Bundle Public Board Meeting 21 May 2026

Item 11 - Integrated Performance Report - Cover paper - Board May 2026
Item 11 - Integrated Performance Report - Year End Report 2025-26v2
Item 11a - IPR Board update - Sickness Absence May 2026

11.b BREAK - 10 minutes

12 Business Case: Paediatric Neurodevelopmental Assessment Pathway
Item 12 - Business Case - Paediatric Neurodevelopmental Assessment Pathway Mar 26 v2 - Public Board

13 Business Case: Early Supported Stroke Discharge
Item 13 - Business Case - Early Supported Stroke Discharge v1.0 Board

14 WORKFORCE

14.a People and Culture Committee Chair's Assurance Report: 8 April 2026
Item 14 - People and Culture Committee - Chairs assurance report - April 26 Final LM

15 Guardian for Safe Working Hours - report postponed - verbal update

16 GOVERNANCE AND WELL LED

16.a Code of Governance Compliance
Item 16 - Code of Governance Compliance - May 2026
Item 16 - Code of Governance Compliance - Appendix 1 Compliance Tables April 2026

17 Provider Licence Compliance
Item 17 - NHS Provider Licence Compliance

18 Audit Committee Annual Report (including Committee Terms of Reference)
Item 18 i - Audit Committee Annual report_effectiveness review_TOR May 2026 FINAL
Item 18 i - Audit Committee TOR May 2026 V14 Draft with track changes

18.a Committee Terms of Reference
Item 18 ii - Committees review of terms of reference for approval May 2026

19 Declarations of Interests and Fit & Proper Person Test
Item 19 - Declarations of Interest and Fit and Proper Persons Test - Final
Item 19 - Directors Declarations of Interest 2025-26 - 06 05 2026

20 Significant Risks And Risk Assurance Report (including Risk Appetite Statement)
Item 20 - Significant Risks and Risk Assurance Report - Board 210526

21 Use of Trust Seal
Item 21 - Use of Trust Seal - July 2025 to March 2026

22 Board Assurance Framework – Update on Review Process for 2026-27
Item 22i - Board Assurance Framework – Update on Review Process for 2026-27
Item 22ii - BAF 2026-27 - Summary_of_Proposed_Strategic_Risks - v2

23.a ANY OTHER BUSINESS. QUESTIONS ON BLUE BOX ITEMS AND CLOSE.

23.b 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.

24 BLUE BOX ITEM: Glossary

Item 24 - BLUE BOX ITEM - Glossary - v2.2 - April 2026

25 BLUE BOX ITEM: Workplan

Item 25 - BLUE BOX ITEM - Trust Board Workplan Public v5 2026-2027 30 04 2026

Leeds Community Healthcare NHS Trust

Trust Board Meeting Held In Public
Boardroom, Building 3,White Rose Office Park
Millshaw Park Lane, Leeds LS11 ODL

Date 21 May 2026
Time 9.30am – 12.10pm
Chair Helen Thomson DL, Acting Trust Chair

AGENDA			Paper
2026-27 1	9.30	**Welcome, Introductions and Apologies** *(Acting Trust Chair)*	**N**
STANDING ITEMS			
2026-27 2	9.35	**Declarations Of Interest** *(Acting Trust Chair)*	**N**
2026-27 3		**Questions From Members Of The Public**	**N**
2026-27 4		**Minutes Of Previous Meetings, Action Log And Matters Arising** *(Acting Trust Chair)*	
4a		Minutes of the meeting held on: • 27 March 2026	**Y**
4b		Action Log	**Y**
4c	9.40	**Patient Lived Experience**	**N**
STRATEGY AND PARTNERSHIPS			
2026-27 5	10.00	**Interim Chief Executive's Report** *(Dr Sara Munro)*	**Y**
QUALITY AND SAFETY			
2026-27 6	10.15	**Quality Committee Chair's Assurance Report:** 12 May 2026 *(Professor Ian Lewis)*	**Y**
2026-27 7	10.20	**Mortality Report, including Annual Report** a – Q4 Report 2025-26 b – Annual Report 2025-26 *(Dr Ruth Burnett)*	**Y**
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2026-27 8	10.25	**Business Committee Chair's Assurance Reports**: 21 April 2026 and 19 May 2026 *(Lynne Mellor)*	**Y** *Report from May to be tabled*
2026-27 9	10.30	**Audit Committee Chair's Assurance Report**: 7 April 2026 *(Khalil Rehman)*	**Y**
2026-27 10	10.35	**Charitable Funds Update Report:** 6 monthly report *(Sam Prince)*	**Y**
2026-27 11	10.40	**Integrated Performance Report** *(All Execs)* Including • Sickness Rate Trajectories • Waiting List Trajectories	**Y**
	10.50	**BREAK – 10 minutes**	
2026-27 12	11.00	**Business Case: Paediatric Neurodevelopmental Assessment Pathway** *(Sam Prince)*	**Y**
2026-27 13	11.10	**Business Case: Early Supported Stroke Discharge** *(Sam Prince)*	**Y**

