure that our estate remains responsive to the needs of both our communities and our workforce.

ACCESSIBILITY ACROSS OUR ESTATE



Most accessible site: Burmantofts, Chapeltown and Woodhouse Health Centres, the Reginald Centre, Rutland Lodge

Least accessible site: Kippax, Rothwell, Wetherby and Yeadon Health Centres, Hannah House

Accessibility is critical to delivering equitable services across Leeds. Our people use a mix of public transport, private vehicles, cycling and walking to reach our sites. We have assessed accessibility through public transport and car travel analysis, supplemented by feedback from the engagement sessions.

This analysis highlights variation across the estate in geography, transport connectivity and car parking provision. Some sites are well-connected, while others face challenges that create barriers for patients and staff.

Accessibility has been assessed across three primary travel modes:

Weekday AM/ PM travel time via bus and rail services to each sites, including service frequency and number of interchanges. Coverage varies across some areas.

Indicative drive-time catchments (weekday AM/PM) were calculated using road network distance, typical speed limits and known congestion constraints.

Indicative cycle-time catchments modelled assuming an average cycling speed of 15km/ hour (9.3miles/ hour).

** Catchment populations are based on LSOA residential population data and where an LSOA population-weighted centroid falls within a travel-time catchment, the full LSOA is included. Figures are indicative.*

Access to our estate is important from both a staff and patient perspective. Accessibility was raised frequently by stakeholders as part of the engagement workshops. To support a greater understanding, feedback from these sessions was further considered alongside a high-level analysis of public transport. The table below highlights where accessibility across our estate is working well and where challenges have been identified.

	Public Transport	Car	Parking
What Works Well	• Certain inner and central sites demonstrate stronger transport connectivity, making them more accessible for patients, staff and partners. Examples include: Burmantofts, Chapeltown, Hunslet and Kirkstall Health Centres. • Across most sites, public transport catchments expand in the afternoon periods, offering greater accessibility later in the day.	• Car access supports service coverage in peripheral areas, including Kirkstall, Rothwell, Wetherby and Yeadon, where public transport links are limited. • Some sites benefit from clearer access and more manageable parking. These include Pudsey and Woodhouse Health Centres and White Rose Office Park.	• A few locations have parking provisions that actively support operational efficiency and service delivery, such as at St George's Centre and White Rose Office Park, enabling timely staff deployment and smoother patient flow.
What Does Not Work Well	• Some peripheral sites face weaker transport connectivity, with longer bus journeys and limited transport options, including Wetherby and Yeadon Health Centres.	• Accessibility also varies by time of day- morning peak congestion can affect punctuality and service flow, for example, around Middleton Health Centre during school pick up periods.	• In areas with limited public transport, there is greater reliance on car travel. Parking constraints and restrictions have been raised as challenges at several sites: o Seacroft Clinic and East Leeds - double yellow and fines) o Yeadon Health Centre - parking fines) o Rutland Lodge - parking described as a 'nightmare' o Woodsley Road - very small bays, congestion, with Friday pressure linked to nearby users. • Wayfinding challenges in shared buildings (e.g., Beeston Hill) create operational pressures.

Source: SHAPE Atlas and engagement session feedback. This is a high-level assessment and does not replace detailed transport or access studies.

REQUIREMENTS OF THE ESTATE

'The golden thread' positions the estate as a critical enabler of integrated care, workforce effectiveness, population health improvement and system suitability.

The implications set out below draw together these national and regional drivers and articulate what they collectively mean for the estate - providing a clear bridge between strategic context and the guiding principles, processes and investment decisions that follow.

Neighbourhood and Community-Based Care

- Buildings must enable co-location with primary care, mental health, local authority and VCSE partners
- Shift from single-purpose buildings towards integrated service provision
- Alignment of service delivery and Local Care Partnership (LCP) boundaries
- Buildings must function as local anchors for care, prevention and early intervention
- Estate to increasingly function as a shared system asset, not a single-provider source

Reducing Health Inequalities

- Investment prioritised in areas of highest deprivation and demand
- Estate decisions must explicitly consider accessibility, transport, inclusivity and local need
- Estate plays an active role in addressing inequality, not just accommodating services

Workforce Support and Development

- Buildings must support multidisciplinary team working, collaboration and supervision
- Increased need for agile working environments, touchdown space and shared facilities
- Estate quality directly underpins recruitment, wellbeing and productivity

Digital Enablement

- Reduced reliance on paper records and fixed admin spaces
- Requirement for robust digital infrastructure to support virtual care, shared records and hybrid working
- Spaces designed for adaptability, not static service models

Sustainability and Net Zero

- Carbon performance becomes a core investment and prioritisation criterion, not an add-on
- Focus on fabric first, energy efficiency and lifestyle value, particularly in ageing assets
- Estate rationalisation and disposals support both financial and carbon reduction objectives

Optimising Assets and Financial Sustainability

- National capital constraints drive a 'best use of what already exists' approach
- Clear strategic justification required for retention, reinvestment or disposal
- Preference for phased, flexible solutions over fixed, long-term commitments

SHAPING OUR ESTATE'S FUTURE

FORWARD THINKING

Having established the guiding principles of our estate, we can now look ahead to shaping its future. This position has been reached through a combination of strategic context, stakeholder engagement and system-wide priorities, maintaining ***'the golden thread'*** from national policy through to place-based delivery across our estate.

The principles articulate the future direction for our estate and the role it must play in enabling effective service delivery. Together, they provide a clear and consistent framework for planning, developing and managing the estate, ensuring alignment with clinical strategy, workforce requirements and wider system objectives, while enabling practical, place-based solutions that meet the needs of both current and future service delivery.

Collectively, the guiding principles define the intended future state of our estate and the way in which it will support organisational priorities and ambitions.

Improve our estate to meet future demand and population health needs by prioritising assets based on condition and location, enabling effective consolidation and estate rationalisation.

Co-create spaces that promote staff wellbeing and positive experiences for patients and visitors.

Use of digital innovation to create smarter, more efficient buildings and improve accessibility to all.

Create environments that enable integrated working, support collaboration, and foster a shared culture.

Prioritise delivery of spaces that enable excellent front-line service delivery, foster inclusion and productivity.

Develop a shared definition of flexible, adaptive and culturally inclusive spaces that support hybrid working, workforce needs and changes in the service delivery model.

Embed sustainability and social value in every estate decision, ensuring the sites contribute positively to health, equity and the environment.

Adopt a mixed ownership approach (i.e. leasehold and freehold) that drives long-term value, supports flexibility and promotes an inclusive estate.

DELIVERING THE VISION

Leeds Community Healthcare
NHS Trust

DELIVERING OUR STRATEGIC PLAN

This SEP responds to a changing NHS landscape, including the emerging provider partnership and the continued development of Neighbourhood Health Models (all ages) across Leeds.

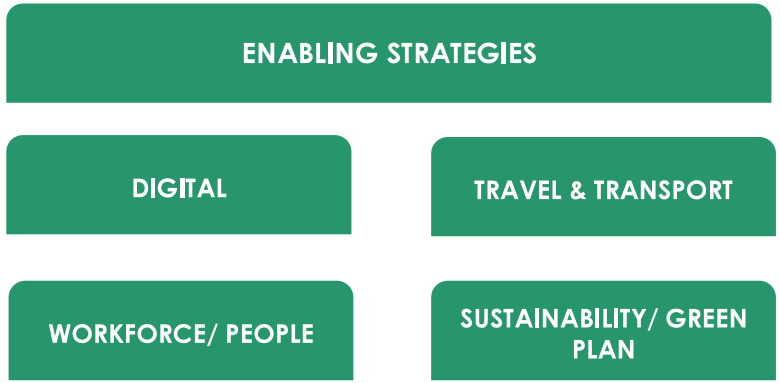
While this creates some uncertainty in terms of detailed delivery planning, our Trust is well- positioned to lead the neighbourhood health agenda through its established estate footprint, strong presence within communities and co-location of adult, children and specialist services.

The SEP provides a clear medium-term framework for estate planning, investment and decision-making. This includes:

- Categorising the freehold, leasehold and LIFT estate using NHS England's definitions of 'core, flex and tail' to guide future service provision.
- Development of a framework to support future estate decision-making and to ensure the estate continues to provide safe, accessible and compliant premises while working towards the strategic goals.
- Recognising key estate constraints and dependencies.

A detailed three-year Implementation Plan will be developed, setting out a clear programme of investment, improvement and optimisation to support service transformation, staff wellbeing and inclusivity. This plan will be reviewed annually to ensure alignment with organisational priorities and the evolving Leeds System context.

Delivery of the SEP will be overseen by the Trust's Estates Strategy Implementation Board, with bi-annual updates to the Business Committee. Successful delivery will require close alignment with wider enabling strategies, recognising that the estate underpins all aspects of organisational performance and service delivery.



CORE, FLEX, TAIL

Our estate has been categorised, using the NHS England's 'core, flex and tail' framework, drawing on the data analysis, service mapping and service feedback from the engagement workshops. While categorisation may evolve as the neighbourhood health model develops, this assessment provides a clear view of each building's current strategic fit, condition, location, service criticality and adaptability.

This approach provides a system-recognised basis for prioritising investment and guiding decisions on retention, adaptation or disposal, ensuring the estate remains fit for current and future service delivery. This categorisation informs three clear priorities for the Trust:

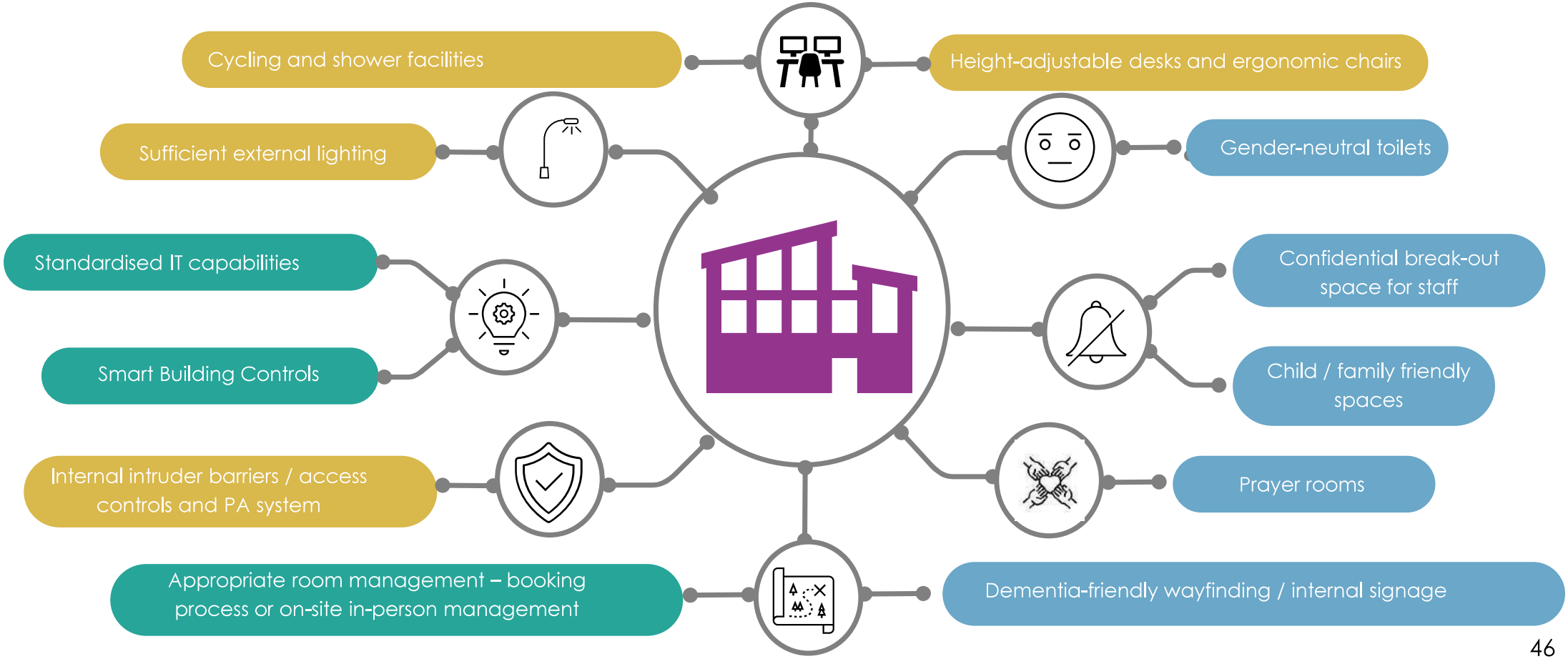
- **Protect and prioritise Core assets -** focus investment on buildings critical to service delivery, workforce needs and system priorities, ensuring facilities remain safe, sustainable and fit for purpose.
- **Enable flexibility through Flex assets -** retain and adapt selected sites to support evolving service models and future change.
- **Release or repurpose Tail assets -** identify low-value, poorly aligned buildings for rationalisation, disposal or alternative use to enable reinvestment.

A clear delivery pathway for each asset will be set out in the Implementation Plan.

Category	Details	Freehold	Leasehold	LIFT
Core	• Estate that is **flexible, fit-for-purpose, and integral** to delivering the ICS's long-term clinical strategy • Typically features **level access, compliant room sizes [spaces]**, and long-lease/PFI/LIFT structures (presumed core unless exceptional) • Should represent **the best-quality sites** and be prioritised for investment	• Bramley Clinic • Hannah House • Hunslet Health Centre • Kirkstall Health Centre • Pudsey Health Centre • Rothwell Health Centre • Seacroft Clinic • Morley Health Centre	• Kippax Health Centre • St George's Centre • White Rose Office Park	• Armley Moor Health Centre • Beeston Hill Health Centre • East Leeds Health Centre • Middleton Health Centre • Parkside Health Centre • Reginald Centre • Wetherby Health Centre • Woodhouse Health Centre • Wortley Beck Health Centre • Yeadon Health Centre
Flex	•Estate that **can meet [space] standards and support long-term delivery** with investment • Example: **- Medium-quality sites** near core assets with potential for expansion or better utilisation **- Isolated, lower-quality** assets providing essential access (e.g., rural sites), kept as interim solutions • Flex assets may later be re-categorised as core or tail	• Chapeltown Health Centre • Halton Centre • Holt Park Health Centre • Meanwood Health Centre	• Rutland Lodge • St Mary's Hospital • Thornton Medical Centre • Park Edge Health Centre	
Tail	• **Old** Estate, **poor quality, and not fit-for-purpose** • **Little potential for improvement** (e.g. converted residential properties) • **Cannot deliver modern service models** or meet space standards	• Burmantofts Health Centre • Woodsley Road		

OUR ESTATE BLUEPRINT

As opportunities for investment and transformation materialise, we are committed to improving our estate by the inclusion of the features that deliver on our strategic estates plan principles and provide the foundations for improved staff and patient experiences using our estate. Further, introduction of measures to ensure we keep our building users safe, and improve sustainability and digital capabilities to ensure our buildings work intuitively will be prioritised. These features will be standard across the estate, to promote equality and equity for staff using our premises.



A CASE FOR INVESTMENT

While the Neighbourhood Health Model (all ages) continues to mature, estates matters should be subject to a case for investment, to ensure resources are focused on delivering safe and compliant buildings, and investment is proven to be value for money and support the medium to long term strategic direction.

The key considerations ensure that decisions are risk-based, strategically aligned and focused on delivering long-term system benefits.

This approach enables the Trust to prioritise scarce capital effectively, address safety and compliance risks, support service delivery and focus on sustainable, long-term improvements, rather than short-term reactive expenditure.

The framework provided here is an example, and requires furthers refinement by the Trust, particularly in terms of the scoring and weighting of each consideration to provide a standard and transparent approach to investment. Suggesting weighting of each key consideration is set out in Appendix 3.

KEY CONSIDERATIONS	DESCRIPTION
STRATEGIC IMPORTANCE AND ALIGNMENT WITH POLICY	Assesses how critical the site is to delivering core services, supporting high-deprivation populations and addressing health inequalities. Considers co-located services, integrated care services and potential to operate as a Neighbourhood Health Hub. Evaluates alignment with future service models, policy commitments and the Trust's long-term objectives to support sustainable system-wide priorities.
BUILDING CONDITION AND COMPLIANCE	Evaluates the physical condition of the asset, backlog maintenance, statutory compliance (fire, accessibility, infection control) and safety risks. Considers lifecycle position and potential operational disruption if issues are not addressed, reflecting overall resilience.
AFFORDABILITY AND VALUE FOR MONEY	Assesses capital and revenue implications, including lifecycle costs, efficiency gains and savings from rationalisation or energy improvements. Determines whether any proposed investments provide the best value for the Trust and the wider system over the long term.
OPERATIONAL IMPACT AND SERVICE DELIVERY	Considers patient capacity, workflow efficiency, adaptability for new models of care, co-location of services and future service growth. Examines whether investment improves patient experience, supports multi-disciplinary teams and enables integrated neighbourhood care.
RISK	Assesses operational, clinical and environmental risks, including non-compliance, service disruption, health and safety and environmental hazards. Evaluates likelihood and impact, highlighting risk exposure if investment is delayed or not undertaken.
DELIVERABILITY	Considers planning and regulatory approvals, site readiness, funding availability, workforce and programme capacity and stakeholder engagement. Assesses dependencies, potential service disruption during works and the likelihood of achieving outcomes on time and within budget,

INVESTMENT OVER THE NEXT 2 YEARS

Development of a 3-year implementation plan will follow, over time being aligned to the city's Neighbourhood Health model, as that emerges. However, there are a number of confirmed capital investment streams over 2026/27 and 2027/28, as well as potential opportunities for transformational change across our sites, should further capital be secured. In advance of the full implementation plan being developed below provides an overview of areas of focus over the next 2 years, which includes activity rolled over from the last implementation plan.

SCHEME	DESCRIPTION
Hunslet Health Centre	£0.5m has been secured through Return to Constitutional Standards funding to convert an unused, former opticians attached to Hunslet Health Centre. The space will be internally linked to the wider Health Centre and transformed to provide additional clinical capacity at the site. The funding is allocated in 2026/27, so works will need to be complete by March 2027.
Chapeltown Health Centre	£4m has been secured through Return to Constitutional Standards funding to deliver a full site programme of works at Chapeltown Health Centre in 2027/28. The scheme aims to both increase capacity and improve accommodation quality, potentially including an extension to the existing building. There is a requirement to produce a business case to support the investment which will be produced in 2026/27, ahead of works starting on site the following year.
Children & Young Person's Learning Disabilities and Autism Crisis Accommodation	£1.3m has been secured through Return to Constitutional Standards funding to deliver crisis accommodation for young people with learning disabilities and autism in 2027/28. The scheme sits with LCH to be delivered but will be done so in close partnership with LYPFT and the Local Authority.
Burmantofts Health Centre	Finding a solution to Burmantofts Health Centre will remain a priority for LCH. This will necessitate close working with the Local Authority on its local regeneration plans, identifying and aligning options for investment in some form of new community asset which enables health service provision – which may not be LCH as the asset owner.
Option Appraisals & Feasibilities	Lead-in times for capital investment, especially when looking to transform space, can often be length, requiring option appraisals and feasibility studies. It is intended to identify sites which would be prioritised if further rounds of capital funding were to become available, producing options appraisals/feasibility studies to maximise the chances of securing funding through being at a more advanced stage than 'concept'.
Disposal of Horsforth and Otley sites	Whilst offers have been accepted on both sites, work continues to complete on the sale transactions. It is anticipated that Otley will complete in 2026/27, with less certainty on when Horsforth will complete as the sale is conditional on the purchaser securing planning consent for re-development of the site.

CONSTRAINTS AND DEPENDENCIES

Delivering the SEP requires a clear understanding of the factors that may limit progress as well as conditions that must be in place for successful implementation. The following constraints highlight the operational, financial and physical challenges within the current estate, while interdependencies identify the key decisions, partnerships and enablers that our Trust relies on to move forward. Together, they set out the practical realities that shape the pace, scope and feasibility of this plan, ensuring that future decisions are both realistic and grounded in the wider strategic context.

CONSTRAINTS

These constraints shape what is feasible and create boundaries around investment, sequencing and prioritisation:

Strategic uncertainty – pending decisions at organisational and System level affect long-term planning.

Restricted capital availability – limited funding constrains estate improvements and transformation.

Lease costs – rising rent and capitalisation of non inter-NHS lease agreements impact affordability.

Ageing estate – significant maintenance liabilities in the pre-1985 estate increase risk exposure.

Poor utilisation governance – inconsistent room/space management reduces efficiency and Value for Money (VfM).

Digital and technology limitations – some buildings cannot yet support new models of care or hybrid working.

Sustainability barriers – constraints around retrofitting, decarbonisation and enabling works, in operational environments.

DEPENDENCIES

These elements need to progress concurrently or be resolved to unlock implementation:

Maturity of the Neighbourhood Health Model – estate decisions must reflect service redesign ambitions.

Sustainability/Net Zero investment – interventions must align to Trust-wide decarbonisation plans and capital availability.

Alignment with Digital Strategy – hybrid working, virtual care, digital consultations and infrastructure readiness influence estate design.

Capital availability – funding options must be available to adapt and repurpose space for future service needs.

Travel & Transport Plan – linked to sustainability and car parking management.

Car Parking Policy – Organisational position required to manage demand and capacity across all sites to support service delivery, linked to Travel & Transport Plan.

NEXT STEPS

This Strategic Estates Plan is ultimately about positioning LCH on the road to delivering on the NHS 10 Year plan, by moving from treatment to prevention; analogue to digital; and hospital to community. It sets out a course to ensure the estate remains safe, compliant, and of high-quality, and provides the principles and framework to target investment into the estate where it will most benefit both staff and service users.

There are a number of important next steps following approval of the SEP by Business Committee, to ensure the Trust maximises opportunities while broader conversations of Neighbourhood Health delivery for all ages and the merger of LCH and LYPFT mature.

1. Share the Strategic Estates Plan with LYPFT, for consideration and comment
2. Socialising the agreed principles the SEP with Leeds System Partners via the Leeds Strategic Estates Board, exploring opportunities for co-location, collaboration and optimisation of assets
3. Development of an implementation plan, with a focus initially on improvements to the 'core' estate to support the neighbourhood health model in the medium to long term
4. Preparation of a sustainability roadmap, detailing the measures the organisation will need to take to reach net zero carbon, on a building-by-building basis. Those buildings categorised as core and flex will be prioritised.

APPENDICES

Leeds Community Healthcare
NHS Trust

APPENDIX I. INDEX OF MULTI DEPRIVATION SCORE

The table below shows the Index of Multiple Deprivation (IMD) scores, indicating that around half of the Trust's sites are located in the most deprived areas of Leeds, compared with only 12.5% in the least deprived areas. This highlights the critical role of the estate in addressing health inequalities across the city.