WORKFORCE			
2026-27 14	11.20	**People and Culture Committee Chair's Assurance Report:** 8 April 2026 *(Rachel Booth)*	**Y**
2026-27 15	11.25	**Guardian for Safe Working Hours – verbal udpate (report postponed)** *(Dr Ruth Burnett)*	**N**
GOVERNANCE AND WELL LED			
2026-27 16	11.30	**Code of Governance Compliance** *(Dr Sara Munro)*	**Y**
2026-27 17	11.35	**Provider Licence Compliance** *(Helen Robinson)*	**Y**
2026-27 18	11.40	**Audit Committee Annual Report - including Committee Terms of Reference** *(Helen Robinson)*	**Y**
2026-27 19	11.45	**Declarations of Interests and Fit & Proper Person Test** *(Acting Trust Chair & Company Secretary)*	**Y**
2026-27 20	11.50	**Significant Risks And Risk Assurance Report (including Risk Appetite Statement)** *(Dr Sara Munro)*	**Y**
2026-27 21	11.55	**Use of Trust Seal** *(Helen Robinson)*	**Y**
2026-27 22	12.00	**Board Assurance Framework – Update on Review Process for 2026-27** *(Dr Sara Munro)*	**Y**
CLOSING BUSINESS			
2026-27 23	12.10	**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 23.

***Blue Box Items – To Note**		
2026-27 24	**Glossary**	**Y**
2026-27 25	**Workplan**	**Y**

Item
2026-27
4a

Leeds Community Healthcare NHS Trust

Minutes: Trust Board Meeting Held in **Public**
Date: 27 March 2026
Location: Wetherby Health Centre, Hallfield Road, Wetherby, LS22 6JS

Attendance:		
Present:	Helen Thomson DL	Acting Trust Chair
	Dr Sara Munro	Interim Chief Executive
	Jenny Allen	Director of People (JA)
	Dr Ruth Burnett	Executive Medical Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Alison Lowe OBE (AL)	Non-Executive Director
	Heather McClelland	Interim Executive Director of Nursing and AHPs
	Lynne Mellor (LM)	Associate Non-Executive Director
	Andrea Osborne	Executive Director of Finance & Resources *(from item 139)*
	Sam Prince	Executive Director of Operations
	Khalil Rehman (KR)	Non-Executive Director
In Attendance:	Christy Holland	Wharfedale Physiotherapy (*for item 139*)
	Dayle Lynch	Associate Director of Estates – Strategy
	Helen Robinson	Company Secretary
	Rosie Tam	Clinical Lead Physiotherapist (Wharfedale Recovery Hub) (*for item 139*)
	John Walsh	Freedom to Speak Up Guardian (*for item 145*)
Minutes:	Sue Grahamslaw	Interim Corporate Governance Officer
Apologies:	Rachel Booth	Non-Executive Director
	Laura Smith	Director of People (LS)
	Hannah Beal	Deputy Director of AHP's and Clinical Education
There were no members of the public nor members of staff observing the meeting.		

Item 2025-26 (135): 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 Rachel Booth and it was noted that the Executive Director of Finance and Resources would join the meeting shortly.

Item 2025-26 (136): 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 Acting 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 (137): Questions from members of the public

There were no questions from members of the public.

Item 2025-26 (138): Minutes of Previous Meetings, Action Log and Matters Arising

a) Minutes of the meeting held on 5 February 2026

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

b) Action log

There were two actions on the log to review:

2025-26 (118): Youth Board: list of Youth Board meeting dates to be circulated by email: It had been agreed that the Youth Board would revisit Trust Board in November. However, in the meantime, they should receive feedback on the questions they had previously raised and draft pledges should be considered. The Executive Director of Operations confirmed a list of dates would be circulated. The Interim Chief Executive noted that the Youth Board should also be included in the transition work going forwards. **Action closed.**

2025-26 (129) – Freedom to Speak Up – Planning Toolkit: It was advised that it was expected the Planning Toolkit would be received at the June 2026 People & Culture Committee meeting which would then be advised to Board through the Committee's AAA Report. **Action ongoing.**

Closed Action 2025-26 (88) – Health Equity Five Year Tactical Plan: The Executive Medical Director noted that the paper front cover sheets now included whether Health Equity Data was included in each paper. However, this was not always completed and reports should be written with equity in mind, when appropriate, and committee chairs would monitor it's use.

There were no further actions or matters arising to address.

Non-Executive Director (IL) highlighted that at the Board workshop in April 2026 it should be considered whether a digital strategic risk should be included in the Board Assurance Framework (BAF) for 2026/27.

Item 2025-26 (139): Patient Lived Experience – Wharfedale Physiotherapy Service

The Clinical Lead Physiotherapist from Wharfedale Recovery Hub and another Physiotherapist from Wharfedale Physiotherapy joined the meeting and gave an overview of their work and highlighted a case study of a gentleman with complex medical conditions who had had recurrent falls and had been referred to Wharfedale Recovery Hub. The patient's physiotherapy status on arrival was outlined together with the daily and weekly goals at different stages of recovery which would ultimately mean the patient could return home. The equipment challenges were explained, including the need for specialist bariatric equipment. The timeline of the patient's improvements was shared. A Multi-Disciplinary Team approach worked well to provide overall care which included family involvement to help with clearing the patient's home to enable equipment and other adaptations to his home to be provided for his continuing progress.

The outcome was that the patient was discharged home after 11 weeks, with a neighbourhood team visiting to assist with mobilisation through the day. Patient feedback was that he felt motivated by the positive relationship with the Wharfedale Recovery Hub Team. The lessons learned included the need for bariatric equipment within the hub and the additional equipment requirements.

The Interim Executive Director of Nursing and AHPs welcomed the compassionate description of the patient's journey. The challenges relating to the patient's recovery in an acute setting were summarised as well as the desire to help acute staff by providing an avenue for appropriate patients to have a positive outcome at the Recovery Hub.

The link with primary care and the patient's GP practice was questioned, with the Executive Medical Director noting the need for liaison to provide a holistic and proactive approach.

The dedication to help the patient and provide a positive trajectory for their recovery was highlighted by Non-Executive Director (LM) and suggested that the Hub consider looking at the cost savings from the interventions they made which could support a case for change.

The presenters were asked how the Board could support them. They suggested investment in rehabilitation as it would bring improved quality of life which would save costs on carers, equipment and long-term healthcare. It was noted that Wharfedale Recovery Hub was well staffed and there would be increased benefits if other Recovery Hubs were staffed in the same way. The Executive Director of Operations noted that additional resource was being put into business case modelling in the Trust which would help with pathway modelling for where to focus active support and the cost benefit of intervening at different points which could help reduce the length of stay for patients.

Trust Board members thanked the Wharfedale Recovery Hub staff for their insightful presentation.

The Executive Director of Finance and Resources joined the meeting. The Wharfedale Recovery Hub presenters left the meeting.

Item 2025-26 (140): Interim Chief Executive's Report

The Interim Chief Executive presented the report and highlighted the following Trust activities since the last meeting:

- The new Interim Executive Director of Nursing and AHPs was welcomed to the Board and it was noted that work was underway to realign clinical lead reporting lines and clinical governance.
- Medium Term Plan – the Trust plan had been considered compliant and, unlike many other Trusts, no alterations had been required. National Oversight Framework (NOF) metrics were awaited for 2026-27 and the Trust would be required to provide regular Plan updates.
- Integrated Performance Report – it was positive that the Trust had moved up to segment 3. A new set of metrics would be applied next year.
- Neighbourhood Health in Leeds – the National framework had now been published and the requirement was to design services around neighbourhood health. Provider partnerships could hold budgets. West Yorkshire was an outlier and so likely to have greater autonomy on where patients go and on decision making.
- The changes in the ICB leadership were advised.
- Leeds Provider Partnership (LPP) – conversations had been held around the changes and the risk of people changing roles. Tim Riley had been appointed as Director of the developing LPP, a post funded by the ICB, which would enable capacity in terms of delegated responsibilities.
- Industrial Action – the announcement was not expected but the Trust had tried and tested processes in place to mitigate the risks.

Outcome: The Trust Board noted the report.

Item 2025-26 (141): Quality Committee Chair's Assurance Report

The Quality Committee Chair, Non-Executive Director (IL), presented the report from the meeting on 24 March 2026 that had been tabled at the Board meeting. The following points were highlighted:

- Service spotlight was the Community Stroke Rehab Team where limitations regarding BI and data outcomes were noted, resulting in challenges when considering equity.
- There was a discussion on a Regulation 12 that had been issued by the CQC around HMYOI Wetherby relating to the lack of a second checker – action for compliance had been accepted by the CQC but NHSE were keen for further consideration of the second checker option.
    - As a result of similar issues relating to controlled medication, the Committee had requested a summary of previous audits around controlled drugs to be taken to the May meeting.
    - The Executive Medical Director explained that the Trust was confident the correct processes were in place but if the second checker was mandated, additional funds would be required from NHSE. Work to strengthen the understanding of policies and processes was underway in Wetherby. The Interim Chief Executive highlighted that a there was a need to obtain a commitment from the CQC that their response to issues was not always to require an increase in staffing as that was not the NHSE/CQC agreement following the Well-Led inspection.