Area	IMD Score
Armley Moor Health Centre	58.29
Beeston Hill Community Health Centre	47.03
Bramley Clinic	24.78
Burmantofts Health Centre	53.10
Chapeltown Health Centre	50.93
East Leeds Health Centre	41.02
Halton Clinic	18.37
Hannah House	10.59
Holt Park Health Centre	5.37
Hunslet Health Centre	35.28
Kippax Health Centre	5.20
Kirkstall Health Centre	30.09
Meanwood Health Centre	12.88
Morley Health Centre	11.91

Area	IMD Score
Middleton Health Centre	54.99
Park Edge Medical Centre	52.89
Parkside Community Health Centre	22.89
Pudsey Health Centre	29.90
Reginald Centre	51.93
Rothwell Health Centre	12.49
Rutland Lodge Medical Practice	5.88
Seacroft Clinic	68.66
St Georges Centre	17.46
St Mary's Hospital	14.78
Thornton Medical Centre	57.78
Wetherby Health Centre	23.98
Woodhouse Health Centre	29.08
Woodsley Road Health Centre	18.17
Wortley Beck Health Centre	48.64
Yeadon Health Centre	33.35

Quintile	Key
Most deprived (40 and above)	
High Deprivation (30-40)	
Mid Deprivation (20-30)	
Low Deprivation (10-20)	
Least Deprivation (0-10)	

Source: English Indices of Deprivation, 2025.

IMD scores reflect the LSOA in which each estate site is located.

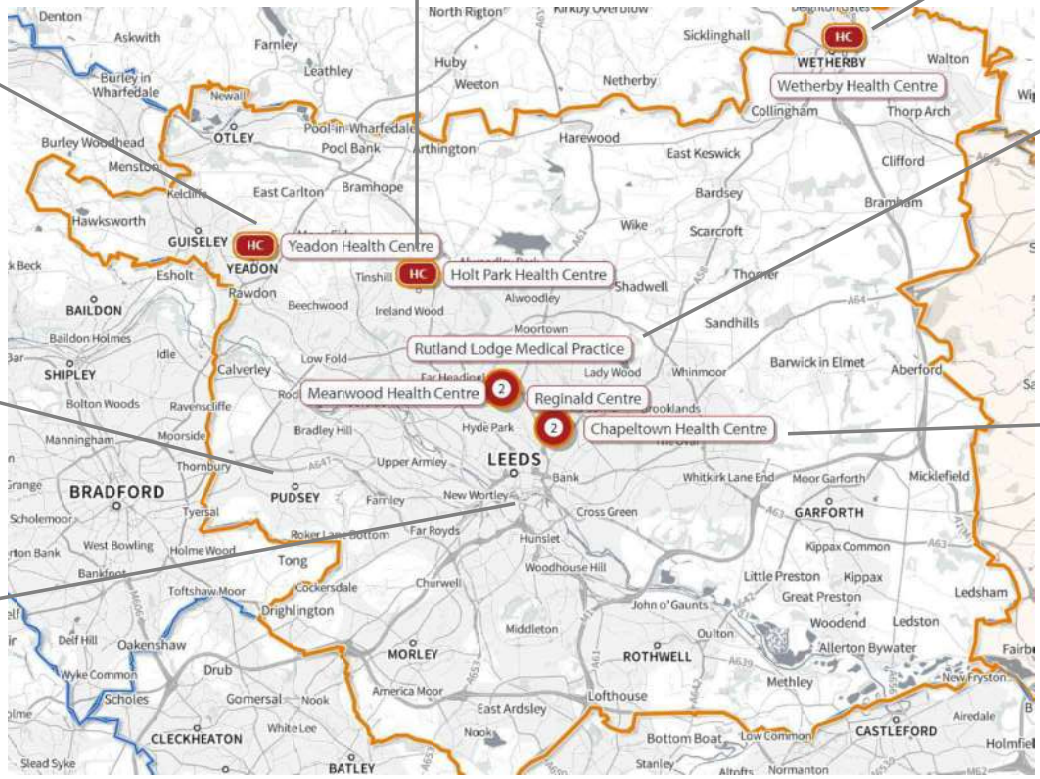
APPENDIX 2A. SERVICES LOCATION - NORTH

Yeadon Health Centre
Dental
Falls Service
MSK
Neighbourhood Team
Children's SLT
PHINS 0-19
Podiatry

Meanwood Health Centre
Gynaecology
Neighbourhood Therapy Team
MSK
Podiatry
Children's SLT

The Reginald Centre
CAMHS
Children's SLT
Dental
Eating Disorders
ICAN
Paediatric Ophthalmology
PHINS 0-19
SLT

Holt Park Health Centre
Podiatry
Neighbourhood Team
PHINS 0-19



Wetherby Health Centre	
Children's SLT	Podiatry
MSK	Police Custody
Neighbourhood Team	

Rutland Lodge Medical Practice
CUCS
Healthcase Management Service GPs
MSK
Neighbourhood Team

Chapeltown Health Centre	
Cardiac	LMWS
CIVAS	Long Term Conditions
Communication Aids	Palliative Care
Community Cancer Care	Podiatry
Community Midwives	PHINS 0-19
Diabetes	Respiratory
Eye Screening	Sexual Health Service
IPC	Speech & Swallowing
ISHS	TB Clinic
LCH Security Team	

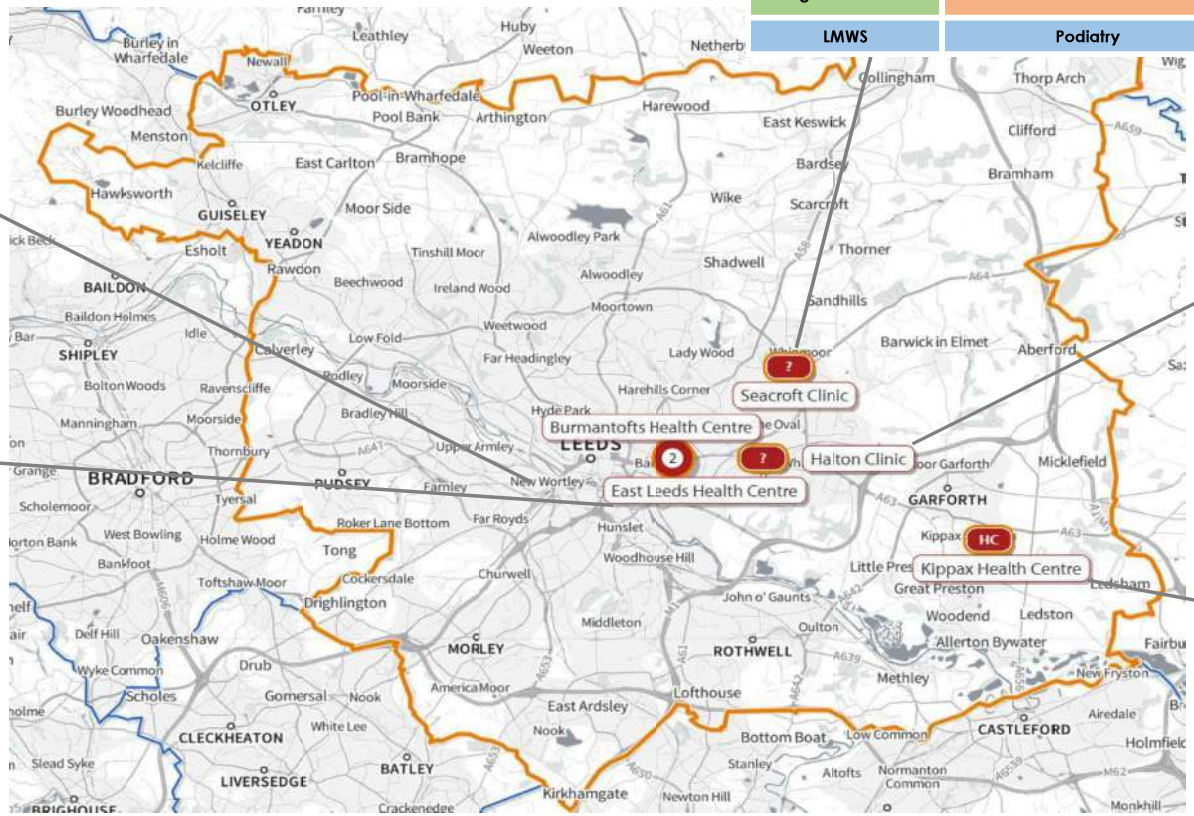
Key	Code
ABU	
CBU	
SBU	
Corporate	

APPENDIX 2B. SERVICES LOCATION - EAST

Burmantofts Health Centre
- Homeless & Inclusion Team
- LMWS
- Mind Mate
- PHINS 0-19
- Sexual Health Services

East Leeds Health Centre
- CUCS
- Diabetes
- GP Vaccination
- Gynaecology
- Health Case Management
- Infant Mental Health
- LMWS
- LTHT Midwives
- MSK
- Paediatric Ophthalmology
- Podiatry
- PHINS 0-19

Key	Code
ABU	
CBU	
SBU	
Corporate	



Seacroft Clinic

Cardiac	Neighbourhood Therapy Team
CUCS	Paediatric Ophthalmology
Integrated Wounds	PHINS 0-19
LMWS	Podiatry

Halton Clinic
- Cardiac
- Children's SLT
- CUCS
- LMWS
- Neighbourhood Clinic
- PHINS 0-19
- Podiatry
- Seacroft NT and ASC
- SLT
- Research and Development

Kippax Health Centre
- ACS
- Adult Nutrition & Dietetics
- Adult SLT Diabetes
- Cardiac
- LMWS
- LTHT ACS
- LYPFT Soft Therapy
- MSK
- Neighbourhood Team
- Podiatry
- SLT

APPENDIX 2C. SERVICES LOCATION - SOUTH

Morley Health Centre
ACS
Blood Pressure Wise
Community Links (3rd Party)
Children's SLT
Clinical Education
CUCS
IT
MSK
Neighbourhood Team
Podiatry
Respiratory
Wound Service

Parkside Community Health Centre
Adult Nutrition and Dietetics
CAMHS
CUCS
Cardiac
Dietetics
LMWS
Infant Mental Health
PHINS 0-19
Weight Management

Beeston Hill Community Health Centre
CUCS
Dental – LTHT (Leeds Dental Institute)
Gynaecology
ISHS
Leeds Sexual Health
MSK
Neighbourhood Clinic
Podiatry
SLT
TB Clinic

Hunslet Health Centre	
ACS	Neighbourhood Clinic
Children's Dietetics	Nights (NT)
Children's Oximetry Clinic	Optima Health
Children's Wellbeing	PHINS 0-19
CIVAS	Podiatry
Diabetes Services	TB (office)
LMWS	Welfare Rights
Optima Health	

St George's Centre
Community Dental
CUCS
MSK
Neighbourhood Clinic

Hannah House
Children's Community Nursing Team

Middleton Community Health Centre	
ACS	Midwives
Adult SLT	Neighbourhood Team
Cardiac	PHINS 0-19
Community Dental	Podiatry
CUCS	NT Triage
LMWS	

Rothwell Health Centre
Podiatry
ACS

White Rose Office park	
Corporate Services	Podiatry
ICAN	SLT

Key	Code
ABU	
CBU	
SBU	
Corporate	

APPENDIX 2D. SERVICES LOCATION - WEST

St Mary's Hospital
Community Neurological Rehabilitation Services
Community Stroke Rehabilitation
Clinical Training

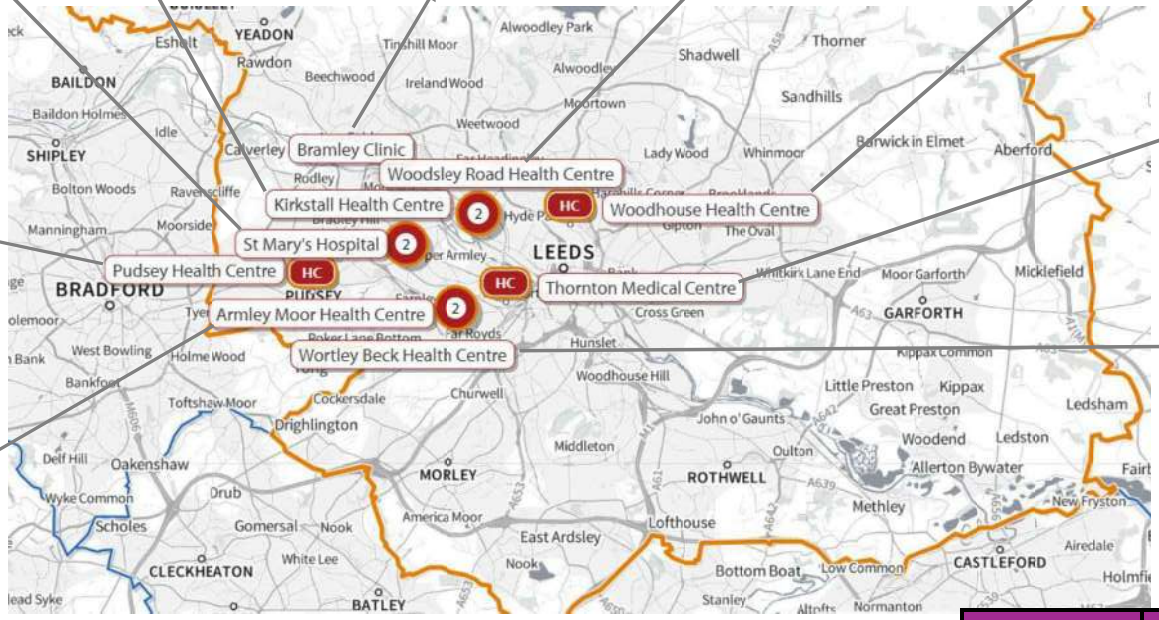
Kirkstall Health Centre
Children's SLT
CYMHS
Podiatry
Health Visitor
Mindmate

Bramley Clinic
ACS
CAMHS
DESP
Forward Leeds
LMWS
Neighbourhood Clinic
PHINS 0-19
Podiatry

Woodsley Road Health Centre
School Immunisations
Mindmate
Neighbourhood Therapy Team
Neighbourhood Clinic
Wounds Service

Woodhouse Health Centre	
0-19 NCMP	Midwives- 3rd Party (LTHT)
Blood Pressure Wise	School Immunisation
CUCS	Speech & Swallowing
LMWS	Podiatry
Midwives	

Pudsey Health Centre
ACS
Cardiac
Hearing Aid Technician
LMWS
Midwives
Neighbourhood Clinic
Paediatric Ophthalmology
PHINS 0-19
Podiatry
SLT



Thorton Medical Centre
CAMHS
Wound Clinic

Wortley Beck Health Centre
Adoption and Fostering Clinic
Audiology Clinic
Children's Community Eye Service
Children's SLT
CPC Clinic
Joint Ophthalmology Clinic
Midwives
Paediatric Ophthalmology
PHINS Baby Clinic
Physio Assessment Clinic
PND Clinic

Armley Moor Health Centre
ACS
Audiology ICAN
Children's SLT
Diabetes Services
Gynaecology Service
Leeds Sexual Health
MSK
Neighbourhood Team Clinic
Podiatry

Key	Code
ABU	
CBU	
SBU	
Corporate	

APPENDIX 3. FRAMEWORK- WEIGHTING

To support consistent and transparent prioritisation of estate investment, each key consideration needs to be assigned a relative weighting, reflecting importance in guiding decisions.

Weightings help ensure that strategic alignment, safety, compliance, operational impact, affordability and deliverability are all appropriately reflected in the overall prioritisation. This allows the Trust to focus capital on sites that deliver the greatest long-term benefit, while maintaining a defensible and systematic approach to investment planning.

Key considerations	Suggested weighting	Rationale/why it matters
Strategic importance and alignment with the system strategy	25%	Sites are highly aligned with the Trust's clinical strategy, neighbourhood care models and health inequality reduction provide the greatest long-term system impact. The highest weighting ensures capital prioritisation supports strategic objectives, rather than short-term fixes.
Building condition and compliance	25%	Safety, statutory compliance and structural integrity are non-negotiable. Poor condition can lead to service disruption, regulatory breaches or patient/staff harm. Equal weighting with the strategic fit ensures high-risk assets are addressed promptly.
Affordability and value for money	20%	Capital is limited; therefore, investment must deliver sustainable financial outcomes. The weighting reflects the importance of balancing cost-effectiveness with strategic needs and operational priorities.
Operational impact and service delivery	15%	Investment should improve patient capacity, workflow and integrated service delivery. Slightly lower weighting acknowledges that operational benefits are important but cannot override safety or strategic alignment.
Risk profile	10%	Capture operational, clinical, environmental and compliance risks if investment is delayed. Lower weighting reflects that while risk is critical to consider, it is particularly captured in condition and compliance and strategic fit.
Deliverability	5%	Considers the feasibility of implementing works with planning, funding, approvals and workforce constraints. Weighted lowest because deliverability is important for practical planning but does not determine strategic value or safety.

Item
2025-26
13

Leeds Community Healthcare NHS Trust

Committee Escalation and Assurance Report

Name of Committee:	People & Culture	**Report to:**	Trust Board 27th March 2026
Date of Meeting:	17th March 2026	**Date of next meeting:**	8th April 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. Both 'Staff Story' and Network chair presentations prompted good discussion and grounded the meeting.

Alert	Action
N/A	N/A

Advise

- Sarah Brownlow, Clinical Service Manager in Neighbourhood Teams, shared her story highlighting the flexible and compassionate support she received while balancing work responsibilities with caring for her terminally ill mother. Health Assured bereavement counselling was highlighted as having been particularly beneficial. It was noted that more visible and targeted communication about available support services, especially bereavement counselling, would help ensure staff know what is available when needed. Her comments about her experience of occupational health input was less favourable and prompted further discussion about the identified issues with the supplier's performance and actions being taken to address under-performance.
- The Committee approved the new LCH Strategic People Framework and noted the closedown of the LCH Workshop strategy 2021-26. E-rostering KPIs were agreed in principle subject to further refinement and offline discussion. The Committee was also updated on the national job evaluation developments and reported that recent Employment Rights Act changes would require only minor policy adjustments with minimal financial impact.
- Medium Term Plan – It was noted that the plan has been signed off as compliant by NHSE. The importance of mapping critical milestones for both LCH and LYPFT was emphasised, ensuring that workforce reductions and redeployments are managed collaboratively and Boards are sighted on the impact. It was noted that robust quarterly self-assurance statements against the Medium Term Plan would be required from the Board and it was acknowledged by the committee that updates on progress as well as indicators against the workforce national planning requirements including band and agency reductions would be helpful.
- The Draft Strategic Estate Plan was presented for consideration, and it was suggested that direct feedback from patients and services be incorporated into estates planning to ensure that developments meet the needs of all stakeholders, with plans to enhance involvement and inclusion in future design processes. To be discussed further in Public Board in March 2026.
- Updates were provided on people KPIs, including a 1% reduction in sickness absence rates reported in February, ongoing work to improve staff engagement, and the introduction of new dashboards and toolkits to support managers and teams. The Committee discussed the importance of leadership

Committee Escalation and Assurance Report

training compliance, particularly among executives, and agreed to review and improve training completion rates. This would be followed up by a discussion in the Non-Executive Director meeting on 25 March 2026.

- The Committee received a progress report in relation to NOF activity as well as a Neighbourhood Teams sickness deep dive - recent changes in team structure had caused anxiety and adjustment challenges among staff, committee heard how additional project management support might have been beneficial during major transitions. Committee members asked for a clear summary of the interventions being implemented, systematic monitoring and reporting of their impact, triangulation of data and service engagement, and inclusion of demographic data and self-rostering practices in future analysis. Concerns were raised about the quality and responsiveness of the Occupational Health service. An update on the impact of contract management of Occupational Health was requested at the next meeting.
- The Committee reviewed the annual effectiveness survey report for P&C and noted some positive feedback within its first year and some areas for improvement including a review of attendees, clarity of actions agreed and more discipline around timing of key agenda items such as staff story and network presentations.

Assurance

- The Committee received comprehensive updates on the work undertaken in relation to NOF sickness absence and engagement and were assured that the programme of work was delivering to plan.
- Freedom to Speak up Guardian (FTSUG) Annual Report – the report was noted. Various options around training for all staff were discussed and it was agreed to conduct a feasibility study on priority training and review at the next meeting in April. The Committee agreed to explore how other Trusts had managed this process and to consider alternative solutions where available.
- The Committee noted the release and content of initial embargoed 2025 Staff Survey results and noted that the engagement scores had held from last year and the NOF ranking on engagement had increased this year.
- It was agreed that the People and Cultural elements of the Trust Integration Programme would become a standing item at the People & Culture Committee.
- Rashed Khan, Chair of Disabilities, Neurodiversity & Long-term Conditions (DNLTC), presented the history, past and current achievements, and the vision for the future of the network. He explained the existing challenges, including how changes to reasonable adjustments impacted staff health and how organisational changes affected their overall health and wellbeing. He shared plans for the coming months, including increasing awareness, working with the Senior Leadership Team to actively recruit staff with DNLTC conditions, and ensuring DNLTC representation in shaping a more inclusive workforce through advisory and co-productive roles.

Risks Discussed and New Risks Identified

The People related risks had been pulled from the risk register and were presented to Committee. It was noted there were no risks currently rated as “extreme”, although 19 risks had a ‘high’ score (between 8-12). Two static risks had reduced in score since being reviewed at the Risk Management Group.

Committee Escalation and Assurance Report

Focus on static risks would continue at RMG in March. The Committee was concerned about the risk relating to unauthorised access to patient records and requested further information about how this risk was being mitigated at the next meeting.

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	**Risk score (current)**	**Overall level of assurance provided that the strategic risk is being managed (or not)**	**Additional comments**
Risk 3 Failure to comply with legislative and regulatory requirements. If the Trust is not compliant with legislation and does not adhere to relevant national frameworks, including embedding the findings from the Well-led developmental review, there is a risk to patient safety, governance, and performance which could impact on staff and patient safety.	16 (extreme)	Reasonable	
Risk 6 Failure to effectively engage staff and leaders as well as to support their health and well-being in the current context: If the Trust is unable to effectively engage and motivate all staff including leaders through impactful health and well-being interventions, a focus on inclusion, excellent leadership development and support in the current challenging context, then the impact will be a reduction in the overall quality of care and staff wellbeing and a possible misalignment with the key objectives of the Trust.	12 (high)	Reasonable	Reasonable assurance overall but impact of contract management in relation to Occupational Health to be reviewed in April 26.