- Quality Committee requested an update on the previous controlled drugs audit to go to next meeting
- The issues with Business Intelligence software were raised and the Executive Director of Finance and Resources reported that it was a national issue with the portal meaning the local solution would be a huge administrative task. The BI team had restructured as demands escalated. A business case was in development on how to sustain the work and if investment into digital would be of benefit.
- An alert from QAIG had been received on transportation of pathology samples and the mitigations in place.

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

Outcome: The Trust Board noted the Quality Committee Chair's Assurance Report.

The Freedom to Speak Up Guardian joined the meeting.

Item 2025-26 (142): Business Committee Chair's Assurance Report

Chair of the Business Committee, Associate Non-Executive Director (LM), presented the reports from the meetings on 25 February and 25 March 2026, highlighting the following points:
From the February meeting:

- Alert received from estates relating to the asset register just being established on MiCad, noting how items on the register would be considered in the transition and the need to link with the internal audit on estates and review the estates value for money work for the transition.
- Progress was being made on waiting lists with improvements in the trajectories, although there was still some concern about waits in paediatric neuro development.
- Digital Strategy updates were provided and a list of priorities being developed. EPR (Electronic Patient Record) and SD WAN (Software Defined Wide Area Network) were key areas

From the March meeting:

- Alert on the Waiting List limited assurance Internal Audit Report which highlighted a concern on data quality. The Committee requested a deep-dive into data gaps, especially on equality.
- Progress was being made on waiting list reductions but there was a need to understand how the reductions had been made.
- EPRR limited assurance Internal Audit Report received with assurance and learnings provided at the meeting. Audit Yorkshire to review the additional assurances provided.

The Director of Finance and Resources also reported there had been a follow up on the digital strategy in February and the priorities in line with the Wildly Important Goals (WIGs) had been received at Committee. Attention was drawn to a perceived disconnect between what the Trust could afford and the requests for investment into digital. If the cost benefit could be identified and correlation was feasible, it would clarify the prioritisation of projects.

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

Outcome: The Trust Board noted the Business Committee Chair's Assurance Reports.

Item 2025-26 (143): Audit Committee Chair's Assurance Report

Chair of the Audit Committee, Non-Executive Director (KR), presented the report from the meeting on 10 March 2026 noting that there was good progress with Internal Audit reports prior to Year End.

Items covered at the Audit meeting had included:

- Going Concern Consideration.
- Head of Internal Audit Opinion – noting there was still work to do.
- Quality Committee scrutinised the PSIRF Internal Audit Report and concluding outcomes.
- Finance was positive with another HFMA checklist for consideration.

Non-Executive Director (LM) noted that the Audit Committee had considered the EPRR Internal Audit Report in addition to the Business Committee and Quality Committee, which had all considered the actions. Audit Committee sought to gain assurance that the correct controls were in place

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

Outcome: The Trust Board noted the Audit Committee Chair's Assurance Report.

Item 2025-26 (144): Charitable Funds Committee Chair's Assurance Report

The Charitable Funds Committee Chair, Non-Executive Director (AL), presented the report from the meeting on 19 March 2026, outlining the following points:

- The Transformation Grant application to NHS Charities Together had been unsuccessful. Alternative fundraising opportunities were discussed.
- Staff Engagement with the Charity was a concern.
- The integration would require further consideration for the Charity with charity registration and other legal requirements.

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

Outcome: The Trust Board noted the Charitable Funds Committee Chair's Assurance Report.

Items taken out of agenda order owing to presenter availability.

Item 2025-26 (145): Freedom to Speak Up Report – 6 monthly Update – Annual Report

The Freedom to Speak Up Guardian presented the report which provided the Board with an annual report on the work of the Freedom to Speak Up Guardian (FTSUG) from 1 April 2025 to 26 March 2026. The following points were highlighted:

- A positive report meaning the Trust was in a strong position but there was always work to do.
- 255 concerns had been raised, mainly informally, but an overall increase concerning Trust and wider NHS issues.
- In terms of NOF Staff Engagement, the Trust's position had improved, as had staff feeling secure to raise concerns about unsafe clinical practice.
- Positive signs that the work of the Freedom to Speak Up Champions had embedded by being included in development work.
- The work of the clinical concerns forum was triangulating actions with overall workforce concerns
- The assurance to Board was that there had been a large number of referrals from within the organisation, covering all business units, locations and bands.
- The LCH FTSUG was working with LYPFT to consider an appropriate model for the new organisation.
- The National Guardian's office would close in June, with the work being absorbed in the NHS centrally.
- Guardians have met as a group and provide support to each other and share learnings.