Author:	Helen Robinson/Rachel Booth
Role:	Company Secretary/Committee Chair
Date:	18/03/26

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 14
Title of report:	Freedom To Speak Up Annual Report
Meeting:	LCH Board Meeting
Date:	27 March 2026

Presented by:	John Walsh - Freedom to Speak Up Guardian
Prepared by:	John Walsh - Freedom to Speak Up Guardian

Purpose of the report:		
This report provides: the Board with an annual report on Freedom to Speak Up Guardian (FTSUG) work in the trust from 1 April 2025 to 26 March 2026.	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:

There were 255 concerns overall to the FTSUG and the Speaking Up Champions.

32 concerns were raised formally by LCH staff members concerning LCH or LCH services through the Freedom to Speak Up Guardian (FTSUG). 213 concerns were informally discussed or resolved via the FTSUG. The Speaking Up Champions had ten concerns.

The Staff Survey results for FTSU for 2024 – 25 are positive. 72% of staff said they had confidence to raise concerns. For the question about staff feeling secure to raise concerns about unsafe clinical practice we had a score of 82.6%. These are higher scores than the national average we have so far in our data group.

Previously considered by:	People and Culture Committee March 17 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	X

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

Recommendation(s)	The board is recommended to note the report and continue to enable the embedding of this work across the trust.

List of Appendices:	

FREEDOM TO SPEAK UP GUARDIAN ANNUAL REPORT

1 Executive Summary

This report provides the board with an annual report on Freedom to Speak Up Guardian (FTSUG) work in the trust from 1 April 2025 to 26 March 2026.

There were 255 concerns overall raised with the FTSUG and the speaking up champions.

32 concerns were raised formally by Leeds Community Healthcare NHS Trust (LCH) staff members concerning LCH or LCH services through the Freedom to Speak Up Guardian (FTSUG). 213 concerns were informally discussed or resolved via the FTSUG. The Speaking Up Champions had 10 concerns.

The Staff Survey results for FTSU for 2024 – 25 are positive. 72% of staff said they had confidence to raise concerns. For the question about staff feeling secure to raise concerns about unsafe clinical practice we had a score of 82.6%. These are higher scores than the national average we have so far in our data group.

2 The Work

The FTSUG work receives strong ongoing support from the Chief Executive, the executive and non-executive directors, the Chair, the Non-Executive Director with responsibility for speaking up work, the staff networks and the wider trust. A clear form of work has been established and operates well.

Work with the Race Equality Network, the Disability, Neurodiversity and Long-Term Condition Network and the Pride Network is ongoing. Career development work is offered to any staff member from the Global Majority who contacts the FTSUG. This is a plan around their career development linking the staff to support mechanisms in the wider organisation such as mentoring, coaching, interview support and leadership courses. This career development offer now extends to staff who have a health condition. The FTSUG attends the New Starters Forum with the Chief Executive and Director of People to hear and support those new to the trust.

The FTSUG attends the Clinical Students Forum, the Medical and Dental Engagement meeting and the Preceptorship events. Work alongside LCH Safeguarding, HR and Security on Sexual Safety is developing. The FTSUG has been involved in the Quality and Value Programme work in the trust. This has included working with teams and leaders delivering this programme and attending the one and three- day workshops. The FTSUG has been involved in the engagement sessions for the Leadership Restructure work at the trust. The FTSUG attends the Human Factors Meeting with the Director of People, Staffside, the Associate Director of People Solutions, the Associate Director of Strategy, Change and Improvement and the Head of HR to triangulate information about staff experiences of change work in the organisation.

The FTSUG attends the Clinical Concerns quarterly meeting with the Executive Directors of Nursing, Operations and the Medical Director to focus on clinical issues

arising from concerns. The FTSUG attends the meeting with the Executive Director of Operations, Director of People and the Head of HR to look at themes from workforce concerns. This looks at themes from informal and formal concerns and can be escalated where necessary to the board. These meetings are working well and a good source of triangulation and sharing learning.

The FTSUG works at local, regional, and national levels. The local work at LCH continues to develop and evolve. The learning and outcomes include work linking to the WRES, initiatives around neurodiversity, leadership development, staff health and wellbeing and organisational processes. The FTSUG works regionally through the Regional Freedom to Speak Up Network for Yorkshire and the Humber and nationally with the National Guardian Office and NHS England in developing speaking up in the wider health and care system.

Work extending our speaking up champions has been successful and we now have thirteen speaking up champions. We had a meeting of the new group in January with our anti-fraud specialist as guest speaker.

FTSUG work across the Leeds system is ongoing. We now have a Leeds Guardian System Group with FTSUG's from LCH, Leeds City Council, Leeds and York Partnership NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and the chair of the Regional Speaking Up Network to use a systems approach to co-learning and shaping our work. We are also meeting third sector colleagues around supporting speaking up mechanisms in the third sector.

Two peer reviews have been requested by NHS organisations. Both have been completed. There is also a request for a learning review from another NHS provider organisation. Presenting on the LCH speaking up work has taken place externally including working with NHS England on their national webinar on speaking up in General Practice, the LCH Clinical Conference and at Leeds Beckett University with post registered nurses and AHPs

3 Impact

Below is the basic data around concerns raised between 1 April 2025 and 26 March 2026.

The FTSUG received the following concerns formally raised about LCH services.

Adult Business Unit - 3
Children and Families Business Unit - 3
Corporate Services - 9
Specialist Business Unit - 14

Three concerns were raised formally about the trust itself. There were 32 formal concerns overall. Eight of these concerns related to health conditions. There were five concerns from members of the global majority. Four related to race, culture and religion.

The themes of the overall formal concerns included patient care, team behaviours, team culture, leadership, service changes, support around disabilities.

213 concerns were informally discussed or resolved through the FTSUG work. There were 41 informal concerns regarding health and neurodiversity. There were 36 informal concerns from staff from the Global Majority and out of these three concerned races, culture or faith. 10 issues were raised with the Speaking Up Champions.

This brings the overall concerns raised to 255 for the FTSUG and champions. There has been an increase in overall concerns (from 170 in the last annual report to 255 in this report). The champions have an increase from three to 10 concerns. Formal concerns have declined since the last annual report from 41 to 32 and informal concerns have increased from 125 to 213.

There has been an increase in staff from the last staff survey from the Global Majority raising concerns. There is a decrease in staff raising health issues.

The usual form of referral based on formal evaluations to the FTSUG service is word of mouth / advice of colleagues. 70.97% of new referrals come from this source. Informal evaluations agree with this. The second source of referrals in formal evaluations is our intranet and the screen saver we use.

We have seen an increase in staff reporting negative impact from speaking up and raising concerns. Most of these are not via the FTSUG route and it is a small number. Work supporting these colleagues and looking at the issues is underway.

We have undertaken learning around the service. Some of the learning for all involved is ensuring a trauma informed approach in all parts of a process, focus on a person's health conditions and how investigations might impact them, clarity around respective roles and responsibilities of all involved, clear communication on policies and procedures.

The assurances given to the organisation with the role are threefold – national engagement, organisational spread, and local comparison. We are reporting quarterly to and work positively with the National Guardian Office. The FTSUG is meeting staff from across all business units of the trust and at different roles and levels. In terms of local comparison with local NHS trusts, we evaluate well in terms of staff who speak up.

- **Equity**

The FTSUG work includes work on staff with protected characteristics. The FTSUG work enables these voices and needs to be heard in the organisation. The FTSUG work also reflects issues of patient care.

4 Next steps

To focus on the Quality and Value Programme and the Leadership Restructure work.

To share the work of the trust in the wider health and care system.

To work with the FTSUG at LYPFT to create the best model for the new organisation.

To continue to focus on staff with protected characteristics in the trust to see how speaking up can support these staff when needed.

5 Recommendations

The Board is recommended to:

Accept the report and continue its support to embed our speaking up work.

John Walsh
Freedom To Speak Up Guardian
4 March 2026

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 15
Title of report:	2025 National Staff Survey results
Meeting:	Public Board
Date:	27th March 2026

Presented by:	Jenny Allen Director of People
Prepared by:	Catherine Hall, Associate Director, People Solutions

Purpose of the report:		
This report details how we performed in the 2025 National Staff Survey compared to our results in 2024, and with our comparator group data following results being published on12th March 2026.	Approval	
	Discussion	X
	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:

- Whilst there was an expectation of a decline in scores given the challenging context, we are encouraged to see that in fact we have maintained our 2024 scores across all seven People Promise themes, with no significant declines in score.
- Our scores, when compared with our Community Trust comparator group (the highest scoring benchmark group in the NHS), are average across all People Promise Themes, which is an improvement as our 2024 scores were slightly below average in most themes. Locally we remain the highest performer of the Leeds NHS Trusts, both in terms of results and response rate.
- To strengthen our organisational response, we have introduced a new Trust-wide approach to ensure clear, consistent, and accountable Staff Survey action plans across all services. In addition, the NOF Staff Engagement Project is using this year's survey results to further refine and target its interventions, ensuring they directly address the areas of greatest need.

Key focus areas:

- **Staff Engagement**
  Staff engagement is stable at 6.92, with small declines in involvement questions, highlighting the known need to strengthen staff voice and co-design.
- **We Are Safe and Healthy**
  This theme remains challenging, with burnout and health and safety climate among the lowest scoring areas, reinforcing the need for targeted wellbeing and workload interventions.

Previously considered by:	Senior Leadership Team (SLT) Private Board (5th February) People and Culture Committee (17th March)
Outcome of previous discussion/s:	Agreed approach to dissemination of results and intention planning with Business Unit Leaders

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	
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?	WRES and WDES data
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	• Note the release of the 2025 Staff Survey results and national comparator data • Consideration of the initial headlines from the Workforce Race Equality Standard data and Workforce Disability Equality Standard data to be further developed for People and Culture Committee on 8th April and Board Workshop on 23rd April

List of Appendices:	Staff Survey Infographic WRES and WDES data tables

2025 National Staff Survey results

1 Introduction

The 2025 National Staff Survey opened to our staff on 6th October and closed on 28th November 2024. We retained our provider from 2024; IQVIA.

We have received our overall organisational level results and People Promise summary. The People Promise summary provides us with a score out of ten across the seven People Promise themes, along with staff engagement and staff morale scores.

We have also received initial heatmaps by business unit, service and team mapped against our overall organisational results and a basic comparison of our results by question, all our comparable to our 2024 results.

On March 12th further data was released (previously embargoed) and this report contains analysis with our comparator group of community trusts nationally and how we compare locally.

Our results are benchmarked against 14 community trusts in England and compared against the national average scores. Traditionally, the community trust comparator group is one of the highest scoring groups across the whole NHS.

2 2025 Staff Survey Response Rate

The response rate for 2025 was 55%, with 1,789 members of staff completing the survey. This is slightly lower than last year's 60% response rate. We have the highest response rate locally (LYPFT 45%; LTHT 47%)

Comparing response rates over the last few years:

- 2025 – 55% (-5%)
- 2024 – 60% (-1.7%)
- 2023 – 61.7% (+3.4%)
- 2022 – 58.3% (+6.8%)
- 2021 – 51.5%

Bank Staff Survey, for the second year, we invited bank staff to take part in a separate survey. The 2025 response rate was 21.3%, down from 27.5% in 2024.

3. People Promise Themes

In our 'Initial Headlines' paper, shared with the private board in February, we highlighted maintaining our scores in all seven People Promise Themes as determined by our provider IQVIA's tolerance level of >0.3. However, the breakdown

reports that we have since received from the NHS Survey Coordination Centre, apply a narrower tolerance level for determining statistical significance of >0.1.

In the context of another challenging year, our 2025 results showed no significant change from 2024, which demonstrates stability. Now we are able to see our comparator group results we have improved our position slightly from last year and have average scores across all seven themes (we were below the comparator average on 5 of the themes in 2024).

- **Highest scoring theme:** We are compassionate and inclusive - 7.70 a slight increase from last year
- **Lowest scoring theme:** We are always learning - 5.92, a slight increase from 5.84 in 2024, however this is the average score in our comparator group.

,
The theme below of statistical significance is Staff Engagement, whilst we upheld our score from 2024, in our comparator group we have scored 6.92 against an average of 7.09. Staff Engagement is calculated using questions on the themes of motivation, involvement and advocacy, our advocacy sub score is the area of most significance- 6.95 compared with the average of 7.26 (questions about recommending our organisation as a place to work or receive care). This analysis will help inform our actions to improve our staff engagement score.

In terms of the National Oversight Framework our new staff engagement score of 6.92 has ranked LCH as 38/61 trusts, an improvement from a position of 46/61 trusts from our 2024 score. This reflects a national decline in overall staff survey performance, in the context of which we can be proud we have mostly maintained scores across the People Promise themes.

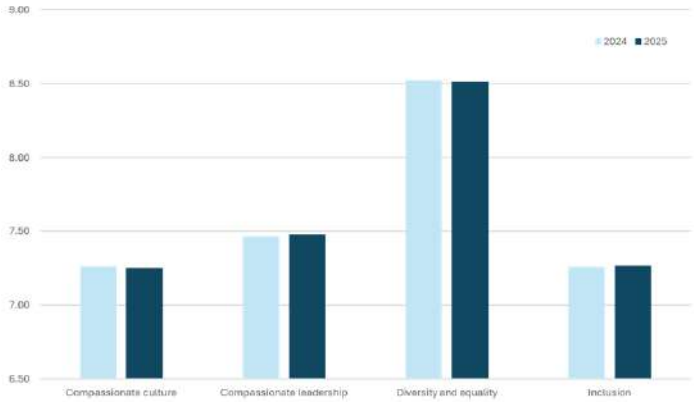
The table below shows our scores over the last four surveys and the comparator average for this year.

People Promise Theme	2021	2022	2023	2024	2025	Comparator Group average
We are compassionate and inclusive	7.57	7.63	7.74	7.63	**7.70**	**7.70**
We are recognised and rewarded	6.36	6.32	6.50	6.40	**6.39**	**6.36**
We each have a voice that counts	7.06	7.07	7.19	7.03	**6.98**	**6.98**
We are safe and healthy	5.94	6.11	6.30	6.27	**6.34**	**6.41**
We are always learning	5.62	5.77	6.03	5.84	**5.92**	**5.92**
We work flexibly	6.47	6.69	6.96	6.89	**6.89**	**6.89**
We are a team	6.87	6.96	7.10	7.09	**7.12**	**7.12**
Staff Engagement	6.98	7.05	7.19	6.95	**6.92**	**7.09**
Staff Morale	5.8	5.86	6.13	6.00	**6.03**	**6.09**

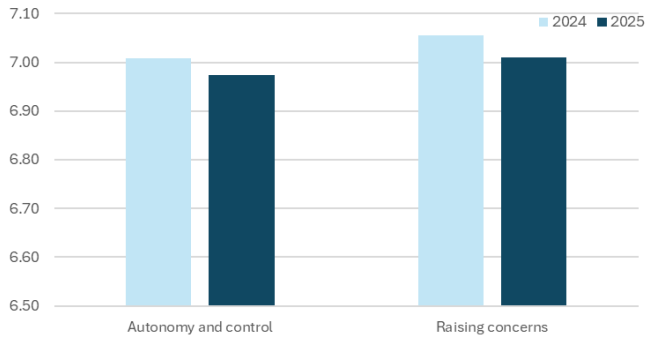
Initial analysis

When analysing individual questions, significant change is considered any change above or below 3% against our 2024 results. Applying the ±3 percentage points threshold to positive question scores, the overall picture is one of stability, with very few significant movements. Out of 108 questions, 102 maintained, 3 improved, and 3 declined.

Here's the breakdown by theme:

<table>
<tr><th>Theme</th><th>Sub Score</th></tr>
<tr><td> 
We are compassionate and inclusive</td><td> 

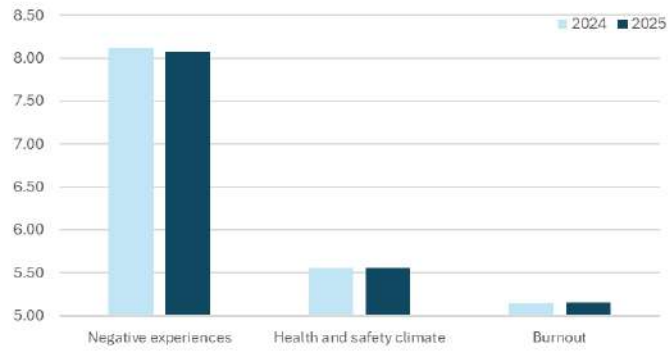
<table>
<tr><td>2024 results</td><td>7.26</td><td>7.47</td><td>8.52</td><td>7.26</td></tr>
<tr><td>2025 results</td><td>7.25</td><td>7.48</td><td>8.51</td><td>7.27</td></tr>
<tr><td>Comparison</td><td>-0.01</td><td>0.01</td><td>-0.01</td><td>0.01</td></tr>
</table>

All 17 questions maintained their scores compared to 2024. This theme continues to be a strength, with consistently high positive responses on respect for individual differences and compassionate leadership. No significant improvements or declines were recorded.</td></tr>
<tr><td> 
We each have a voice that counts</td><td> 

<table>
<tr><td>2024 results</td><td>7.01</td><td>7.06</td></tr>
<tr><td>2025 results</td><td>6.97</td><td>7.01</td></tr>
<tr><td>Comparison</td><td>-0.04</td><td>-0.05</td></tr>
</table>

All 5 questions maintained. While recognition and feeling valued remain steady, this theme continues to score lower than others overall, indicating an ongoing opportunity for improvement.</td></tr>
</table>

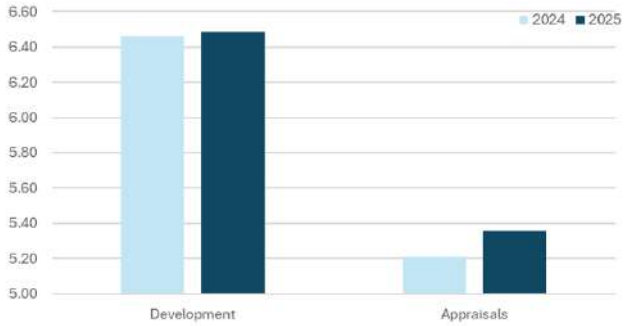
We are safe and healthy



2024 results	8.12	5.55	5.14
2025 results	8.07	5.56	5.16
Comparison	-0.05	0.01	0.02

This theme had 1 question decline and 22 maintained. The decline relates to health and safety climate, aligning with wider concerns about workload and wellbeing. Burnout-related questions remain among the lowest scoring, which relates to stress and pressure staff are experiencing.

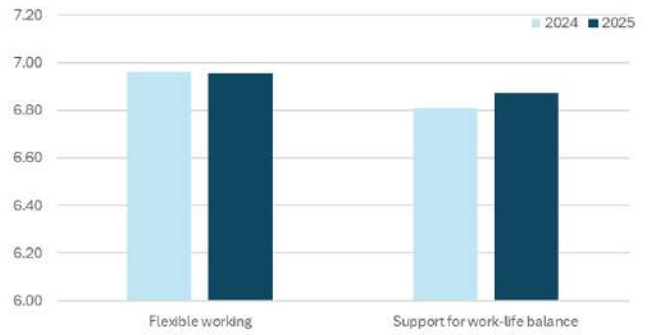
We are always learning



2024 results	6.46	5.21
2025 results	6.48	5.35
Comparison	0.02	0.14

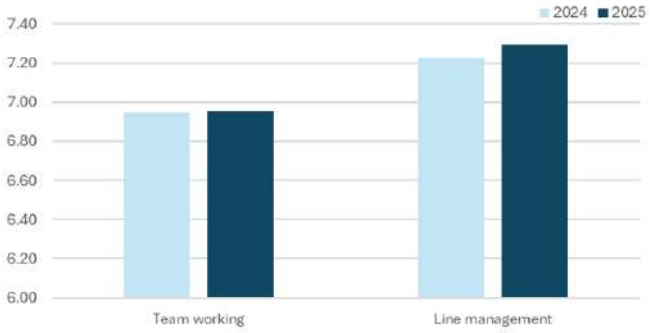
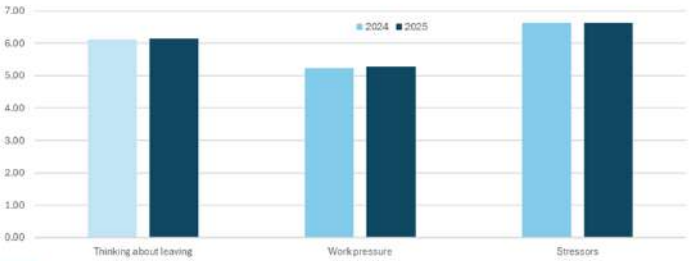
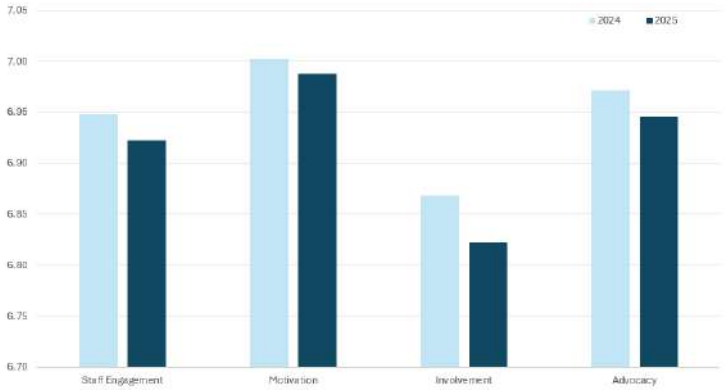
1 question declined, 7 maintained. The decline was in development items, which continue to be a challenge. Development opportunities remain steady but are not improving, highlighting the need for renewed focus on learning and growth.

We work flexibly



2024 results	6.96	6.81
2025 results	6.96	6.87
Comparison	0.00	-0.06

All 4 questions maintained. Flexible working remains stable, with positive scores on manager openness and work-life balance, but no significant gains.

 We are a team	 2024 results: 6.95, 7.28 2025 results: 6.95, 7.29 Comparison: 0.00, 0.07 All 12 questions maintained. Team working and line management indicators remain strong and consistent, with no significant changes.
 Morale	 2024 results: 6.12, 5.23, 6.63 2025 results: 6.15, 5.30, 6.63 Comparison: 0.03, 0.07, 0.00 Morale has improved slightly to 6.03 from 6.00 in 2024, driven by small gains in work pressure and retention indicators.
 Staff Engagement	 2024 results: 6.95, 7.00, 6.87, 6.97 2025 results: 6.92, 6.99, 6.82, 6.95 Comparison: -0.03, -0.01, -0.05, -0.03 Staff engagement is stable at 6.92, a slight decrease from 6.95 in 2024, with small, non-significant declines across motivation, involvement, and advocacy.

Overall

The analysis confirms that most areas are stable, with isolated declines (which are not classed as significant) in safe and healthy and always learning themes. These align with organisational priorities for wellbeing and development. Improvements were minimal and dispersed, reinforcing the need for focused action plans in 2026.

4. Workforce Race Equality Standard and Workforce Disability Equality Standard Headlines (See Appendix 2 for data)

WRES Headline Summary (Indicators 5–8)

The 2025 WRES data shows a persistent pattern of racial inequality across safety, culture, progression and leadership behaviours. Although there has been gradual improvement over time, BME staff continue to experience disproportionately higher levels of harm, lower confidence in fairness, and reduced trust in leadership compared to White colleagues. Abuse from patients and colleagues has declined and gaps have narrowed, but not closed, and BME staff still report significantly lower confidence in equal opportunities and are almost three times more likely to experience discrimination from managers or colleagues. Overall, the data shows that progress remains slow and uneven, highlighting the need for a more intentional, confident and culturally intelligent approach to leadership and everyday culture across LCHT.

WDES Headline Summary (Metrics 4–9)

Across the 2025 WDES indicators, Disabled staff continue to experience poorer workplace treatment, reduced inclusion and lower confidence than non-disabled colleagues, with disparities remaining consistent over several years. Disabled staff report higher levels of harassment and bullying from the public, managers and colleagues, fluctuating confidence in speaking up, lower belief in fair progression, higher pressure to work when unwell, and lower satisfaction that their work is valued. Experiences of reasonable adjustments remain steady but have not improved, and engagement scores show a long-standing gap. Overall, the data highlights a persistent, disproportionate risk for Disabled colleagues and signals the need for a more intentional, disability-focused approach to culture, adjustments, management capability and everyday inclusion

➢ 5 Impact

Against the backdrop of a challenging year, it was anticipated that our scores would decline. Whilst this does reflect in some specific areas, we have largely maintained our position from 2024..

We Are Safe and Healthy continues to be one of our most challenging themes. Although most questions maintained their scores, burnout and health and safety climate remain among the lowest performing areas, although we meet the average score for burnout in our comparator group.This is an NHS-wide issue (the overall, all- trust national burnout score is 4.98) and signals the importance of addressing workload pressures in our services, alongside LCH taking an organisational health approach as part of Staff Survey intention planning for 2026. In addition, the NOF Sickness Project will use these insights to help target interventions aimed at reducing sickness absence and improving overall staff wellbeing.

On a positive note, last year we saw significant improvements in feedback relating to flexible working and work-life balance following targeted work in this area. While there was no further increase this year, maintaining these scores is an achievement. We are also pleased to see that colleagues remain happy with their teams and managers, with high positive scores reflecting the kindness and compassion shown across the organisation. Our compassionate leadership scores are average or slightly higher than our comparator group in 2025, again something we can be proud of maintaining in the context of both operational pressure and significant change.

On the questions relating to raising concerns we have significantly higher than average scores in two out of the 4 questions when compared with other community trusts demonstrating a continued confidence of staff in feeling able to tell us when things go wrong and confidence that we will act on that information. Additionally our National Oversight Framework ranking of 9/61 trusts for Raising Concerns has been maintained.

6 Next steps

Leaders in the organisation have now received their team and service results via a newly developed Staff Survey Dashboard which enables the user to access their data easily.

We have moved into a new phase of action following the publication of the 2025 NHS Staff Survey results. Our focus is on embedding improvement and healthy team culture at every level of the organisation.

We have introduced a structured intention planning process where services and teams propose actions to improve or celebrate their scores. The areas we want to see improvement in are Staff Engagement, We are Safe and Healthy (to target improvement toward the National Oversight Framework scores) and the Equality and Diversity sub-score theme, as well as one additional People Promise theme of their choice. This approach will enable local ownership and accountability for improvement. Intention plans have been distributed to managers for completion with their teams by the end of March, to ensure rapid ‘you said we did’ actions.

The ongoing NOF Staff Engagement project will provide tailored support to teams and services that score below the organisational average, ensuring that interventions are focused where they are most needed. A number of services that have high sickness absence and low staff engagement scores have been identified for focused support, with a diagnostic tool being developed using the Organisational Health Index.

We are planning further analysis of our results, including a focus on WRES and WDES data to inform the content of our Board Workshop on 23rd April.

7 Recommendations

The Board is recommended to:
Note the release and content of the 2025 Staff Survey results.
Note and support the launch of Intention Planning for 2026, enabling services and teams to propose actions for improving or celebrating their scores in Staff

Engagement, We are safe and healthy, the Equality and Diversity sub-score theme and one additional theme of their choice.

Hannah Stankler
People Projects Manager

Updated 12th March 2026 by Catherine Hall, Associate Director People Solutions

2025 Staff Survey **Results**

Leeds Community Healthcare NHS Trust

HEADLINES

55% of substantive staff completed the survey

15% of bank colleagues also took part

6.92 out of **10** Staff Engagement Score

Comparison to last year: **6.95 out of 10**

6.03 out of **10** Staff Morale Score

Comparison to last year: **6.0 out of 10**

PEOPLE PROMISE THEMES

We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team
7.63 out of 10	**6.40** out of 10	**6.99** out of 10	**6.26** out of 10	**5.93** out of 10	**6.92** out of 10	**7.13** out of 10
Comparison to last year: **7.63**	Comparison to last year: **6.40**	Comparison to last year: **7.03**	Comparison to last year: **6.27**	Comparison to last year: **5.84**	Comparison to last year: **6.89**	Comparison to last year: **7.09**

AREAS TO CELEBRATE

92%

…of colleagues feel that the organisation encourages us to report errors, near misses or incidents.

90%

…of our workforce feel trusted to do their job.

88%

…of colleagues feel that their role makes a difference to patients/ service users.

83%

…of colleagues would feel secure raising concerns about unsafe clinical practice.

80%

…of staff feel the people they work with are understanding and kind to one another.

79%

…of colleagues feel their manager is interested in listening to them when they describe challenges they face.

79%

…of colleagues feel that the organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).

78%

…of colleagues feel that their manager takes a positive interest in their health and wellbeing.

AREAS TO CONSIDER

20%

…of colleagues never/ rarely feel worn out at the end of their working day/shift.

25%

…of colleagues feel an appraisal has helped them to improve how they do their job.

27%

…of colleagues never/ rarely feel they have unrealistic time pressures.

WANT TO KNOW MORE?

Check out the Staff Survey Hub on My LCH or speak to your line manager about local results and action plans.

WRES and WDES Metrics 2025

Workforce Race Equality Standard

WRES 5 – Harassment, Bullying or Abuse from Patients and the Public

WRES Indicator	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months *White staff percentage in brackets.	22.4% (25.7%)	21% (26.5%)	21% (24%)	23.8% (26.4%)	16.3% (23.9%)	17.7% (18.8%)	17.6% (18%)	18% (18.1%)

WRES 6 – Harassment, Bullying or Abuse from Colleagues

WRES Indicator	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months *White staff percentage in brackets	21.2% (16.7%)	24.1% (16.7%)	24.8% (16.4%)	19.3% (16%)	12.9% (12.8%)	15.2% (11.7%)	14% (12.1%)	14.3% (10.4%)

WRES 7 – Equal Opportunities for Career Progression or Promotion

WRES indicator	Metric description	2018	2019	2020	2021	2022	2023	2024	2025
7	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion (*white staff % in brackets)	41% (65.4%)	39.9% (64%)	40.5% (66.3%)	45.6% (65.9%)	49.8% (62.9%)	50.4% (66.7%)	50.5% (63.2%)	50.4% (60.2%)

WRES 8 – Discrimination from Manager or Team

WRES indicator	Metric description	2018	2019	2020	2021	2022	2023	2024	2025
8	Q17, In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team (*white staff % in brackets)	16.9% (3.9%)	17.9% 4.3%)	15.3% (4.3%)	13.7% (4.3%)	12.1% (4.2%)	11.3% (2.7%)	7.6% (3.9%)	9.4% (3.8%)

Workforce Disability Equality Standards

WDES Metric	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
4a(i)	Staff experiencing harassment, bullying or abuse from the public in the last 12 months *(Nondisabled staff scores in brackets)*	34% (22%)	31% (24%)	34% (22%)	34% (24%)	14% (9%)	25% (16%)	23% (17%)	23% (16%)
4a(ii)	Staff who have experienced harassment, bullying or abuse from managers in the past 12 months *(Nondisabled staff scores in brackets*	11% (7%)	12% (5%)	15% (7%)	12% (7%)	9% (5%)	10% (3%)	7% (4%)	9% (4%)
4a (iii)	Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months. *(Nondisabled staff scores in brackets)*	21% (11%)	19% (12%)	20% (11%)	20% (10%)	14% (9%)	14% (9%)	16% (8%)	14% (6%)
4a(iv)	Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months. *(Nondisabled staff scores in brackets)*	56% (56%)	55% (57%)	60% (60%)	49% (53%)	58% (59%)	54% (60%)	61% (57%)	63% (69%)

WDES 5

WDES Metric	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
5	Percentage of Disabled staff compared to nondisabled staff believing that the Trust provides equal opportunities for career progression or promotion *(Nondisabled staff scores in brackets)*	59% (65%)	57% (64%)	56% (65%)	58% (65%)	54% (64%)	63% (65%)	63% (55%)	54.8% (59.9%)

WDES 6

WDES Metric	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
6	Percentage of Disabled staff compared to nondisabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (presenteeism) *(Nondisabled staff scores in brackets)*	30% (20%)	22% (15%)	29% (17%)	26% (16%)	24% (13%)	19% (11%)	19% (14%)	24.1% (13.2%)

WDES 7

WDES Metric	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
7	Percentage of Disabled staff compared to nondisabled staff saying that they are satisfied with the extent to which the organisation values their work (Nondisabled staff scores in brackets)	44% (51%)	49% (60%)	50% (57%)	44% (53%)	45% (55%)	50% (57%)	54% (45%)	41.1% (54.3%)

WDES 8

WDES Metric	Metric description	NHS Staff Survey 2018	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
8	Percentage of staff with a long-lasting health condition or illness, saying that their employer has made adequate adjustment(s) to enable them to carry out their work	83%	79%	79%	81%	77.6%	78.4%	80.8%	80.5%

WDES Metric 9

WDES Indicator	Metric description	NHS Staff Survey 2019	NHS Staff Survey 2020	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023	NHS Staff Survey 2024	NHS Staff Survey 2025
9a	Staff engagement score (0-10)							
	The staff engagement score for Disabled staff, compared to nondisabled staff. (*Non-disabled staff score in brackets)*	6.8 (7.2)	6.8 (7.4)	6.8 (7.3)	6.6 (7.1)	6.7 (7.2)	6.9 (7.3)	6.6 (7.1)

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 16
Title of report:	Going Concern Consideration
Meeting:	**Trust Board**
Date:	**27 March 2026**

Presented by:	Andrea Osborne – Executive Director of Finance
Prepared by:	Annette Clough -Assistant Director of Finance Andrew Davies – Contract Manager (LYPFT)

Purpose of the report:		
In preparing the annual accounts those charged with governance are specifically required to consider whether the Trust is a going concern so that financial statements are prepared on that basis.	Approval	X
	Discussion	
	Assurance	

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:
• This report has been prepared to assist Audit Committee, and Board, with this consideration.

Previously considered by:	Audit Committee – 10.3.26
Outcome of previous discussion/s:	Agreed to recommend to Board that the accounts were to be prepared on a going concern basis

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

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

Recommendation(s)	Board are asked to approve the preparation of the 2025/26 annual accounts on a going concern basis.

List of Appendices:	

1.0 PURPOSE OF THIS REPORT

1.1 This report provides information to the Audit Committee and Board upon which the assessment of the concept of going concern can be made. The accounts to be approved by the Board will be prepared on a going concern basis subject to this assessment.

2.0 BACKGROUND

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

NHS trusts are considered to be going concerns unless there are plans to dissolve them without the transfer of the services to another entity. There are no plans to dissolve Leeds Community Healthcare in 2025/26 but a merger with Leeds York Partnership FT is in progress and expected to conclude in 2026/27. All current services will be transferred to the new entity and therefore the 2025/26 accounts should be on the basis of a going concern.

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

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

2.4 The financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the Trust **without** the transfer of the services to another entity, or has no realistic alternative but to do so. Therefore whilst the Trust Board have approved the strategic outline case supporting the recommendation to dissolve the Trust, continuation of service provision in the future remains anticipated and therefore as a public sector body is considered to be a going concern.

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

3.0 CONTENT

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

3.2 The Trust's financial monitoring throughout 2025/26 provides evidence that financial duties and targets will be met. The Trust is forecasting to achieve a £0.9m surplus agreed with WYICB by the end of March. Historically, the Trust has achieved all its regulatory financial duties.

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

3.3 The Trust expects to have a detailed income and expenditure revenue budget for the year approved by the Board by 31st March 2026. A source and application capital plan will also be presented to the Board for approval.

3.4 The Trust's liquidity remains very strong with circa £48m forecast to be in the bank at year-end; £49.8m was held at the end of February 2026. The Trust is confident it has sufficient cash resources to meet all its liabilities in 2026/27.

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

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

3.7 The planning and contracting processes for 2026/27 have commenced and the Trust is participating fully in the revenue and capital planning for 2026/27. NHS contracts are due to be signed with Commissioners by the end of March 2026. Whilst we remain in a recurrent financially challenged system, and face a number of risks and uncertainties, there is clear evidence of continued provision of services being planned by Commissioners.

3.8 The Trust has entered into a collaborative contract to provide dental services with Bradford District Care Trust as lead provider and Mid Yorks and Locala for a seven year contract with the option to extend for another three years. The service delivery commenced in April 2025.

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

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

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

4 CONCLUSION

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

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

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

5 RECOMMENDATIONS

5.1 Board are recommended to approves the preparation of the 2025/26 annual accounts on a going concern basis.

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 17
Title of report:	**Significant Risks and Risk Assurance Report**
Meeting:	Trust Board
Date:	27 March 2026

Presented by:	Dr Sara Munro, Interim Chief Executive Officer
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 9 March 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 121 open risks on the risk register, 18 of which have been managed to the target level. • Two risks score 15 (extreme) and 18 risks score 12 (high) • There are 3 risks that score 12 or above that have been the same score for more than 12 months (static). • Patient harm is the most common risk theme, followed by demand exceeding capacity and compliance with standards and legislation.

Previously considered by:	Risk Management Group 19 March 2026 Quality Committee 24 March 2026 Business Committee 25 March 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 (February 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 (February)
Total Open Risks	121	117
Risks Scoring 15 or above	2	2
New Risks	12	22
Closed Risks	8	11
Risk Score Increasing	1	0
Risk Score Decreasing	8	11

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**	**17**	**Cautious (4 – 6)**
There are currently 600 waiters on the list. Work has commenced to transfer adults and children who are on a WY provider waiting list awaiting diagnosis (single or dual) and fall into waiting time tranches with those waiting the longest being prioritised. In the 1st instance with new provider availability identified 20 school age children to contact and transfer to West Oaks Clinic. As provider availability is realised will be looking to transfer more child waiters in this way and hence the waiting list will continue to reduce. Also waiting list validation to continue to further identify who has already had an assessment and can therefore be removed from the waiting list. (update 6/2/26)				
1383: Mind Mate Neurodevelopmental Referral Triage Waiting List	**Operational**	**15**	**5**	**Cautious (4 – 6)**
The ND backlog work undertaken by Northpoint is progressing as planned and as of February 2026, the following was reported: 966 total opt-ins for clinical triage. The waiting list was at approximately 2500 prior to the backlog work commencing. 144 completed triage who met clinical suitability and forwarded to Right to Choose providers. Only 5% of those triaged do not meet clinical suitability to date. 897 exported from Mosaic (current EPR). 1560 children/referrals remain on Mosaic. 801 inputted onto the Northpoint Laptus patient management system Opt-out letters are to be sent to those who did not opt-in to inform of discharge next steps unless indicate otherwise. (update 03.03.2026)				

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 shows the 12-month trend for the risks currently scoring 12 and 15+

Ref	Title	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
1179	Impact/Management of Neurodevelopmental Assessment Waiting List	15 →	15 →	15 →	15 →	15 →	15 →	15 →	15 →	15 →	15 →	15 →	15 →
1383	Mind Mate Neurodevelopmental Referral Triage Waiting List						15 →	15 →	15 →	15 →	15 →	15 →	15 →
877	Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
954	Diabetes Service waiting times	9 →	12 ↑	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
957	Increase in demand in the adult speech and language therapy service.	12 ↑	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
1125	National supply issues with enteral feeding supplies by Nutricia	9 →	12 ↑	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
1221	Likelihood of a cyber attack	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
1313	Climate Adaptability Resilience Planning		12	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
1319	The number and long waits of high priority patients on the ABU Therapy waiting lists				12	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
1327	Finance Team Capacity & Capabilities			9	9 →	9 →	9 →	12 ↑	12 →	12 →	12 →	12 →	12 →

Ref	Title	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
1356	Change in Patient Safety Profile							12	12 →	12 →	12 →	12 →	12 →
1363	Capacity within the Patient Safety Team							8	8 →	8 →	8 →	12 ↑	12 →
1366	Manual STI test requests risk patient safety and increase operational burden							12	12 →	12 →	12 →	12 →	12 →
1379	Civil unrest / protests, staff safety							12	12 →	12 →	12 →	12 →	12 →
1384	Mind Mate Mental Health Referral Triage Waiting List							12	12 →	12 →	12 →	12 →	12 →
1373	Complaint actions								12 →	12 →	12 →	12 →	12 →
1391	Faster Data Flow will not accurately reflect waiting times								12 →	12 →	12 →	12 →	12 →
1419	Primary care reduced staffing levels in secure estates										12 →	12 →	12 →
1426	Staff shortages across police custody suites										12 →	12 →	12 →
1437	Failure to comply with ionising radiation requirements										12 →	12 →	12 →

3.3 Since the previous report in February the number of risks scoring 12 has reduced from 20 to 18, three risks scoring 12 have reduced to below 12 and one risk has increased to 12.

3.4 In the previous report two risks scoring 12 and above had been at the same score for more than 12 months (static), the number of static risks has increased to three (Risks 877, 1179 and 1221).

When risk scores have been static for over 12 months, the detail is escalated to TLT and the Board Committees. Static risks are also a standing agenda item at the Risk Management Group (RMG). A risk that remains static over several months, may be an indication that further work is needed to control the risk. Highlighting risks that have been static in score focusses discussion on whether more can be done to manage a static risk, or whether the risk should be accepted at the level it has reached.

4. Risk profile – all risks

4.1 The total number of risks on the risk register is currently 121. Of these there are 55 clinical risks and 66 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	1	6	8	0	0	15
3 - Moderate	3	21	33	10	1	68
2 - Minor	0	10	15	4	1	30
1 - Negligible	1	2	1	1	0	5
Total	5	41	58	15	2	121

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-seven 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	
Four 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, 1307, 1308, 1319, 1335, 1353, 1354, 1356, 1359, 1361, 1363, 1365, 1366, 1369, 1373, 1392, 1393, 1395, 1396, 1405, 1419, 1426, 1437, 1374, 1387, 1414, 1421, 1453
[2] Risks: 772, 954, 957, 994, 1015, 1098, 1179, 1198, 1311, 1383. 1384, 1433
[3] Risks: 902, 1206, 1221, 1242, 1313, 1379, 1391, 1400, 1422, 1428, 1434
[4] Risks: 1227, 1228, 1412, 1413

Theme Five: Transformation - Capacity	
Two 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 21 May 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: 9 March 2026

[5] Risks: 1217, 1327

Leeds Community Healthcare NHS Trust

Agenda item:	2025-26 (18i)
Title of report:	Board Assurance Framework Quarterly Update
Meeting:	Trust Board
Date:	27 March 2026

Presented by:	Dr Sara Munro, Interim Chief Executive Officer
Prepared by:	Helen Robinson, Company Secretary

Purpose of the report:

It is a requirement for all Trust Boards to ensure there is an effective process in place to identify, understand, address, and monitor risks. This includes the requirement to have a Board Assurance Framework (BAF) that sets out the risks to the strategic plan by bringing together in a single place all the relevant information on the risks to the Board being able to deliver the organisation's objectives.

As previously noted, following the agreement of the Trust's strategic objectives and priorities for 2025/26, the BAF is reviewed on a quarterly basis and this report aims to share the outcome with the Board. Any amends made during the March review remain in red font in the Appendix.

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 March review remain in red font in the Appendix.
- The score for Strategic Risk 3 (Failure to comply with legislative and regulatory requirements) has increased to 16 during the Q4 review.
- The score for Strategic Risk 4 (Failure to deliver financial sustainability) has increased to 16 during the Q4 review.
- The explanation for the above changes in scores can be found in the Appendix in the summary table on page 3 and in the detail for those Strategic Risks.
- The outputs of all committees overseeing strategic risks during Q4 resulted in reasonable assurance, but with comments added where individual items led to limited assurance.

Previously considered by:	
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_Mar_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 March 2026, the Executive Directors have undertaken the fourth 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 2026 the Board reviewed it's risk appetite at a Board development session, and the appropriate amendments were added into the BAF document.

2.3 During January to March 2025 the Audit, Quality, Business and People & Culture 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.

2.4 The Board is reminded that the BAF is presented here for assurance on its completeness as of March 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 subsequently be reviewed on a quarterly basis and the outcome shared with the Board in May, September, January and March.