Non-Executive Director (AL) triangulated the FTSUG report with the staff survey results noting the low confidence level of those with protected characteristics, specifically the disabled and BME staff. It was advised that there was still work to do on behaviours to stop discrimination. The strengthening of the EQIA process had highlighted some areas which was resulting in a deep dive on inclusion at the April People and Culture Committee. Assurances were provided that concerns were taken seriously and some became personal conduct matters. The Freedom to Speak Up Guardian offered a meeting to consider the themes with Non-Executive Directors (AL) and (KR).

The Freedom to Speak Up Guardian confirmed he felt well supported by the Trust, including the leadership team and reported that staff had improved how they considered equality in their work.

The Interim Chief Executive noted that some concerns could be complex but that the executive team knew how to navigate such issues.

Outcome: The Board noted the report and continued to support the embedding of this work across the Trust.

Item 2025-26 (146): Strategic Estates Plan

The Executive Director of Finance and Resources explained that the Strategic Estates Plan (SEP) was being brought to the Board for approval, recognising that the discussion at the recent Business Committee had requested further development of the strategy. The Board therefore should look at what was needed for the next stage and incorporating neighbourhood health. The strategy set out where the Trust wanted to be in the next two years and then the framework for where to be in the years afterwards. Engagement would need to come from the SEP and this was yet to be developed.

Non-Executive Director (AL) noted that the financial directors at LYPFT had reviewed the document and not raised any concerns.

The Associate Director of Estates – Strategy explained the SEP reviews that had taken place at Committee and Leadership team levels. The plan was in three sections – current position, ambitions for where the Trust needed to be, and how to get to that position – a blueprint for transformational changes – which provided the opportunity to engage with patients. The SEP included a framework case for investment and where to prioritise capital to ensure a good standard of maintenance and that the Trust remained statutorily compliant. Regional ICB approval would be needed and there could be a rationalisation of the estate during the Trusts' transition.

Non-Executive Director (KR) explained that the Business Committee had concerns regarding the delivery plan and the mapping of risks such as Burmantofts. He requested additional work on the SEP.

Additionally, there was concern about how the estate would look strategically once the Trust had transitioned and how that would fit with the new organisation's clinical strategy which would provide direction.

The Executive Director of Finance and Resources explained that strategic plans were in the pipeline but LCH's vision and framework was unclear going into a combined estates strategy. The Interim Chief Executive concurred that the context had shifted since the beginning of the SEP and there was a need to consider a fundamental operating model for estates planning.

The Acting Trust Chair confirmed that it was not possible to approve the Strategic Estates Plan as there was more work to be done. However, it was noted that it was going in the right direction although this was likely to be overtaken by the integration. It was suggested that the joint executives could begin to work on an integrated SEP for consideration.

The Associate Director of Estates left the meeting.

Outcome: In lieu of approval, the Trust Board requested additional work to be completed on the Strategic Estates Plan by the Executive Team in light of the Trust's future integration plans.

The items returned to agenda order.

Item 2025-26 (147): Integrated Performance Report

The 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 and highlighted the following key points:

- There was positively around the improved segmentation score, noting that the projection and forecasting had been successful.
- Safe Domain: The Interim Chief Executive was given assurance that the PSII details were considered at Committee level and, whilst a backlog remained, it was being addressed and data was being reviewed at QAIG.
- Effective Domain: There was nothing new to report.

- Caring Domain: The Interim Executive Director of Nursing and AHPs advised the measures were considered reasonable and further review of the data would be required at QAIG.
- Responsive Domain: the Executive Director of Operations advised the numbers were continuing to reduce for the 52-week waits; the 18-week waits were below target and had hit the next year's target.
- Well-Led Domain: the Director of People (JA) noted that sickness had peaked at 8.5% in January but reduced slightly in February. Work was underway to understand hotspot areas and deep-dives were underway to report back to the People and Culture Committee. In addition, work was ongoing with Occupational Health to be proactive to prevent staff from going sick in the first place. The positive BME statistics were noted.

The Non-Executive Director (LM) considered there was potential to see increasing dissatisfaction in the Trust as the web and cloud-based Datix data was combined. The Interim Executive Director of Nursing and AHPs explained it was hoped a marker would be on the data timeline to understand when Datix changes were being made and if there were any significant changes as a result of the transfer to a cloud-based system. It had been agreed there would be 6-monthly review for data themes.

- Finance Domain: The Board were advised that financial performance remained on track to produce the £900k surplus and the Quality and Value programme was progressing well. However, as the ICB would go into deficit as a result of other trusts' deficits, it was unlikely that the Trust would receive any redistribution of funds.

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

Outcome: The Trust Board received and noted the IPR report.