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

18 March 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 13 March 2026

Ref	Strategic Risk	Lead Director	Current Score (Mar 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 Q4, the Trust continues to face significant pressure in balancing financial requirements with the need to maintain and improve clinical quality. The impact of the Q&V transformation programme has not yet been fully realised, and forthcoming trust integration activity is expected to introduce further change. Although quality oversight processes are embedded and providing assurance on trends and themes, there is currently insufficient evidence of sustained improvement to justify a reduction in the risk score. There is further risk due to the change in executive leadership and the clinical governance team being in OPEL 3 due to lack of capacity. This is being mitigated through the appointment of fixed term Executive Director of Nursing and Allied Health Professional and Quality and Deputy Director of Quality Governance. The score therefore remains unchanged.
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	12	12	At the end of quarter 4 the risk remains at target (12). Continue to see good progress on the waiting list initiatives though the NOF segmentation remains unchanged.
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	~~12~~ 16	6	At the end of quarter 4 the risk has increased from 12 to 16. Whilst we have been rated as amber green on our board provider capability assessment by NHSE which is positive and we are making progress in improving some aspects of performance in our NOF metrics we have seen a deterioration in our sickness rate (NOF metric) and the board is not assured that we can demonstrate compliance with the CQC fundamental standards following a board workshop in January. we have identified gaps in our governance, oversight and assurance in relation to CQC standards requiring action to address. We have received a regulatory breach notice for Wetherby YOI. The Director of Nursing and AHPs left the trust on the 28th February.
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	12	Following the final review of 2025/26 the risk has reduced from 16 to 12 because of having an agreed medium term financial plan in place, providing the conditions to enter the new year with robust plans to deliver financial balance. During the year an Internal Audit of Financial Sustainability has provided Significant Assurance. Operational risk 1329: Failure to deliver financial balance has been closed as the 2025/26 financial position is on track to deliver to forecast. A new operational risk will be opened in relation to delivery of the 2026/27 financial plan.
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 quarter 4 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	Following the final review of 2025/26. The sickness and engagement projects are well underway and linked by the overall theme of organisational health. An evidentially based approach to undertaking this work has been developed and tested with a specific service and is now being rolled out to other services based on the data and evidence in terms of sickness, engagement and other well led measures – this enables us to target services as needed. Our latest Staff Survey results have held from last year against all the People Promise themes which in the current changing climate with Q&V work continuing as well as the announcements about the Trust Integration Programme is to be celebrated. Given however, the degree and extent of change and continued high sickness rates (although reduced in February) the risk score remains at 12.
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 quarter 4 there is no change to the risk score. 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 2025/26, there is no change to the risk score due to ongoing lack of clarity about the implications of the changes to the ICB. They have consulted on the proposed new structure, and we have provided feedback from the trust and through the Leeds provider partnership highlighting risks and queries in the proposed place by structure and what that means in terms of delegation and accountability. We remain actively involved in shaping the Leeds provider partnership and joint committee and the CEO will be involved in the recruitment to the new place-based structures for the ICB.

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**				✓		Jan Quality Committee - Reasonable overall but: • Medical devices – limited assurance received • Clinical training systems recording – limited assurance received
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**				✓		Jan 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	4	**16**	Increased from 12 to 16			✓		Jan Quality Committee - Reasonable overall but: • Medical devices – limited assurance received
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**				✓		Jan Business Committee: Reasonable assurance via a robust discussion held on the Medium-Term Plan Feb Business Committee: Reasonable assurance but noted the risk in the Estates Strategy re: asset register
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**				✓		March Audit Committee: Reasonable assurance but concerns raised regarding Internal Audit EPRR report
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**				✓		March People & Culture Committee: Reasonable assurance overall but impact of contract management in relation to Occupational Health to be reviewed in April 26

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**				✓		

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.

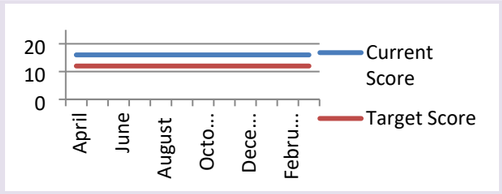
Strategic Objective: Work with communities to deliver personalised care / To embed equity in all that we do

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: 27/02/2026

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:
At the end of Q4, the Trust continues to face significant pressure in balancing financial requirements with the need to maintain and improve clinical quality. The impact of the Q&V transformation programme has not yet been fully realised, and forthcoming trust integration activity is expected to introduce further change. Although quality oversight processes are embedded and providing assurance on trends and themes, there is currently insufficient evidence of sustained improvement to justify a reduction in the risk score. There is further risk due to the change in executive leadership and the clinical governance team being in OPEL 3 due to lack of capacity. This is being mitigated through the appointment of fixed term Executive Director of Nursing and Allied Health Professional and Quality and Deputy Director of Quality Governance. The score therefore remains unchanged.

Rationale for Target Score (including any constraints to reaching risk appetite within the next 12 months):
The elevated risk score reflects the Trust position of the Q&V programme, where the full scope and impact of changes to patient pathways are not yet fully understood, in addition to work towards the Trust Integration Programme. Until greater clarity is achieved, uncertainty remains regarding the potential effects on care quality. As these transformations progress and mitigation strategies take effect, the risk is expected to decrease. However, due to the timescales, 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 2027, 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
- Corporate redesign steering group
- Q&V Board
- ~~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 and clinical governance workstreams to QAIG
- Quarterly Patient Safety Summits
- Internal audit schedule

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: • Appointment of fixed term Executive Director of Nursing and Allied Health Professional and Quality and Deputy Director of Quality Governance	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 and Executive Director of Operations	July 2026

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)	• Performance Brief (safe, caring effective) • Mortality report • QAIG assurance reports and minutes • Risk report	• Internal audit report • PLACE inspection report • Patient experience report: complaints, concerns, and feedback • Ofsted / HMIP / CQC / SEND inspections

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

Action	Owner	Due by
Strengthen the assurance framework by implementing systematic deep dive reviews and benchmarking exercises. This will ensure governance processes are not only compliant with regulators but are fully aligned and consistent across LCH and LYPFT ahead of the acquisition.	Executive Director of Nursing and AHP's	30 September 2026

• Patient safety (including patient safety incident investigations) update report • Safeguarding annual report • Learning and development report • IPC Annual report • Quality Account • PSIRP (Y2 org plan) • ~~Organisation Strategy Update~~	• Safeguarding Committee minutes and AAA report to Quality Committee • IPC Committee minutes and AAA report to Quality Committee		

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)
954: Diabetes Service waiting times (12)
957: Increase in demand in the adult speech and language therapy service (12)
1384: Mind Mate Mental Health Referral Triage Waiting List (12)
1373: Complaint actions (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: Change in Patient Safety Profile (12)
1319: The number and long waits of high priority patients on the ABU Therapy waiting lists (12)
1341: Implementation of digital letters – PHINS (12)
1426: Staff shortages across police custody suites (12)
1437: Failure to comply with ionising radiation requirements (12)
1419: Primary care reduced staffing levels - Wetherby YOI, Adel Beck and Aldine House Staffing levels below safer staffing numbers (12)
1444: Clinical governance vacancies/absences and increased 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.

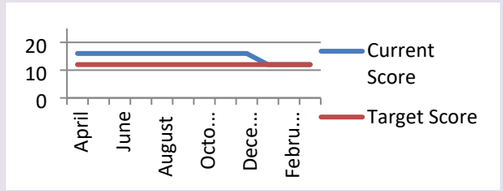
Strategic Objective: Work with communities to deliver personalised care / To embed equity in all that we do

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: 12/3/26

Risk Rating
(likelihood x consequence)
Current score:
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 quarter 4 the risk remains at target (12). Continue to see good progress on the waiting list initiatives though the NOF segmentation remains unchanged.

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	Dec 2026
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. The internal audit report has given limited assurance on waiting list management with a number of areas to address in terms of data quality, waiting list validation and patient safety/clinical prioritisation. Management responses have been provided, and Executive director will attend the next audit committee to give update on progress.	Executive Director of Operations / Executive Director of Finance	~~Q3~~ ~~End of Q4 for IA report~~ Complete

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

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• 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) • Scrutiny Board minutes (TB)

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 were received at the February Board meeting.	Executive Director of Operations	~~Sept 2025~~ ~~Jan 2026~~ Complete

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)
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)
1319: The number and long waits of high priority patients on the ABU Therapy waiting lists (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.

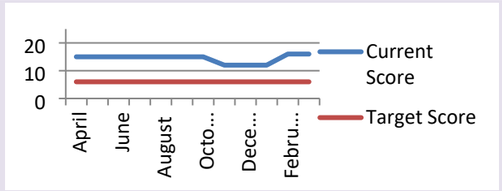
Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity 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: 9/3/25

Risk Rating
(likelihood x consequence)
Current score:
4 x ~~3~~ 4 = 16
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 quarter 4 the risk has increased to 16. Whilst we have been rated as amber green on our board provider capability assessment by NHSE which is positive and we are making progress in improving some aspects of performance in our NOF metrics we have seen a deterioration in our sickness rate (NOF metric) and the board is not assured that we can demonstrate compliance with the CQC fundamental standards following a board workshop in January. we have identified gaps in our governance, oversight and assurance in relation to CQC standards requiring action to address. We have received a regulatory breach notice for Wetherby YOI. The Director of Nursing and AHPs left the trust on the 28th February.

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. • 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 met with CQC regional director to establish working relationships at a senior level. • Interim director of nursing with significant experience joining 16th March and will be the Nominated Individual. • Additional deputy level post also appointed to provide extra capacity and expertise to improve quality governance arrangements including assurance to the board on CQC compliance.	Executive Director of Nursing and Allied Health Professionals	31 March 2026
Gaps in control were identified though the Well-led review and action plan (3-year action plan). Actions relating to compliance and governance have been prioritised for implementation in the 1st year.	TLT	End of 2025/26

	There is a gap in control relating to ensuring completeness of the regulatory and legislative requirements to inform this strategic risk. To address this a comprehensive list of legislative and regulatory requirements will be pulled together. A paper was taken to TLT on 11 June. The Board capability assessment has been completed. CQC requirements will be covered as part of the January 2026 Board workshop.	TLT	~~End of Q1 Q3 2025/26 31 Jan 2026~~ Complete

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

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• 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

Link to Risk Register (material risks scoring 10 or above):

1391: Faster Data Flow will not accurately reflect waiting times (12)
1437: Failure to comply with ionising radiation requirements (12)
1444: Clinical governance vacancies/absences and increased demand (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.

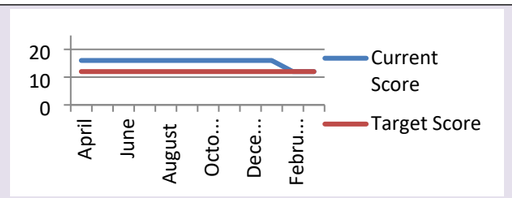
Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do

Risk Appetite	Open (8-12)	**Status: In or out of Appetite**	In	**Lead Director/risk owner:** Executive Director of Finance and Resources

Committee with oversight: Business Committee

Date last reviewed: 2/3/26

Risk Rating
(likelihood x consequence)
Current score:
3 x 4 = 12
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. Following the final review of 2025/26 the risk has reduced from 16 to 12 because of having an agreed medium term financial plan in place, providing the conditions to enter the new year with robust plans to deliver financial balance.
During the year an Internal Audit of Financial Sustainability has provided Significant Assurance. Operational risk 1329: Failure to deliver financial balance has been closed as the 2025/26 financial position is on track to deliver to forecast. A new operational risk will be opened in relation to delivery of the 2026/27 financial plan.

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
- Maintenance of Medium-Term Financial Plan
- LCH productivity group established

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	~~End of Q4 25/26~~ Complete
2. Develop a systematic approach to using benchmarking data to inform the Q&V programme	EDFR	End of Q1 26/27
3. Focus redirected onto reviewing the Well-led Finance Toolkit (NHSE) Going to Audit Committee in March 2026.	EDFR	~~End of Q4 25/26~~ Complete
4. Implementation of IPR process	EDFR	End of 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:		
5. Development and approval of the Estates strategy. Strategy has been developed and will go to Trust Board for approval 27 March 2026	EDFR	End of Q4 25/26
6. Digital strategy – stocktake of progress.	EDFR	~~End of Q4 25/26~~ Complete
7. Finalise year 2 priorities in the Digital Strategy	EDFR	End of Q1 26/27

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) • National Cost Collection report (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. Embedding of the new approach to IPR reporting	EDFR	End of Q1 26/27

Link to Risk Register (material risks scoring 8* or above):

1217: Digital and BI teams have insufficient capacity (9)

1187: Insufficient IT Resilience leading to the risk of extended outages of the infrastructure (8)

* For this SR risks scoring 8+ due to smaller number involved

Strategic Risk 5:

Failure to maintain business continuity: If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.

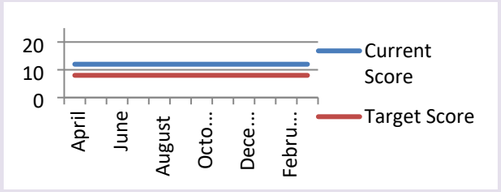
Strategic Objective: Use our resources wisely and efficiently both in the short and longer term / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

Risk Appetite	Minimal (1-3)	**Status: In or out of Appetite**	Out	**Lead Director/risk owner:** Executive Director of Operations

Committee with oversight: Business and Audit Committees

Date last reviewed: 12/3/26

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 quarter 4 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
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. Non-compliant mobile phones addressed however CE+ recertification was not achieved during the recent reassessment audit. The Audit Committee agreed at its meeting in March that the Trust would prepare for CE+ but would not seek re-certification.	Executive Director of Finance and Resources	~~Sept 2025~~ ~~Feb 2026~~ Complete
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. Additional capacity / expertise has now been secured	Executive Director of Finance and Resources	~~End Q3~~ ~~End Q4~~ Complete
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	• 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)	• Internal audit (BC/AC) • Data Security & Protection Toolkit audit (AC) • Assurance from external contractors re: cyber security resilience recovery

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

Action	Owner	Due by
As a result of the EPRR internal audit receiving limited assurance, an internal audit action plan is in place and executive director to attend the Audit Committee to update on progress.	Executive Director of Operations	April 2026

• Cyber Security Report (AC) • Sustainability and Climate Adaptability Steering Group AAA report (BC) • Digital strategy update (BC)	• Performance Brief (Responsive) (BC) • Information Governance Approval Group minutes (AC) • Statutory/mandatory training compliance (Performance Brief) (BC) • Information Governance and Data Security Reporting to Audit Committee (AC)	• Penetration Tests Results (AC)	
Link to Risk Register (material operational risks scoring 10 or above): 1221: Likelihood of a Cyber Attack (12) 1313: Climate Adaptability Resilience Planning (12)			

Strategic Risk 6:
Failure to effectively engage staff and leaders as well as to support their health and well-being in the current context:
If the Trust is unable to effectively engage and motivate all staff including leaders through impactful health and well-being interventions, a focus on inclusion, excellent leadership development and support in the current challenging context, then the impact will be a reduction in the overall quality of care and staff wellbeing and a possible misalignment with the key objectives of the Trust.

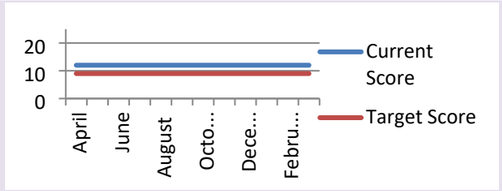
Strategic Objective: Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do

Risk Appetite	Cautious (4-6)	**Status: In or out of Appetite**	Out	**Lead Director/risk owner:** Director(s) of People (DoP)

Committee with oversight: People and Culture Committee

Date last reviewed: 11/3/26

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.
Following the final review of 2025/26. The sickness and engagement projects are well underway and linked by the overall theme of organisational health. An evidentially based approach to undertaking this work has been developed and tested with a specific service and is now being rolled out to other services based on the data and evidence in terms of sickness, engagement and other well led measures – this enables us to target services as needed. Our latest Staff Survey results have held from last year against all the People Promise themes which in the current changing climate with Q&V work continuing as well as the announcements about the Trust Integration Programme is to be celebrated. Given however, the degree and extent of change and continued high sickness rates (although reduced in February) the risk score remains at 12.

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 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~~ Complete
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	• 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~~ Complete

	• 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)		

Link to Risk Register (material risks scoring 10 or above):

1379: Political Climate / protests, staff safety (12)
1327: Finance Team Capacity & Capabilities (12)
1426: Staff shortages across police custody suites (12)
1444: Clinical governance vacancies/absences and increased demand (12)

957: Increase in demand in the adult speech and language therapy service (12)
1419: Primary care reduced staffing levels - Wetherby YOI, Adel Beck and Aldine House Staffing levels below safer staffing numbers (12)
877: Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand (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.

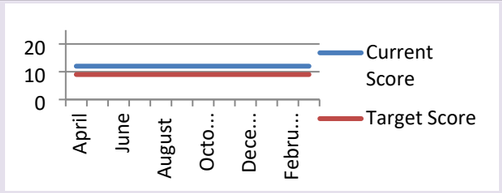
Strategic Objectives: Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity 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: 12/3/26

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 quarter 4 there is no change to the risk score. 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	30 June 26
There is a gap in availability, analysis and use of data to undertake equity analysis and take mitigating action. 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	~~31 Mar 2027~~ End of Q1 2026/27
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	• 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	Medical Director	~~End Q4 2025/26~~

• Organisation Strategy Update (BC/QC)				(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, further work paper to be taken to the Board to address the comments raised. Workshop deferred by Board from March to May 26. A reporting development plan has been laid out in the 5-year tactical plan. 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. 3 specific KPIs relating to completeness of ethnicity recording will be added in accordance NHSE statement on inequalities.		End of Q3 2026/27	
				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. Terms of reference for the audit have been agreed.	Medical Director	July 2026 Audit Committee	
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.

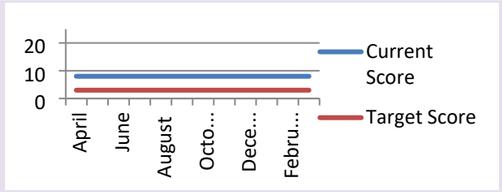
Strategic Objective: Collaborating with partners to enable people to live better lives / To embed equity in all that we do

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: 9/3/26

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 2025/26, there is no change to the risk score due to ongoing lack of clarity about the implications of the changes to the ICB. They have consulted on the proposed new structure, and we have provided feedback from the trust and through the Leeds provider partnership highlighting risks and queries in the proposed place by structure and what that means in terms of delegation and accountability.
We remain actively involved in shaping the Leeds provider partnership and joint committee and the CEO will be involved in the recruitment to the new place-based structures for the ICB.

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 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 of ~~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

Leeds Community Healthcare NHS Trust

Agenda item:	5b
Title of report:	Patient Safety including Patient Safety Incident Investigations update report September 2025 –February 2026.
Meeting:	Quality Committee
Date:	24 March 2026

Presented by:	Sheila Sorby, Deputy Director of Nursing and Quality
Prepared by:	Sarah Yeomans, Patient Safety Manager

Purpose of the report:		
The purpose of this bi-annual report is to provide the Quality Committee with assurance that patient safety is being effectively managed across the organisation. It outlines the management of patient safety incidents, the robustness of Patient Safety Incident Investigations (PSIIs), and the actions taken to embed learning and improve the quality of care. The report also highlights any emerging concerns, themes, or risks that require escalation to the Committee for oversight and further action.	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:

Patient Safety Incident Investigations are not consistently meeting the defined timeframe for completion set at the terms of reference meeting. This is logged on the Risk Register under Risk ID 1357. A process for extension has been developed to ensure consistency of oversight and escalation.

Patient Safety Incident Investigation Actions are not being completed within defined timeframes. As a result, patient safety cannot be assured until there is evidence of action completion and embedding into practice. This is logged on the Risk Register under Risk ID 1359. Action extension processes have been reviewed and updated to include Corporate Business Unit actions.

The number of Inquests received have increased significantly between 2023/24 and 2025/26. This rising and sustained increase is placing substantial pressure on

the Patient Safety Team and Clinical Services as no additional resource is available to support this increased workload. This is logged on the Risk Register under Risk ID 1361. Consideration of the future management of this workload is being considered a part of Quality and Value and exploring the potential of a legal secondment.

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	

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	x	Why not/what future plans are there to include this information?	This will be reviewed using the Patient Safety Dashboard once available.

Recommendation(s)	The Committee is recommended to: • Receive and note the contents of this paper. • Provide any feedback required.

List of Appendices:	Appendix 1 – Process for PSII extension Appendix 2 - Learning and actions from approved Patient Safety Incident Investigations Appendix 3 - Process for Overdue Patient Safety Incident Investigation (PSII), Patient Safety Learning Response (PSLR) Action Management.

Patient Safety including Patient Safety Incident Investigations update report September 2025 - February 2026

1 Executive Summary

During the reporting period, twelve incidents were declared as Patient Safety Incident Investigations (PSIIs), six of which were deaths progressed in line with National PSIRF Priorities, this is consistent with previous reporting periods.

One Independent Review for a patient death has been commissioned by the Integrated Care Board which LCH will contribute to alongside other providers to identify learning.

In addition, two PSIIs from the previous reporting period remain in progress, these have been extended and are planned to be approved within the next six weeks. A further PSII has been reopened pending additional information which will be added as an addendum following feedback received.

Twelve PSIIs which progressed in line with PSIRF have been approved and a further external review of a child death commissioned by the previous Executive Director of Nursing and Allied Health Professionals to provide assurance regarding the care delivered by Trust services has also been approved. Learning and actions from these PSII are included in Appendix Two.

No Never Events were recorded within the Trust during this reporting period. However, a partner-led Never Event (retained foreign object post-procedure) remains under investigation, and the final PSII will determine where accountability for the Never Event should sit.

Completion of PSII reports and associated actions continues to fall outside required timescales, and risks remain open until evidence of action completion and embedding is demonstrated.

The number of inquests received has also increased significantly, placing additional pressure on the Patient Safety Team and Clinical Services without the corresponding resource.

2 Introduction

The purpose of this bi-annual report is to provide the Quality Committee with assurance that patient safety is being effectively managed across the organisation. It outlines the management of patient safety incidents, the robustness of Patient Safety Incident Investigations (PSIIs), and the actions taken to embed learning and improve the quality of care. The report also highlights any emerging concerns, themes, or risks that require escalation to the Committee for oversight and further action.

3 Current position/main body of the report

Patient Safety Incident Investigations declared in reporting period
(based on the date the incident was declared a PSII)

Of the twelve PSIIs reported this period, eleven are LCH investigations, identified in line with the Trust PSIRP. The remaining one is a Bradford Never Event investigation which LCH are contributing to with potential LCH learning.

- One of the eleven LCH investigations has had an external lead investigator commissioned.
- Six of these incidents were patient deaths and these have been reported and progressed as PSIIs in line with the national PSIRF priorities. This number of incidents is consistent with previous reporting periods.
- All PSII investigations have a timescale for completion agreed within the initial terms of reference meeting. Of the eleven LCH investigations, five have exceeded this timescale and have had extensions agreed.

There is one additional incident which has been commissioned as an Independent Review by the Integrated Care Board following discussion with NHS England, LCH are contributing to this investigation.

A number of operational and capacity constraints continue to impact the timely completion of Patient Safety Incident Investigation (PSII) reports. These include:

- An imbalance of capacity of lead investigators to meet the current demand

- Unplanned staff absence affecting continuity and progress and therefore increased workload pressures across teams / functions including Clinical Governance and lead investigators

- Delays in receiving essential information from multiple external providers and sign off processes within multi-organisational PSIIs.