Item 2025-26 (148): People and Culture Committee Chair's Assurance Report 17 March 2026

The People and Culture Committee's Chair, Non-Executive Director (LM), presented the report from the meeting on 17 March 2026, noting the positive meeting with in-depth discussions, especially relating to sickness and absence and associated deep-dives.

There were not considered to be any issues that required an alert to the Board.

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

Outcome: The Board noted the People and Culture Committee Chair's Assurance Report.

Item 2025-26 (149): 2025 National Staff Survey results

The Director of People highlighted the following points from the report:

- Engagement scores were similar to last year, when other Trusts' engagement had decreased – this was positive considering the organisational changes; the Trust was currently average in the sector.
- Areas to celebrate included compassion, role of managers, and Freedom to Speak Up was strong.
- Areas of concern included health and safety, staff sickness and inclusion.
- Some interventions had had a positive impact on WRES and WDES reports.
- An intention plan on engagement, health and wellbeing and inclusion had been requested of each Business Unit.

The Board were reminded that there was a board workshop on inclusion in April 2026 and also a deep-dive scheduled at the People and Culture Committee.

It was noted by Non-Executive Director (AL) that a reduction in the rate of harm was being celebrated but there was concern that there was any harm and there should be zero tolerance.

In addition, Non-Executive Director (KR) highlighted that the infographic did not capture other staff members who may have been traumatised, and that gaps in culture could be demonstrated more positively. The "Discrimination from Manager or Team" data was highlighted in the WRES report noting the positive work to reduce the figures since 2018 but there was concern relating to the increase this year. Further analysis and reflection were requested.

Action: WRES 8 – Discrimination from Manager or Team data to be analysed further and reflections provided.
Responsible Officer: Director of People

There were further discussions relating to the figures for staff agreeing that appraisals helped them do their jobs better and the percentage of staff saying they experienced burn out, noting that every service had been asked to consider what this meant in their areas as they reviewed their dedicated dashboards. These would ultimately create an intention plan for the organisation.

The Interim Chief Executive recognised that there were some areas which required improvement, the stability with engagement was welcomed but also there needed to be improvement to demonstrate to staff that the Trust was listening to them. Both LCH and LYPFT achieved the same engagement score. The work on qualitative data was usually considered at Committees but a formal response was now required to be provided to commissioners for the new staff standards.

Non-Executive Director (KR) also brought the significant change in WDES metric 7 ("*Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which the organisation values their work"*) to the Board's attention. It was explained that this had been discussed at the People and Culture Committee and that action plans were at a local level but that oversight was still required to ensure management behaviours were appropriate. However, the need to ensure the plans were owned by each service meant that the work was delegated to operations' managers so it was not seen as just a plan for senior managers.

It was confirmed that all staff networks now had chair-people, including staff-side. These reported to the People and Culture Committee.

Outcome: The Trust Board:

- Noted the release of the 2025 Staff Survey results and national comparator data.
- Considered 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 8 April 2026 and Board Workshop on 23 April 2026.

Item 2025-26 (150): Going Concern Statement

The Executive Director of Finance and Resources presented the Going Concern Statement, noting the integration had no bearing on the Going Concern as it was based on a continuation of services. She explained this had been considered at the Audit Committee meeting on 10 March 2026 and recommended to Board for approval.

Outcome: The Trust Board approved the preparation of the 2025/26 annual accounts on a going concern basis.

Item 2025-26 (151): Significant Risks and Risk Assurance Report

The Interim Chief Executive Officer presented the quarterly update report noting the changes being made to the Risk Management Group with Executives now attending, the inclusion of Internal Audit final Reports on the agenda, and an update on policy compliance to be brought to future meetings.

The Non-Executive Directors welcomed the developments to the Group especially around the review of Internal Audit reports and the inclusion of a risk trend report to Board. It was noted that the formatting of the risk trend report had become mixed up in the transfer to the board pack.

Action: Risk trend report with original formatting to be circulated.
Responsible Officer: Company Secretary.

The Executive Director of Finance and Resources welcomed the thematic analysis which would prove useful to triangulate when making investment decisions.

Outcome: The Trust Board:

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

Item 2025-26 (152): Board Assurance Framework (BAF) Quarterly Update Report

The Interim Chief Executive Officer presented the quarterly update report, noting the two changes in the scoring of risks:

- The financial risk had been reduced from 16 to 12.
- The legislative risks had increased around gaps in controls owing to evidence in compliance.

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

Item 2025-26 (153): Any other business Questions On Blue Box Items And Close

Items in the Blue Box were noted and no questions were raised.

No matters of any other business were raised.

The Chair closed the meeting at 12:18pm**.**

Date and time of next meeting

Thursday 21 May 2026 9.30am
Boardroom, Building 3, White Rose Office Park,
Millshaw Park Lane, Leeds, LS11 0DL.

AGENDA ITEM 2026-27 (4b)

Leeds Community Healthcare NHS Trust
Trust Board Meeting (held in public) Action Log: 21 May 2026

Key		Key colour code
Total actions on action log	4	
Actions on log **completed** since last Board meeting on 27 March 2026 with a **proposal to close**	2	
Actions due for completion by 21 May 2026 – for update at the meeting	2	
Actions not due for completion before 21 May 2026		
Actions outstanding at 21 May 2026**: not having met agreed timescales and/or requirements**		

5 February 2026				
Agenda Item Number	**Action Agreed**	**Lead**	**Timescale/ Deadline**	**Status**
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	List of Youth Board dates circulated to Board members 7 April 2026. **Propose to Close**
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.

27 March 2026				
Agenda Item Number	**Action Agreed**	**Lead**	**Timescale/ Deadline**	**Status**
Item 2025-26 (149)	**2025 National Staff Survey Results:** WRES 8 – Discrimination from Manager or Team data to be analysed further and reflections provided.	Director of People	May 2026	
Item 2025-26 (151)	**Significant Risks and Risk Assurance Report:** Risk trend report with original formatting to clarify trends to be circulated.	Company Secretary	By email following meeting	Circulated 14 April 2026 **Closed: Action Complete**

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.

Agenda item:	2026-27 (5)
Title of report:	Interim Chief Executive's Report
Meeting:	Trust Board meeting Held in Public
Date:	21 May 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 • Reasons to be Proud

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 and/or workforce)?	Yes		What does it tell us?	
	No	x	Why not/what future plans are there to 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 to the Board

21st May 2026

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

1. OUR SERVICES AND OUR PEOPLE

Staff Survey and Board Intention Planning

The Trust Board recently engaged in a Trust Board workshop focussed on the organisation's Staff Survey results with a deep dive into WRES (Workplace Race Equality Standard) and WDES (Workplace Disability Equality Standard) scores and feedback. One of the main outputs from the workshop was the Board's setting out of its intention plans in response to the Staff Survey feedback. There was a great deal of reflection on our WRES and WDES results and a strong commitment to strengthening inclusion, equity and belonging across the organisation by taking clear, visible action informed by staff feedback and workforce data.

This action includes communicating a strong leadership commitment to improving colleague experience, deepening engagement with staff networks to better understand lived experiences, and embedding inclusion-focused conversations into Board assurance and service visits. Through targeted oversight of identified hotspot areas, improved transparency in workforce processes, and the use of robust data to address inequalities, the Board aims to drive meaningful, evidence-based change. Central to this is a shared sense of accountability, with Board members leading by example through personal pledges and active listening, ensuring that every colleague feels valued, respected, and able to thrive.

These actions are recommended to the Board as summary output from the discussions at the Board workshop and there is a commitment to translating these intentions into tangible improvements in staff experience, ensuring that all colleagues feel valued, included, and able to thrive in our organisation.

SEND inspection

Leeds received an Area Wide SEND Inspection, from the Care Quality Commission and Ofsted between 13th April and 1st May 2026. It was an intense and demanding inspection process, and we are grateful to all our staff who took part in the inspection. Inspectors heard about, and in some cases saw firsthand, practice that makes a real difference to children, young people, and families.

Areas flagged for improvement were not a surprise including the fragility of leadership and governance arrangements at a senior level due to recent changes across all the agencies. For health provision the priority improvement areas have been identified as:

- Strengthening of the reviewing/revising of Education Health and Care Plans including focus on transition to adulthood,
- Variable health provision across schools,
- Concerns about neurodiversity waiting times and care and support provided whilst waiting.

The final report is expected before the end of June. Work is already underway on the initial feedback and Heather McClelland is our Executive lead ensuring we are suitably involved and overseeing our own actions.

Trust Leaders Network

Ongoing visible engagement remains a key focus of the Executive team and in addition to more regular online ask sara and trust leader's events we are holding our second in person trust leaders' network on the 14th of May with approx. 70-80 staff expected to join. We can share a further update at the board meeting on the outputs from the day. We will be covering:

- Trust integration programme
- Innovation Pots and Making stuff better updates
- First engagement event for the development of the Vision, Values and Behaviours for our new look organisation which will be facilitated by Co-create.