Risk Position (Risk ID 1357)
This issue is captured on the risk register as Risk ID 1357, currently assessed as 12 – Moderate.

Impact
The delays present a risk of harm not being identified and mitigated promptly, which may affect future patient safety until learning and actions are embedded. There is

also an impact on patients and families already affected by harm, as delays in completing investigations postpone the sharing of learning and outcomes with them.

Mitigations
The following actions are in progress to strengthen governance and improve timeliness:

A formalised extension process for PSIIs has been developed to ensure consistent oversight and escalation of delays. This is currently awaiting review and approval.
Appendix One

Investigator roles are under review as part of the Quality and Value work within the Clinical Governance Team, with the aim of improving capacity and resilience in the investigation function.

It is also to be noted that two PSII reports from the previous reporting period, for the same reasons as above, are awaiting final conclusion. Each have progressed in this reporting period, patient / family engagement has taken place where appropriate and we are expecting final approval within the next 6 weeks. These have all been complex investigations with significant family or other provider input. A further PSII has been reopened pending additional information which will be added as an addendum following feedback received.

Patient Safety Incident Investigations approved in reporting period
(based on date the report was signed off by an Executive Director)

Twelve PSII identified in line with the Trust PSIRP have been approved in the reporting period.

- Nine of the twelve incidents were patient deaths, and these have been reported and progressed in line with the PSIRF National priorities (7) /Local priorities (2).
- Five of those reported under the PSIRF National priority were reviewed and included as part of one deaths exception report due to similar themes of learning identified at Rapid Review Meeting.

In addition, there was one external review of a child death commissioned by the previous Executive Director of Nursing and Allied Health Professionals to provide assurance regarding the care delivered by Trust services which has been approved.

Learning identified and actions taken from approved PSII are included in **Appendix Two.**

Never Events

There were no Never Events reported by LCH. However, a partner led Never Event (retained foreign object post-procedure) remains under investigation, and the final PSII will determine where accountability for the Never Event should sit.

Learning

Patient Safety Learning has continued to be shared organisation wide via the Trust Sharing Learning in LCH Newsletter and Adult and Specialist Business Unit Mortality Meetings. Due to unplanned absences the January Quarterly Patient Safety Summit was cancelled however these meetings are planned to resume in April 2026.

Reporting

The Patient Safety Quality Assurance and Improvement Group (QAIG) AAA reports have strengthened the approach to articulating risk, advice and assurance. Patient safety is heard quarterly for a dedicated patient safety themed business meeting.

Inquest

There has been a sustained rise in inquests received for LCH over the last few years and a reduction in legal instruction to support this work. This is causing substantial pressure on the Patient Safety Workstream as there has not been any additional, allocated resource to support this workload, this is also impacting on the Clinical Services required to produce statements.

Risk Position (Risk ID 1361)
This issue is captured on the risk register as Risk ID 1361, currently assessed as 9 – Moderate.

Impact
There is a risk the PST/Trust does not have the expertise of legal services in Inquest or the resource to progress Inquests timely. These delays and lack of legal expertise could result in harm to families, reputational damage, non-compliance with inquests and staff wellbeing.

Mitigations
The following actions are in progress to strengthen governance and improve timeliness:

A Rapid Review will be completed for all inquests received where patients have had active service involvement in the last six months prior to their death to identify any learning and actions.

Consideration of a legal secondment to support this work is being explored.

The Clinical Governance Team is currently reviewing the inquest workload and management as part of the Quality and Value programme.

PSII Actions

PSII actions are not being completed within the defined timeframes.

Risk Position (Risk ID 1359)
This issue is captured on the risk register as ID 1359, currently assessed as 9 – Moderate.

Impact
Overdue PSII actions mean that the risk of further patient harm remains until there is clear evidence that actions have been implemented, embedded, and are delivering the intended safety improvements

Mitigations
The following actions are underway to strengthen governance and improve the timeliness of PSII action completion:

The process for managing Overdue Patient Safety Incident Investigation (PSII) and Patient Safety Learning Response (PSLR) actions has been reviewed and updated. The revised process clearly outlines responsibilities across Clinical Governance and Business Units.

A further process has been developed for PSII actions assigned to responsible leads within the Corporate Business Unit. This is currently with Corporate Business Unit Heads of Service for feedback prior to finalisation. The proposed approach will also be discussed at the QAIG Patient Safety–focused meeting to agree the reporting arrangements for Corporate overdue actions.

See **Appendix 3** Process for Overdue Patient Safety Incident Investigation (PSII), Patient Safety Learning Response (PSLR) Action Management.

5 Recommendations

The Committee is recommended to:

- Receive and note the contents of this paper.
- Provide any feedback required.

Sarah Yeomans
Patient Safety Manager
11/03/2026

Appendix One – Process for PSII extension

NHS
Leeds Community Healthcare
NHS Trust

One minute guide

Patient Safety Incident Investigation Extension process

Terms of Reference Meeting

- The timescale for completion of a Patient Safety Incident Investigation will be decided at Terms of Reference Meeting.
- The mid-point and final review meetings will be booked after the Terms of Reference Meeting by the Clinical Governance Administrator.

Mid-Point Review Meeting

- To ensure timely and effective investigations, the draft investigation report should be submitted to the Patient Safety Team at lcht.lchsafety@nhs.net no later than 5 working days before the mid- point meeting.
- If the report is not received by this deadline, the meeting will be cancelled. The Patient Safety Team will issue an escalation to the Author, copying in their line manager, Business Unit Quality Lead, Portfolio Lead, Clinical Lead and the Head of Clinical Governance. The Author must then discuss the delay with their line manager and respond to the escalation email with a clear timescale for when the mid-point report will be completed.
- At this point, the Author and line manager should also consider whether an extension to the completion date is required and include this in the email response.
- Extensions of less than 4 weeks must be approved by the Head of Clinical Governance
- Extensions over 4 weeks, or second extension requests, require approval from the Deputy Director of Nursing and Quality
- A revised submission date is confirmed, the Patient Safety Team will arrange a new Mid-Point Review Meeting.
- The Patient Safety Team will upload the email on Datix and add an update in the progress notes

Final Review Meeting

- To ensure timely and effective investigations, the draft investigation report should be submitted to the Patient Safety Team at lcht.lchsafety@nhs.net no later than 5 working days before the final review meeting.
- If the report is not received by this deadline the Patient Safety Team will issue an escalation to the Author copying in their line manager, Business Unit Quality Lead for the Business Unit, Portfolio Lead, Clinical Lead and the Head of Clinical Governance. The meeting will take place however this will be to discuss and consider an extension to the completion date.
- At this point the Author must discuss the delay with their line manager and bring an update to the meeting on the stage and progress of the investigation including extension request.
- Extensions of less than 4 weeks must be approved by the Head of Clinical Governance
- Extensions over 4 weeks, or second extension requests, require approval from the Deputy Director of Nursing and Quality
- A revised submission date is confirmed, the Patient Safety Team will arrange a new Final Review Meeting.
- The Patient Safety Team will upload the email on Datix and add an update in the progress notes

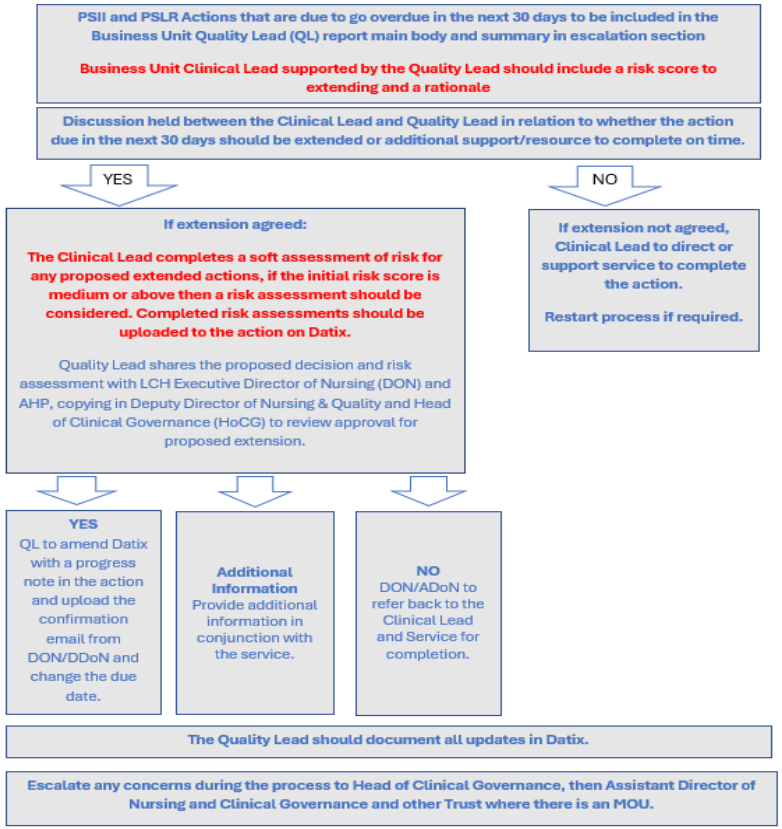
Appendix Two - Learning identified and actions taken from approved PSII	
Learning	**Action**
Lack of adherence to the wound infection framework	A review of the wound infection framework has been completed and a revised Wound Infection Framework for Registered Clinicians has been completed and a Wound Infection Framework for the Non-Registered Workforce has been developed. This will be launched across the trust as a package alongside the lower limb framework and deteriorating patient policy.
Lack of adherence to the lower limb framework	A review of the lower limb framework has been completed, and a simplified version has been created. This will be launched across the trust as a package alongside the wound infection framework and deteriorating patient policy.
Missed/ unallocated patient visits in the Neighbourhood Teams	A reallocation process has been developed for missed or unallocated patient visits
Lack of process for wound swabs if urgent/ out of hours in Neighbourhood Teams	A Standard Operating procedure is in the process of development to include: taking the swab sending the swab follow up of swabs prescribing if required dependent on results.
Lack of professional curiosity	A learning from incidents poster is in development with key information for staff. Professional Curiosity has been added to the overarching improvement plan for themes of learning applicable to all incident types.
Lack of clinical observations/identification of soft signs of deterioration	A Deteriorating Patient Policy has been developed. This will be launched across the trust as a package alongside the lower limb and wound infection framework.
A lack of process for responding to carers concerns in the Neighbourhood Teams	A process has been developed for staff to use as a guide to ensure responses are provided to carers in a timely way.
Management of patients with diabetes	A pathway will be created for the management of patients with diabetes across the system.

Recording of unwise decisions	A review of the S1 template for consent and capacity has been completed and work is ongoing with the SystmOne team to make changes to the wording on the questionnaire to make this clearer for staff.
Assessment of capacity for patients with unstable diabetes which may affect their mental capacity.	A guide has been created for assessing capacity for patients with diabetes
Lack of awareness of Panton-Valentine leucocidin positive Methicillin Resistant Staphylococcus Aureus	An information leaflet has been created by the IPC team and shared with all GP's. This will be discussed at the next Patient Safety Summit.
Lack of personalised care in Neighbourhood Teams	NICE Guidance was reviewed as part of a working group. A Survey was sent to staff to gather data on barriers and challenges, enablers and their views and ideas around personalised care and how it could be improved. A How to guide has been created for personalisation of care plans.
Lack of communication between services through a multidisciplinary approach	A complexity checklist is being developed to support staff in decision making around patient complexity which encourages multidisciplinary working
Gaps in the SOP for LMWS NHS Talking Therapies' managing unplanned absence and single point of failure in the case of clinician absence.	Review and update of the SOP including How clinical risk is reviewed, management of new patients presenting with high risk, impact of multiple unplanned absence on cancelled appointments. Updates to the web referral form to include urgent support details and standardised out of office responses within the service which includes guidance and contact information for patients with escalating risk

Appendix Three - Process for overdue Patient Safety Incident Investigation (PSII), Patient Safety Learning Response (PSLR) Action Management.

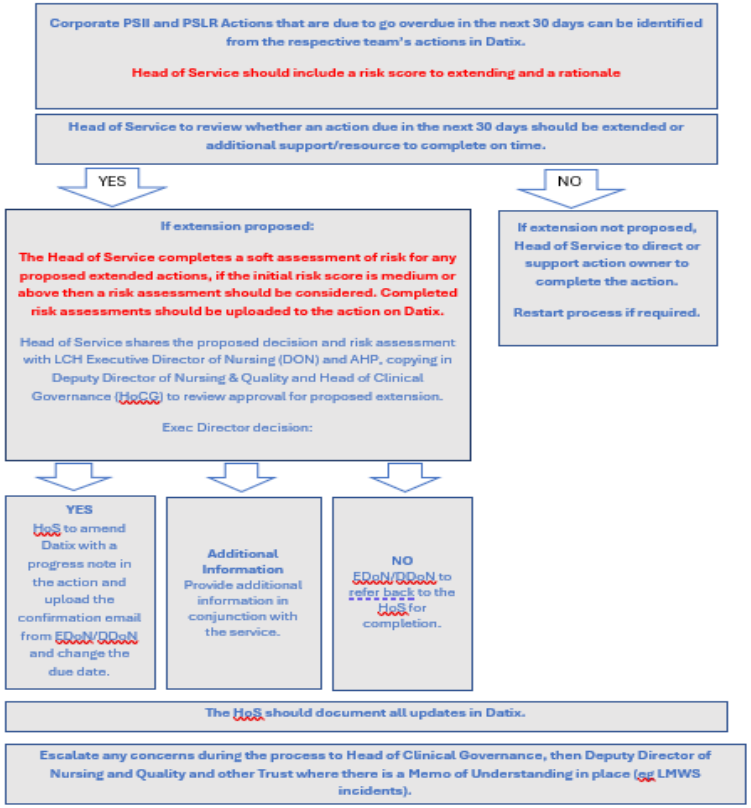
Appendix 1 – SBU/CBU/ABU - Overdue Patient Safety Incident Investigation (PSII), Patient Safety Learning Response (PSLR)Action Management

PSII and PSLR actions should not become overdue. Should they become at risk of being overdue full clinical and risk assessment of the action must be completed. Any potential for extension to completion timescales must be assessed to mitigate any risk to patient safety from those known risks. The following flowchart describes the process for management of those actions



Appendix 2 – Corporate Business Unit - Overdue Patient Safety Incident Investigation (PSII), Patient Safety Learning Response (PSLR) Action Management

PSII and PSLR actions should not become overdue. Should they become at risk of being overdue full clinical and risk assessment of the action must be completed. Any potential for extension to completion timescales must be assessed to mitigate any risk to patient safety from those known risks. The following flowchart describes the process for management of those actions



Leeds Community Healthcare NHS Trust

Agenda item:	5c

Title of report:	Infection Prevention and Control (IPC) Board Assurance Framework (BAF)

Meeting:	Quality Committee
Date:	24th March 2026

Presented by:	Sheila Sorby Deputy Director of Nursing, Allied Health Professionals and Quality, DIPC					
Prepared by:	Liz Grogan Head of Infection prevention and Control, Deputy DIPC					
Purpose: (Please tick ONE box only)	Assurance	☒	Discussion	☐	Approval	☐

Executive Summary:	The Infection Prevention and Control BAF provides assurance that Leeds Community Healthcare (LCH) is compliant or partially compliant with the criterion as outlined in the revised Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022). The purpose of the document is to ensure that patients who use Leeds Community Healthcare NHS Trust services receive safe and effective care. It is paramount that effective prevention of infection must be part of everyday practice within LCH and be applied consistently by everyone.

Previously considered by:	Quality Committee: March 2024, September 2024, March 2025, September 2026 Board: March 2024, September 2024, March 2025, September 2025

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

Is Health Equity Data included in the report (for patient care	Yes	☒	What does it tell us?	Equity is embedded into a large proportion of the work delivered by the IPC Team in accordance with

and/or workforce)?				the Health and social care Act. For example: Data around HCAI is provided within the report for example MSSA and some of the activities we undertake within the service around system work and engagement with underrepresented communities, with specific emphasis on our upstream approach to support those living in the most deprived communities, having a greater risk of infection and increased usage of antibiotics.
	No	☐	Why not/what future plans are there to include this information?	

Recommendation(s)	Quality Committee is recommended to note the contents of the IPC BAF.

List of Appendices:	Appendix 1: Key line of enquiry (partial compliance)

Infection Prevention and Control – Board Assurance Framework

1 Introduction

'Good infection prevention and control (IPC), including cleanliness, is essential to ensure that people who use health and adult social care services receive safe and effective care.' This updated version (April 2025) of the infection prevention control board assurance framework (BAF) is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The purpose of the framework is to provide assurance to the board on the compliance with the updated version of the Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022).

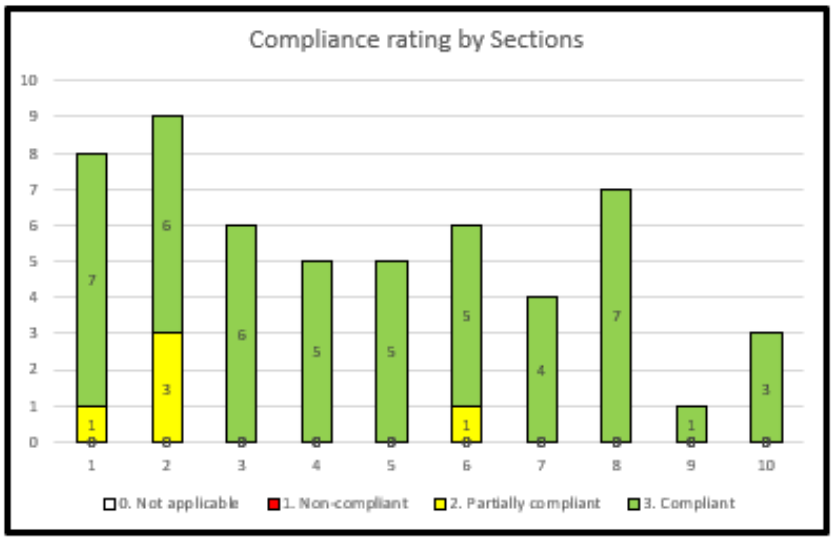
2 Current position

The document provides information on the identified Key Lines of Enquiry (KLOE) and provides assurance of the specific measures that LCH have in place to control the spread of infection.

3 Impact

- **Quality**

The majority of elements are fully compliant. There are some areas highlighted as '*partial compliance'* however there are mitigating plans in place and progress has been made since this document was reviewed in September 2025, where a new version of the document was updated.



- **Risk and assurance**

Identified elements of partial compliance are highlighted in the document and are as follows;

- Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM – namely around compliance with Hand Hygiene from across the clinical areas in LCH.
- There is evidence of compliance with National cleanliness standards including monitoring and mitigations (excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract these setting will have locally agreed processes in place). The main concern and lack of assurance relates to third party contracts where LCH delivers care for example: Wetherby Young Offenders Institute, Leeds City Council Adel Beck etc.
- There is limited assurance around water safety and ventilation, which should include a water and ventilation safety plan for LCH. Water safety meetings are diarised 6 monthly however further work is required around the appropriate escalation and treatment plan of locations that are testing positive. There is also a gap of assurance from third party locations e.g. Leeds City Council, Adel Beck, Wetherby Young Offenders etc. It has been escalated to IPCC that there is no Ventilation Meeting in place.
- There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09. Greater assurance is required planned maintenance activity from LCH Estates Team, that links in with appropriate risk assessments being completed by appointed contractors.
- That all identified staff are fit-tested as per Health and Safety Executive (HSE) requirements and that a record is kept – provision in place to continue fit testing relevant clinical staff in line with A-Z of pathogens, locally held excel document in IPC however more robust mechanism being sought. A plan is in place for this to be added onto the digital solution purchased by LCH 'Coreshare'. Which will be completed and in place by May 2025, we are now in the testing phase and due to some errors this is not likely to be fully rolled out across services until January 2026.
- There is evidence staff are trained to an agreed standard for identified extended clinical skills and the staff member has completed a competency assessment (if required for the skill) which is recorded in their records – this requires further collaborative work with the Clinical Education Team / Clinical Leads. An example of this would be assurance around aseptic technique, monitoring of patient observations and catheterisation. Ongoing work is being completed by the DON on improving assurance around competency education and assurance.

➢ 4 Next steps

Review the IPC BAF on a quarterly basis and for the contents of the document to be highlighted at the IPCG. Escalations to be raised at the Infection prevention and Control Committee with an escalation via a AAA report to QC.

➢ 5 Recommendations

Quality Committee is recommended to: note the contents of the IPC Board Assurance Framework and the areas of partial compliance.

Liz Grogan Head of IPC and Deputy DIPC, March 2026.

Appendix 1: Key line of enquiry (partial compliance)

Key line of enquiry (partial compliance)	Risk of partial compliance	Mitigation / current actions
1.6 Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Gaps have been identified in staff compliance with the Standard Precautions Policy, specifically regarding hand hygiene and adherence to "bare below the elbows" requirements.	A newly developed IPC audit tool has been implemented across LCH to enable consistent monitoring of compliance and early identification of non-adherence. IPC education and training are overseen by the IPCC and HSG, with strengthened hand hygiene messaging embedded throughout mandatory training. The staff induction programme includes comprehensive hand hygiene training, supported by regular refresher sessions and access to e-learning modules. A preferred product list ensures staff carry required equipment when undertaking domiciliary visits, enabling compliance in all care settings. Access to hand hygiene supplies when in clinic and in patient areas. Additional mitigation includes increased visibility of IPC champions across services, and targeted support for teams with low audit scores. Feedback loops have been established to ensure learning from audits is shared at team meetings, and managers are required to monitor and address non-compliance promptly through supervision and performance management
2.1 There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	We continue to not have full assurance from external partners regarding cleaning activities at certain sites, for example Leeds City Council at St George's Centre and the Ministry of Justice at Wetherby Young Offenders Institute.	A combined short-life working group with Estates and Facilities continues to operate to address and monitor assurance gaps relating to external cleaning providers. This group reviews issues escalated from IPC Environmental and Cleaning Audits, identifies areas of concern, and agrees actions with the relevant partner organisations. Ongoing

		assurance, risks, and unresolved issues continue to be formally escalated to the IPCC. Strengthened communication pathways, routine review meetings, and shared action plans aim to improve transparency, responsiveness, and overall confidence in external partners' cleaning performance.
2.4 "There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. 2.4.1 Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. 2.4.2 Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01."	When a positive water sample is identified, there must be a clearly defined and consistently applied escalation and management process. Although a water safety expert and Estates lead are actively involved, the current level of assurance remains insufficient. The Water Safety Policy is now overdue for review and requires updating to reflect current risks, responsibilities, and operational processes. In addition, there is currently no formalised plan for the management of ventilation systems. This gap was highlighted at IPCC (9 July 2025) and has been escalated by the DIPC via the AAA to Quality Committee.	A risk assessment has been completed to identify gaps and associated risks arising from the policy being out of date. The Water Safety Group continues to meet on a six-monthly basis to review monitoring results, risks, and areas requiring escalation. However, a dedicated Ventilation Group is now required to develop a Trust-wide plan, covering air conditioning units and ventilation systems across LCH premises and those managed by third-party organisations. The group would provide oversight of compliance, ensure appropriate governance structures are in place, and develop clear operational pathways for responding to ventilation concerns. These requirements will be incorporated into the forthcoming policy review, with regular reporting and escalation through established IPC governance routes.
2.5 There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	There is a risk that we are not fully informed of planned maintenance activities undertaken by external partners. This lack of visibility may impact compliance with HTM requirements within the Built Environment and could affect the safe and consistent provision of services.	A formal process for sharing and reviewing planned maintenance activity is now in place for all LCH-managed premises and is included as a standing agenda item at IPCG to ensure ongoing oversight. IPC audit findings are routinely shared with Estates and Facilities, enabling timely action and increased transparency. Areas identified

		as non-compliant are subject to targeted follow-up, with re-audits scheduled every three months to monitor improvement and provide assurance. Strengthened communication pathways between IPC, Estates and Facilities, and external partners support earlier identification of risks and ensure that any emerging issues are escalated through established governance routes.
6.5 That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	A rolling training programme is in place to support staff requiring FFP3 fit testing. However, there is a risk of inaccuracy within the current fit-testing records because the data is stored on a locally held Excel spreadsheet. This format makes it difficult to maintain accurate, real-time information—particularly when staff leave, change roles, or are on long-term absence. Although this meets HSE compliance requirements, NHS England recommended during the COVID-19 pandemic that organisations store fit-testing data within a formal system such as ESR to ensure workforce-wide visibility and ownership.	Fit-testing records are currently maintained by IPC on a local Excel database; however, this limits visibility and does not provide individual staff or service teams with clear ownership of their compliance status. In March 2025, an app-based solution was identified by the Workforce & Innovation (WFI) team, and a scoping exercise with Corshare is underway to support development. The development of the app has been complex, requiring multiple iterations and integration considerations across systems. Despite this, a rollout across LCH is planned for **Q2 of 2026/2027**, which will allow all clinical frontline staff to be uploaded onto the system and undertake a digital risk assessment to determine their requirement for FFP3 fit testing. In parallel, considerations are being given to how the solution could interface with, or be adopted by, **LYPFT**, ensuring future alignment and reducing duplication where staff work across both organisations. The new digital system aims to significantly improve the accuracy, accessibility, and governance of fit-testing data, bringing LCH in line with NHS England's recommended

		approach. This is on the risk register.
6.6 If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	There is a risk that staff may not be receiving regular updates, refresher training, or competency checks to ensure that clinical practice remains aligned with the current evidence base. Limited assurance around clinical competencies increases the risk of avoidable HCAIs, particularly in areas requiring high-precision skills such as aseptic technique, taking observations as well as the insertion and maintenance of catheters. Without a reliable system for verifying that staff remain competent in these core clinical skills, there is a concern that unsafe variation in practice may occur, potentially compromising patient safety.	Staff currently self-declare their competencies and work autonomously within their professional codes of practice. Bespoke training is available from specialist teams such as CUCS, CVAS and IPC to support key clinical skills, including aseptic technique. LCH is undertaking further scoping work to develop a digital app to record staff competencies and identify additional training needs, for example recognising the deteriorating patient and escalation of soft signs. This development is included on the risk register.

National Infection Prevention and Contr

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·ol Board Assurance Framework

Introduction

The National Infection Prevention and Control board assurance framework ('the framewor
an evidence-based approach to maintain the safety of patients, services users, staff and ot
be used to provide assurance in NHS settings or settings where NHS services are delivered.
compliance with infection prevention and control (IPC) standards (unless alternative interr

The purpose of the framework is to provide an assurance structure for boards against whic
National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act
disease-specific infection prevention and control guidance issued by UK Health Security Ag

The aim of this document is to identify risks associated with infectious agents and outline a
given to adopting an integrated systems approach for individuals at greater risk of ill-healt

Providers, ICBs, and regional teams collaborating to implement best practice in infection p
pathways based approaches across healthcare systems; ensuring AMR forms part of organ

The framework should be used to assure the executive board or equivalent, directors of in
assessment of the measures taken in line with the evidence based recommendations of th
outlined in the Health and Social Care Act 2008: code of practice on the prevention and co
improvement and patient safety. The adoption and implementation of this framework ren
demonstrate compliance with the Health and Social Care Act 2008. This requires demonstr

If the criterion is not applicable within an organisation or setting for example, ambulance

Links

NHS England » National infection prevention and control manual (NIPCM) for England

Health and Social Care Act 2008: code of practice on the prevention and control of infection

rk') is issued by NHS England for use by organisations to enable them to respond using
:hers. The framework is for use by all those involved in care provision in England and can
. This framework is not compulsory but should be used by organisations to ensure
nal assurance mechanisms are in place).

ch the system can effectively self-assess compliance with the measures set out in the
: 2008: code of practice on the prevention and control of infections, and other related
gency (UKHSA).

a corresponding systematic framework of mitigation measures. Consideration should be
h from infection and AMR, including:

revention and control, AMR prevention, and infection management; developing
nisational prevention plans.

fection prevention and control, medical directors, and directors of nursing of the
e NIPCM (or whilst the NIPCM is being implemented) including the relevant criterion
ntrol of infections. The outcomes can be used to provide evidence to support
mains the responsibility of the **organisation and all registered care providers** must
ration of compliance with the ten criteria outlined.

services then select not applicable option.

s - GOV.UK (www.gov.uk)

Legislative framework

The legislative framework required to protect patients, service users, staff and others fro
Act 2008: code of practice on the prevention and control of infections, the duty of care a
associated regulations for employers and employees.

Local risk assessment processes are central to protecting the health, safety and welfare o
assessment process (primary care, community care and outpatient settings, acute inpatie
support services in identifying hazards and risks, and includes guidance on measures that
risks appropriately. Where it is not possible to eliminate risk, organisations must assess a
process and the organisation's governance processes.

Links

Health and Social Care Act 2008: code of practice on the prevention

Health and Safety at Work etc. Act 1974

Primary care, community care and outpatient settings

Acute inpatient areas

Primary and community care dental settings

m avoidable harm in a healthcare setting is detailed in the Health and Social Care
nd responsibilities are set out in the Health and Safety at Work Act 1974, and

of patients, service users, staff and others under relevant legislation. This risk
ent areas, and primary and community care dental settings) has been designed to
should be maintained to improve and provide safer ways of working by balancing
and mitigate risk and provide safe systems of work using the risk assessment

Instructions for use

The adoption and implementation of the National Infection Prevention and Control Boar
registered care providers must demonstrate compliance with the Health and Social Care
the Act.

The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and
be recorded in a text format.

The compliance rating column allows for the selection of a RAG rating for each criteria us
compliant.

Once options have been selected a summary plot for each criteria is generated automati
an organisation/provider across all ten criteria is shown in plots under the summary worl

N.B. Use of the framework **is not compulsory** but should be used by organisations to ens
alternative internal assurance mechanisms are in place). In addition, not all of the criteria
settings.

Please note: Specific URL's referred to in the document can be accessed via the ' Hyperl

d Assurance Framework remains **the responsibility of the organisation and all**
Act 2008. This requires demonstration of compliance with the ten criteria outlined in

allows for evidence of compliance, gaps in compliance, mitigations, and comments to

sing a drop down list. Specifically: not applicable, non-compliant, partially compliant,

cally, which are displayed in the corresponding worksheet. The overall RAG status for
ksheet.

sure compliance with infection prevention and control (IPC) standards (unless
a outlined in the framework will be relevant or applicable to all organisations or

links included in the BAF' tab. Or alternatively, can be accessed by clicking here.

Links

	Secti
1.4	NIPCM
1.6	NICPM
1.8	Primary care, community care and outpatient settings, Acute inpatient areas Primary and community care dental settings
	Secti
2.1	National cleanliness standards
2.2	Patient-Led Assessments of the Care Environment (PLACE
2.4.1	HTM:03-01.
2.4.2	HTM:04-01
2.5	HBN:00-09
2.6	HTM:01-04 NIPCM
2.7	HTM:07:01 HTM:01-01
2.8	HTM:01-05 HTM:01-06
	Secti
3.1	CQC Regulation 12 guidance
3.2	UK AMR National Action Plan
3.3	UK AMR National Action Plan. NICE Guideline NG15
3.4	TARGET Start Smart, Then Focus
	Secti
5	NIPCM
5.2	Isolation prioritisation tool
	Secti
6.2	Roles and responsibilities
	Secti
7	NIPCM
	Secti
9	UKHSA NIPCM A to Z pathogen resource SICPs Monitoring Tool

ion 1

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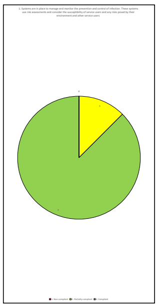
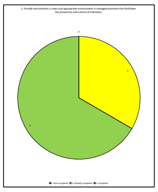
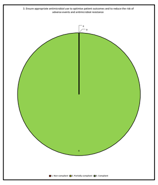
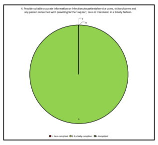
Infection Prevention and Control board assurance framework v5.0

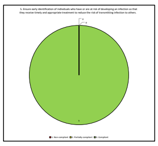
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	There is a robust governance structure where a quarterly IPCG is held, escalations from this meeting feed into QAIG, upwards to Quality committee and then the board. The DIPC is the Executive Director of Nursing and AHPS and the Deputy DIPC is the Head of IPC. Terms of Reference are in place and this is reviewed annually. Programmed actions to involve all staff members and services within the Trust not solely members of the IPC team. There is an Overarching Policy in place detailing the roles and responsibilies of the organisation inline with the Health and Social Care Act code of practice (2022) and has been updated in February 2024.			March 2026 This has been changed to an IPCC from July 2025. The committee is now chaired by the DIPC, with a chairs AAA report that is submitted to Quality Committee.	3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	PPM+ provides monitoring intelligence for community IPC. Relevant policies in place for the Management of Outbreaks in the Community Setting. 7 day provision of IPC to provide SME advice. Engagment with UKHSA for specific infection outbreaks and wider system collaboration. Escalation process outlined in the IPC Overarching Policy. Communicable Disease Control measures in place with LCC for specific gastrointestinal infections.				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Use of Datix is embedded across the organisation, with specific entry points to capture IPC incidents such as sharps incidents and environmental issues. IPC have a process in place to monitor datix on a daily basis and a flow chart that coincides with the policy around sharps management. IPC education events and champion sessions promotes use of Datix and there is an organisational culture of promoting reporting of incidents. Plans in place across the organisation to implement PSIRF, there is an identified patient safety specialist for IPC. Deputy DIPC chairing improvement group for sepsis and deterioration. Learnign in addition is identified through the PSIRF process.				3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	Current policy pack in place that incorporate the detail of the NIPCM and references the content across LCH IPC Policy suite. The current policy manual outlines all relevant criteria as detailed in the Health and Social care Act. Overarchin Policy references NIPCM (2022) and H&SC Act (2022). Training compliance figures are reviewed for each business unit on a quarterly basis and reported via the IPCG and HSG, with escalations of concern made to QAIG and QC.			Update September 2024: To be implemented as part of Annual Plan for 2023-24 / 24-25. All relevant policies now has the NIPCM referenced and the detail reflects the guidance outlined. Frontline staff now complete (ABU) newly updated IPC Level 2 training on ELFH.	3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	PPM+ provides surveillance of MRSA, CDI, GNBSI data, a process is in place for IPC to complete appropriate Post Infection Reviews of specific HCAI's. All outbreaks in inpatient areas such as Wharfdale would be escalated to the DIPC and the Managagement of Outbreakspolicy would be followed, including reporting to UKHSA. Further detail outlined in the Overarching Policy. Escalation and reporting via the IPCG and quarterly to QAIG.			PPM+ platform under review as to how effective this infratructure is. LTHT have moved to a new platform: ICNet and this will be reviewed internally as to whether it can be considered as an effective surveillance system for the community.	3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Hand hygiene, environmental, mattress and cleaning audits are completed throughout LCH. MEG is the electronic auditing platform that captures the relevant information and provides assurance of compliance. This is recorded as part of the quarterly IPCG and escalations are made to QAIG where there are notable concerns. Goverance process detailed in the Overarching Policy.	Gaps identified around effective hand hygiene.	Staff have a preferred product list that outlines the resources required including hand hygiene products for a domicilary vist. IPC Training delivered via ESR is monitored with the majority of services 8-90% compliant. Hand hygiene posters and screen savers are used and targeted training is delivered in low uptake areas.	New Hand hygiene Audit tool rolled out in October 2023. Results from teams across LCH consistently record at 100% which does question the validity of assurance. Further consideration to be given to an AI method of measuring compliance. March 2026 - a risk around hand hygiene compliance from across all three business units has been added onto the risk register. There is a lack of robust evidence following the launch of the audit that clinical staff are not fully compliant with the Standard precautions POlicy and undertaking hand hygiene as outlined in the NIPCM and the WHO 5 Moments, alongside being bare below the elbow.	2. Partially compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Staff receive training as part of induction programme which covers the core fundamental basics of IPC. All staff then undertake statutory and mandatory training as part of E-Learning for Health and the attendance figures for locations are monitored and recorded as part of IPCG and HSG. any concerns escalated to Clinical leads Via Clinical Leads Meeting and QAIG.				3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	IPC support teams with risk assessments where required for example for specific infections e.g. CPE in an inpatient setting. Specific risks discussed via IPCG where an action log is in place.	This KLOE is compliant however to note the following to improve assurance: Formal logging of risk assessments needs to be captured with a more robust system in place.		IPC team have supported with localised training at Wharfdale on localised issues.	3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	The National Cleaning Standards were implemented in November 2022. Monitoring of standards is in place and this is led by the Domestic Services manager. 'Scores on the door' in place and escalation of concerns is identified through IPCG and HSG, with an action log in place. Reports to come via IPCG from Domestic Services Manager. Environmental audits capture areas of non compliance. Working group in place for implementation of standards.	Assurance required from external partners such as WYOI, LCC, Adel Beck, Custody Suits etc. Cleaning Policy to be ratified - currently being completed by LCH Estates and Facilities Team.	Continuation of short life working group to be in place with Estates to discuss assurance from external partners and areas of concern that are escalated from IPC Environmental and Cleaning Audits. We receive audits results from Community Partnerships for the LIFT buildings.	Update March 2025:This continues to be escalated to QAIG around the lack of assurance from external partners. This is on the Risk Register as continues to be a concern around cleaning staff and long term absense.	2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE inspections are undertaken every September. Inspection team in place and external inspectors have been recruited. Action plans and report shared Q1 of fiscal year and shared with DIPC. Escalations taken to QAIG and the Board. Anecdotal feedback to be provided to QAIG prior to national report being recieved.			Currently fully led by IPC, however more of a Facilities and Estates ownership is required. Further discussion required with LTHT / national PLACE team re completion of Wharfdale Inspections. September 2025 - this is now led by LCH Estates Department.	3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	S shape cleaning in place and labelling of patient equipment. Policy in place for reusable materials and a contract is in lace for external decontamination of reusable pieces for dental and podiatry. The IPC Policy manual outlines clearly roles and responsibilities across the trust. A bespoke video has been made by IPC with a voiceover to support the methods of cleaning as outlined in cleaning policy.		National Cleaning Standards in place across the organisation and each area has been accessed and provided with a risk category.	Cleaning Policy has been to the CCPG in March 2024 and is near completion for ratification. It is acknowledged that some elements of the policy will not be in place for example assurance from external landlords e.g. Leeds City Council	3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	Water Safety Group in place with external provision provided by a qualified water expert. Regular legionella sampling from mains taps, as well as dental waterline testing is in place and assurance audit completion for HTM 01-05 from dental.	Escalation of concerns: When a positive sample is detected, there needs to be a clear process for how this is managed. While we do have a water expert and estates lead involved in this work, a greater depth of assurance is required, and the policy is now overdue for review and update.There is no current plan for ventilation, this has been raised at the IPCG 9July 2025) and escalated via AAA to QC by the DIPC.	A risk assessment has been undertaken to identify gaps and risks associated with the policy being out of date.Water Safety Group meets 6 monthly, however a ventilation group is required, to discuss the plan around air conditioning units in LCH premises and third party locations, as well as other ventilations specifics.	Update September 2024: there is now a robust system in place for the maintenance of water coolers and this is monitored via the Water Safety Group. Water machines across the estate have been renewed during 2025. Update September 2025: Concerns raised to DIPC at IPCG and added to AAA report for QC (July 2025). March 2026 - concerns remain around escalation to appropriate individuals including DIPC and DDIPC for Water Safety. There is a gap around Ventilation meetings and this has been escalted on the January AAA report for QC.	2. Partially compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	Water Safety Group in place with external provision provided by a qualified water expert. Regular legionella sampling from mains taps, as well as dental waterline testing is in place and assurance audit completion for HTM 01-05 from dental.	Water Safety Group in place with external provision provided by a qualified water expert. Regular legionella sampling from mains taps, as well as dental waterline testing is in place and assurance audit completion for HTM 01-05 from dental.	Audits are shared by IPC to Estates and Facilities - non compliant areas reaudited 3 monthly.	To discuss with Diane Allison how non compliant elements are captured by Estates and Facilities. Update September 2024: Continues to be captured at IPCG, however the reporting mechanism need strengthening. Update March 2025 - this continues to require to be strengthened. Update September 2025: the water safety groups have been implemented by Estates and there is an escalation process in place for positive testing in LCH premises. Lack of assuance from external partners via third party estate e.g. Leeds City Council where LCH care is provided.	2. Partially compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	All linen within inpatient areas such as Wharfdale is managed by LTHT. Linen policy in place and NIPCM followed. For areas such as Hannah House a process is in place and there is a Management of Linen Policy in place that details the safe processing of laundry.	Assurance required from LTHT of provision and care of linen.		Policy updated March 2024.	3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07-01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Procedure recently fully reviewed and updated. Awaiting ratification of management of Waste Policy. A 'Waste Manager' is in place that is part of the Estates and Facilities Team, with SME provided from IPC. Waste captured as part of the environmental audit. Concerns or escalations of non compliance via the IPCG and QAIG. A duty of care visit was undertaken to the waste collector in October 2024.			Update September 2024: New Waste Policy implemented, recognise that a number of elements in the policy are currently not being followed. New tender process in place for waste disposal company, additional colour coding and a waste manual / guide to be implemented. Shared work with IPC / Waste Manager in Estates. Update March 2025: waste audits are completed, have 3 monthly review meetings with Mitie and Biffa and review the clinical waste quarterly returns. March 2026 - posters and training is being developed by IPC and the Waste manager and is to be launched in Q1 2026/7	3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	External decontamination process in place for dental and podiatry. Annual assurance and monitoring visit made to Tameside by IPC, dental and podiatry. All other equipment is single use and disposed of. Datix in place for instruments returned to Tameside with sharps still attached. March 2026: Deputy DIPC has access to the Steris Dashboard. Decontamination to be added to the IPCC agenda with an assurance report provided by the Deputy DIPC on a 6 monthly basis.			Tender process to be reviewed - discussed with Andrew Davies and Jo-ann Watson - awaiting update. Annual assurance visits made to the provider in Tameside, with dental and podiatry - due to be performed in April 2024.	3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Food safety compliance in place for Wharfdale in patient area and Hannah House. Training monitored via ESR. Compulsary training for relevant staff members. Assurance detailed through PLACE inspections and Environemtnal Audits. Food hygiene is led on by Estates and Facilities, who provide a report to IPCC on a 6 monthly basis.				3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	Ensure clarity of responsibility for AMR within governance responsibilities, including how antimicrobial stewardship (AMS) aspects of Care Quality Commission (CQC) Regulation 12 to prevent individuals from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.	Guidelines for antimicrobial use are developed in line with Leeds health Pathways processes, with microbiology input & peer review prior to approval via the LTHT antimicrobial governance route. AMS identified lead Head of IPC and head of Medicines Management. Flash report goes to QAIG on a quarterly basis outlining AMR updates, NICE guideline changes and precribing figures for LCH.				3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	The IPC Annual Report dtails activtiy on AMS and AMR is captured in the IPC Annual Plan as well as the IPC Overarching Policy. AMR activity is captured in the IPC Annual Report.				3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan. A formal operational lead for AMS is in post with time in their job description. Monitor patterns and trends of sentinel infections and antimicrobial use, the impact of early, accurate diagnosis and intervention upon outcomes and lengths of stay. Where there is variation with other providers which requires attention, develop plans to address unwarranted variation and to support National AMR Plan ambitions.	The Executive Director of Nursing and AHP's as DIPC has overal responsibility for AMR throughout LCH.				3. Compliant
3.4	To optimise patient outcomes and minimise inappropriate prescribing: • Monitor and improve compliance with NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' • Ensure adherence to the principles of Start Smart, Then Focus is implemented and monitored in secondary care. • Ensure AMS is included in mandatory training using national materials such as 'Start Smart, Then Focus' and 'Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET)'.	LCH IPC is part of the WY ICB AMR Collaborative Working Group, as well as the place based AMR group established by LCC. Resouces and tool are shared across the system and used as part of our approach throughout LCH. It is recognised that there is a small amount of prescribing throughout the trust. A flash report will be produced from Oct 23 jointly by Medicines Management and IPC on the systems in place as well as the audit processes to ensure that prescribing is inline with trust guidance. IPC week every November captures AMR as a health promotion day, information and links are available on the Oak and IPC are part of the NHS Futures platform for sharing resources, good working practice and bench marking.			Discussions with MEG about an electronic AMR audit that can be put in place. Considerations given around joint working with LTHT for the paediatric CVAS service.	3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMS are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	IPC support teams with risk assessments where required for example for specific infections e.g. CPE in an inpatient setting. Specific risks discussed via IPCG where an action log is in place. Education bitesize trainign is provided on specific elelemtsn such as CPE, VRE etc.				3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	There are resources available on the Oak highlighting AMR and AMS. LCH IPC are engaged with system work in relation to QI for AMR, due to relatively low prescribing rates internally there are plans in place to undertake deep dive audits/QI approach into services such as podiatry for px, LSH and WYOI.			To engage with ODI re QI for AMR.	3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	There are leaflets and information made available for specific infections. LCH IPC collaborate with PH at LCC to ensure that the information available meets the needs of the population group of Leeds and that alternative materials in multiple languages is available via UKHSA. Links to NHS Choices are shared with patients.			To add to relevant policies the different language options for information sharing.	3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	All policies and leaflets are revised every three years. Information is available on the internal and external internet as well as the Leeds Healthcare Pathways.			Consider QR codes on patient letters, texts to share information about specific infections. Start to share NHS Choices link to specific infections e.g. MRSA, CDI which are reviewed on a national level and available online.	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	All leaflets include the general principles of IPC, including importance of hand hygiene. Other control measures might include cleaning, washing of personal items, cough etiquette etc. as well as the principles of AMR - this would be dependant on the infection.				3. Compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	In patient areas have an infection control board that highlights the important key control measures. As part of national campaigns information shared with colleagues and individuals visiting our inpatient areas and health centres. Stall provide information and we hold external events to promote IPC at venues such as Kirkgate Market, use the display screen at Millenium Sqaure etc. We use social media means by sharing information on 'X@ and the LCH Facebook page. Campaign material for winter vaccination campaigns is ordered from central DH and is shared to public health messaging.				3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Patient passports are in place for catheters, a localised passport is used through the acute and community setting. We have a lead within the IPC Team for Devices related products and they sit on the IPS DRIPP Events.			Previous discussions have been had with CUCS around the auditing and usage of Catheter Passports. Do CVAS use passports for DRIPP?	3. Compliant
5.Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	Patients admitted to inpatient areas are not routinely tested for MRSA unless there is clinical rationale to do so. If patients do have clinical symptoms, swabs/smples are taken and transferred to the laboratry as per SOP. Results are then shared with inpatient area and via PPM+. Policy Manual available on the Oak outlining requirements. Stools assessment and chart in place to ensure prompt samplingfor potential CDI cases.				3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes. The Isolation prioritisation tool is available to assist in patient placement and ongoing isolation decisions.	Patients in inpatient areas have infection status regularly reviewed. Medical provision in place and escalations via GP or 111/999 should this be required. Patients have NEWS2assessment as per clinical need / policy and concerns around deterioration should be promptly escalated. IPC support with risk assessments for in patient areas.			Education and bitesize training in place for sepsis and deterioton.	3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Patient transfer form in place as per policy, for when patients are discharged from inpatient areas to care home or back to acute provison, detailing specific pathogens e.g. MRSA, CDI, CPE etc.			To audit transfer forms from Wharfdale to ensure completion and accuracy of detail. This is a 6 monthly audit on a sample of 20 patients.	3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage displayed on external ward area should an outbreak be in place, as well as specfic restrictions for bays if patients are being cohorted to reduce onwards transmission.				3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Outbreaks of two or more for either staff or patient areas are reported to UKHSA. Outbreak toolkit in place and monitoring / surveillance completed. IPC is a 7 day service and daily checkin of outbreak location are completed where SME is provided.			Point of care testing has been made available to the recovery hubs and wharfdale for potential respiratory infections, which can help detect and provide confirmation of an infection.	3. Compliant
6.Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	Face to face induction training is provided to new starters. This is a 15 minute presentation that captures the basic requires for IPC. All staff are then required to complete either level 1 or level 2 E-Learning for Health Training via ESR.	Induction is not mandated for all staff, as it is only for 15 minutes it does not cover the entirity f IPC that the staff members must be made aware of.	The staff member must complete their ELFH IPC training within a two period of starting.	On average we are >90% compliant with IPC training, however we identify quarterly poor uptake cares and these are escalated to QAIG.	3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Roles and responsibilities are outlined in the IPC Overarching Policy as well as other IPC Policies e.g. Standard Precautions. They are discussed as part of the Induction Training.				3. Compliant
6.3	Monitoring compliance and update IPC training programs as required.	Training compliance figures captured at IPCG and HSG. Escalations of non compliance captured at QAIG via flash report. Average >90% compliance for level 1 and 2 training. Training compliance is added ot the Head of IPC Report for the IPCC where the figures are reviewed.				3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	Staff receive training via E-Learning for Health. Information and videos on donning and doffing is available on the Oak. Staff undertake a PPE and Hand Hygiene Audit. Audit of system one notes for PPE/HH in place.			NIPCM referenced in IPC related policies.	3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff are re fit tested every two years as outlind by the HSE. Staff that are fit tested are recorded on a locally held (IPC) excel document.	A more robust mechanism e.g. ESR / PIP to record competency is required.	A IPC held excel document is stored within IPC, however it does not provide individuals or teams the ownership.	Consideration around co procured PPE within the system for future pandemic prepardness, as well as sustainability approach. Update September 2024: this continues to be escalated to QAIG. A proporation of staff from each service to be fit tested however this needs to be co led between health and safety and IPC will the competency lying with the responsibility of the employee. Update MArch 2025 - a piece of work has been progressed around improving the accuracy of the recording of fit testing. This will improve the individual risk assessment for staff members requiring fit testing. There will be a need for increased trainign sessions to be made available to LCH staff to meet the demand of the new Coreshare App. March 2026: IPC continue to work with business services on the development and launch of the Fit Test App. The process has been complex however set time scales are in place with having the app rolled out in Q2 2026/2027. This remains on the risk register and TLT are updated on the progress.	3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Registered staff should not be carrying out a task if they believe they are not competent. The ABU provides training to clinical and non clinical staff. Non qualified are currently undertaking new competency frameworks delivered by the Neighbourhood Team Clinical Skills and Competency Educators. All of the training provided in ABU has been peer reviewed and assessed by the relevant specialists and there are regular (3-6 monthly) meetings with those specialist services to review training materials and update training as and when there are changes to policies or practice. There are lesson plans and guides in place for all of our training sessions so that if anyone else had to cover a session there is a guide to follow.	To explore further around what is exactly in place for all clinical staff that undertake a procedure. For some clinical competencies staff self declare compliance, however there are gaps around refreshers and where this information is appropriately stored.	Staff self declare competencies and work in an autonomous manner under their relevant codes of practuce. Bespoke training can be provided by specific teams such as CUCS, CVAS and IPC.	Understand gaps for business units and how this could be accurartly recorded on staff profiles on ESR. Update September 2024: an app has been identified by WFI and there is currently a scoping exercise being undertaken. This sits outside of IPC. March 2025 - ongoing discussions with the DON around improving competency and education of staff . March 2026 this continues to be an identified gap and is listed on the risk register.	2. Partially compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Risk assessments are undertaken for inpatient areas for specific infections such as CPE. These are supprted by the IPC Team and coincide with the relevant policy and the NIPCM.	A formal logging system to be in place for risk assessments ? Added to patient notes.		Further education has been provided via the IPC team on completion of risk assessments.	3. Compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •single rooms are in short supply and if there are two or more patients with the same confirmed infection. •there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	In patient areas have specific isolation (side room) facilities. Hannah House is all single side rooms. Wharfdale has a number of side rooms that can be used if a patient has a specific infection e.g. CPE or CDI. Risk assessments are completed in collaboration with the IPC team, to ensure the correct positioning of the patient, including standard precaution principles and tranmission based precautions. If in the event a side room could not be a sourced a Datix would be completed and a hierachy of control measures to reduce onwards transmission would be in place. Isolation Policy available on the Oak and Level 2 IPC training covers isolation principles.				3. Compliant

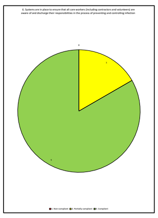


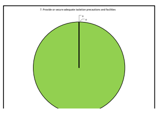




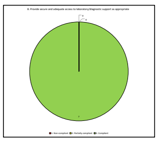


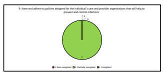


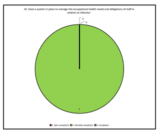




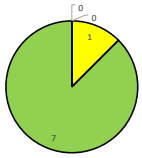
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Contractual arrangements / SOP in place for the processing of laboratry samples with LTHT.			Education system in place to update staff on TBP's. The new HH audit tool captures this that has been rolled out across all three business units.	3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	The IPC team is a 7 day service, details are shared across the trust on how to reach out should additonal support / SME advice be required for specific pathogens / risk assessments. On call manager overnight / weekend / BH should escaltion be required. UKHSA have on call manager details should an ncident management			Transfer form in place at Wharfdale - discussed with Kirsty Jones. To be reaudited on a 6 monthly basis.	3. Compliant
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Contractual arrangements / SOP in place for the processing of laboratry samples with LTHT.				3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	The IPC team is a 7 day service, details are shared across the trust on how to reach out should additonal support / SME advice be required for specific pathogens / risk assessments. On call manager overnight / weekend / BH should escaltion be required. UKHSA have on call manager details should an ncident management meeting be required for a specific outbreak. Contact details for the IPC team available on the Oak. Champions are dispersed across the organisation to support teams, regular champion days are held to educate and they are a point of contact within their services.				3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	SOP is in place for the testing of samples via LTHT laboratry. Microbiology provision provided via a SOP through LTHT. PPM+ platform shares results to the IPC team and a SOP is in place for the details of specific pathogens e.g. MRSA, CDI, E.Coli to be added onto the front page of Sys1 notes. This is to add an additional layer of assurance as laboratry notes should be shared directly with the teams. Advice is provided on Sys 1 around decolonisation, standard precautions, tranmission based precautions etc.				3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Policies are in place for testing of patients should there be a clinical concern of infection. IPC training level 2 provides education on this. Staff undertake NEWS2 clinical assessment and should the patient require a specific swab or sputum sample.			Audit of transfer forms to be undertaken. Liasised with Wharfdale re transfer form back into LTHT should patient have a specific pathogen. To be re audited 6 monthly.	3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Policies are in place for testing of patients should there be a clinical concern of infection. IPC training level 2 provides education on this. Staff undertake NEWS2 clinical assessment and should the patient require a specific swab or sputum sample.				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	SOP is in place with LTHT for laboratory services. This incorporates agreements with other external providers e.g. Collindale (UKHSA) and other providers for specific testing of pathogens e.g. MPX.				3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	SOP is in place with LTHT for laboratory services. This incorporates agreements with other external providers e.g. Collindale (UKHSA) and other providers for specific testing of pathogens e.g. MPX.				3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, NIPCM including the NHSE A to Z pathogens list). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider. The SICPs monitoring tool can be applied to aid this	Specific infection policy is in place that details and references the A-Z of Pathogens. All policies available on the Oak and Leeds Healthcare Pathways. Outbreaks are monitored by the IPC team - which provides as 7 day provision as part of the cooperation agreement with LCC. Tams can contact IPC for support and SOP is in place on how to monitor an outbreak. As per policy all outbreaks are reported UKHSA and an ILOG number is provided to detail on samples. IPC attend any specific IMT's with UKHSA. Bitesize training provided to staff virtually on specific infections, accessed via the Oak. Staff attend online virtual ELFH IPC training Level 1 and Level 2 - attendance rates monitored via IPCG/HSG from BI reports. Onaverage compliance 90-92%			Gap analysis against current policies to identify potential gaps and further fit testing to be completed by IPC as part of the Fit Test App being developed.	3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Pregnancy risk assessment completed by line manager. IPC contacted if in the event of a concern that is escalated.	IPC do not have assurance of risk assessment s that are being undertaken for individual staff members as this is service specific.	Locally held by line managers.		3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Process in place and contract with SWYFT occupational health service. Flow chart for staff to follow in the event of a sharps incident. Lanyard card provided to staff members, posters are displayed, screen savers in place and policy outlines procedure. IPC support staff member by contacting them within 24 hours of datix to support the individual and ensure process followed.				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Contract in place with SWYFT for Occupational Health Provision and staff upon employment complete medical questionnaire via Recruitment and HR.	We do not receive any data from SWYFT outlining OH provision for IPC related activity, for example immunisation, occupational irritant dermatitus, needle stick injury		Escalated to Ann Hobson to discuss KPI's in place with SWYFT.	3. Compliant





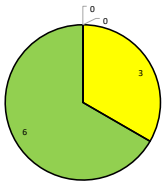


1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users



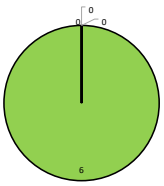
1. Non-compliant 2. Partially compliant 3. Compliant

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



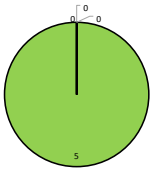
1. Non-compliant 2. Partially compliant 3. Compliant

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance



1. Non-compliant 2. Partially compliant 3. Compliant

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



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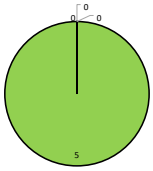
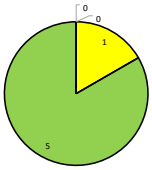
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.



1. Non-compliant 2. Partially compliant 3. Compliant

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



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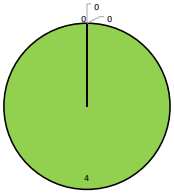
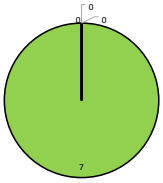
7. Provide or secure adequate isolation precautions and facilities



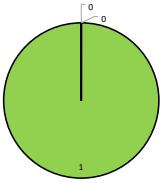
1. Non-compliant 2. Partially compliant 3. Compliant

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



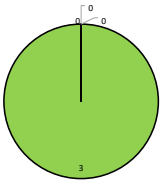
1. Non-compliant 2. Partially compliant 3. Compliant

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

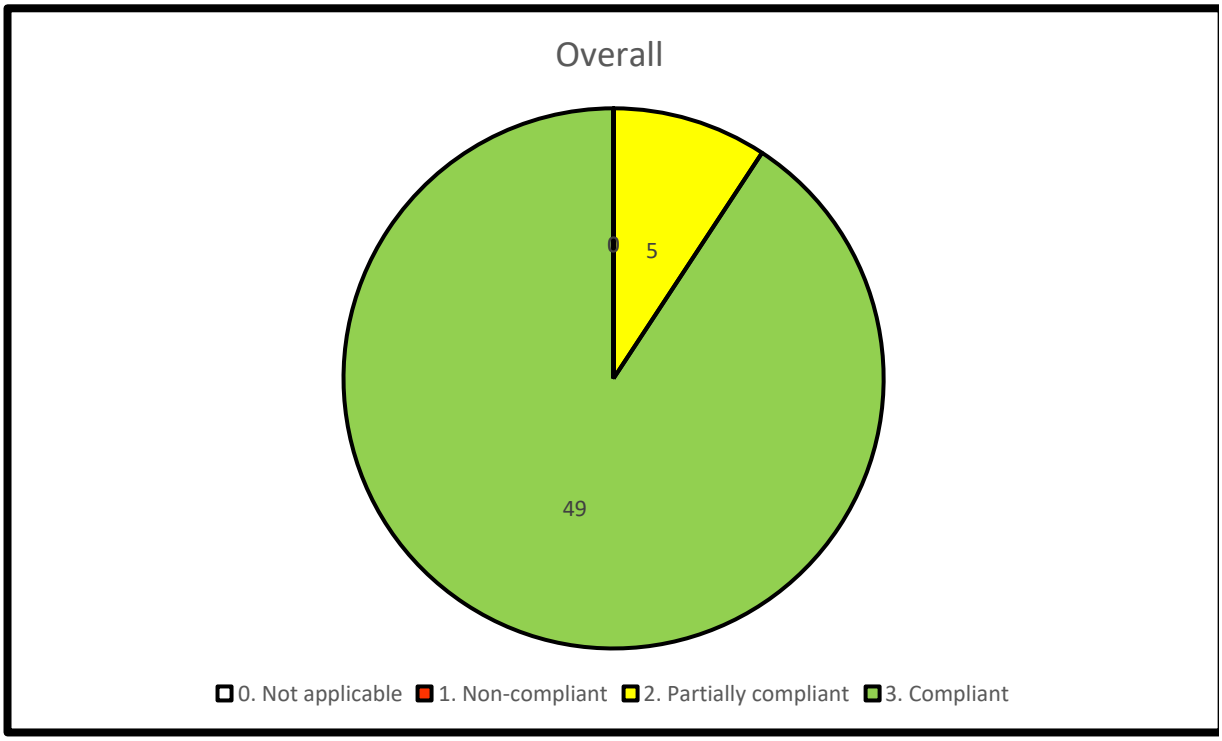


1. Non-compliant 2. Partially compliant 3. Compliant

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



1. Non-compliant 2. Partially compliant 3. Compliant


Overall
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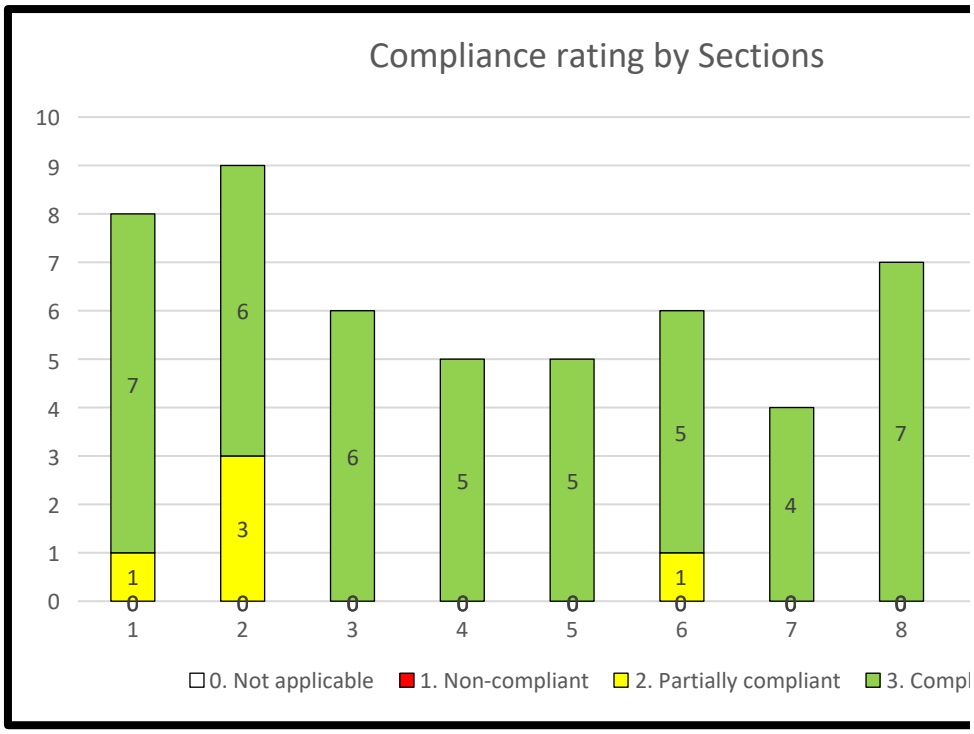
5
49
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant


Compliance rating by Sections
10
9
8
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4
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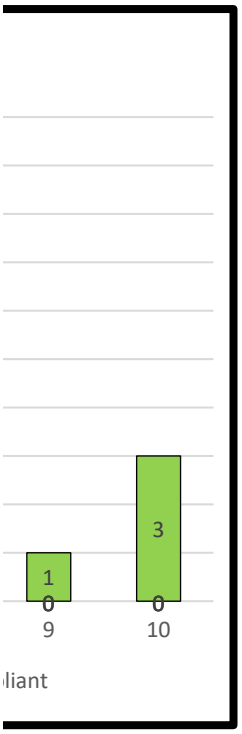
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compl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Leeds Community Healthcare NHS Trust

Agenda item:	25-26 Item 22 (blue box)
Title of report:	Mortality and Learning from Deaths
Meeting:	Board
Date:	18/02/2026

Presented by:	Geraint Jones
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.
- Two deaths were identified this quarter as more likely than not care contributed to the outcome. PSIIs have been raised for both cases.
- 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:	Trust Board 05/02/2026
Outcome of previous discussion/s:	Update to include deaths more likely than not to have been contributed to by care. See highlighted entries.

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)	1. 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.

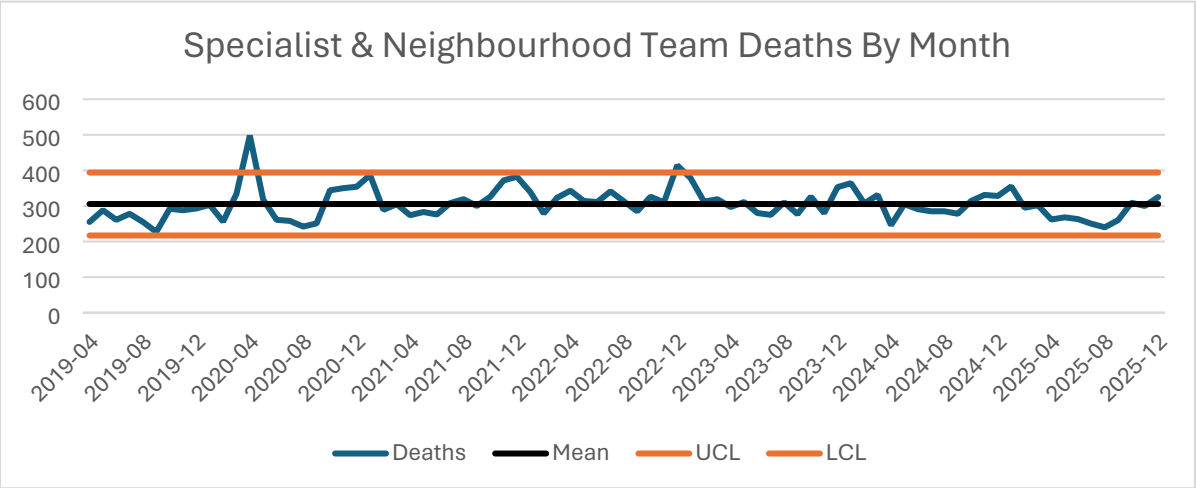
There were 6 deaths recorded for people with a learning disability (LD). 4 of these individuals were known to the NTs, the other two were open to the Specialist Business Unit (SBU) dietetic services but not under active care at LCH at the time of death.

- 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.

Two deaths were judged to be more likely than not contributed to by care, and PSIIs have been initiated for both cases.



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 SystmOne based 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:

Trust board is recommended to:

- Accept this updated report as an accurate reflection of mortality activity, learning and assurance across Adults, Children and LD.

Leeds Community Healthcare NHS Trust

Public Board workplan 2025-26
Version 7: 19 03 2026

Agenda item 2025-26 (23)

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	Not taken in March 26 as superceded by MTP
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	
Chartitable 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	Done as part of IPR work so not taken to Board in March 26
Financial Plan	annual			X							X	Not taken in March 26 as superceded by MTP
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	Incorporated into the IPR item	
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 (deferred due to transition work)	
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