National Oversight Framework

The Trust overall segmentation remains 3 and is unlikely to change for the final quarter of reporting for 2025/26. For the 2026/27 year the domains and metrics the

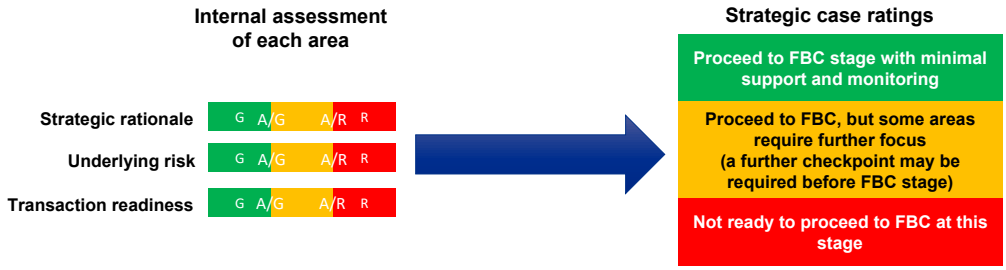
Trust will be measured against will change significantly. We have seen the draft metrics and our Assistant Director of Insight and Intelligence has attended national webinars to understand how they will be implemented but they do remain under embargo until NHSE confirms otherwise. The methodology for calculating some of the metrics are still under development so once this has been resolved we will be able to assess our own performance and report through to next business committee and board.

2. ALIGNMENT WITH LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

The board will receive a separate assurance report from the transition committee which met on the 11th of May 2026 to review progress being made on our workstreams that will support the successful integration of our two organisations for day one.

The national transaction team in NHSE have been undertaking a review of our strategic outline case. This has involved interviews with a range of senior colleagues in both organisations, regional colleagues in NHSE, CQC and the WY ICB. Following synthesis of the intelligence and information gathered they will report to the Regional Support Group for NEYH NHSE region on 3rd June following which we will be informed of the assessment of our strategic case. One of four ratings are given:

Strategic case ratings



We RAG rate each key line of enquiry, which will feed into an overall assessment for each area. This then enables us to develop a SC rating.

The overall SC rating needs to be amber or green to proceed to FBC stage.

We have our next joint board session on the 21st of May which will focus on the culture and engagement workstream.

3. SYSTEM UPDATE

Leeds Place Provider Partnership

In November 2025, partners in Leeds agreed in principle to establish a Leeds Health and Care Provider Partnership, overseen by a Provider Partnership Joint Committee.

The Provider Partnership brings together providers from across Leeds – including Leeds City Council, NHS trusts, general practice, and the voluntary and community sector – to work collectively on shared priorities, service improvement, and system transformation. The Joint Committee is the Partnership's formal decision-making body. It is created by the partner organisations and, once fully established, will use delegated authority to make joint decisions on agreed areas.

All statutory boards, VCSE and primary care are being asked to sign up to a memorandum of understanding and draft terms of reference to establish a joint committee to run in shadow form over the next 12 months. Over recent months, a cross-partnership delivery team has been putting the foundations in place. This has included:

- Developing governance arrangements
- Establishing programme and PMO infrastructure
- Strengthening system-wide capability
- Starting work on future approaches to finance, contracting, and sharing risk and reward

During 2026/27, the Partnership will operate in shadow form ahead of formal constitution, expected no earlier than April 2027. This year will be used to test decision-making, refine ways of working, and strengthen relationships – effectively a "dry run" before formal establishment.

<u>Provider Partnership Joint Committee</u>

The Joint Committee introduces a *new* formal mechanism for collective *decision-making*. Once fully operational, it will have delegated authority to make decisions on behalf of partner organisations in agreed areas.

This will allow Leeds to:

- Move more quickly

- Reduce duplication
- Act with greater confidence as a system

During the shadow year, the Joint Committee will operate as a test model and not yet hold formal decision-making authority. In this period, the Leeds Committee of the West Yorkshire ICB will continue to operate under its current scheme of delegations until the Joint Committee is fully established (expected no earlier than April 2027).

Partnership Leadership Team

The PLT will continue to provide strategic leadership and alignment across the system. Its role includes:

- Building relationships
- Sharing intelligence
- Agreeing system-wide priorities and direction

PLT focuses on culture, strategy, and transformation priorities, but does not hold formal delegated authority.

Leeds GP Confed CEO Update

Gaynor Connor has now taken up post as the new CEO of the Leeds GP Confederation. Gaynor is well known to the executive team and across the city. There have been a number of changes in the senior roles within the GP Confederation, so we plan to review our ongoing relationship especially regarding shared executive roles and opportunities and risks going forward.

Leeds Local Election Results

Following the Local Elections held on 7 May 2026, the political balance of the Council is now as follows:

Labour 48
Conservative 14
Green 11
Reform UK 10
Liberal Democrat.....6
Garforth & Swillington Independents.....3
Morley Borough Independents 3
Social Democratic Party.....3
Independent Cllrs. 1

As no single political group has a majority on the Council, this means there is no overall control. Each political group will be having their group meetings over the next few days to confirm their leader. There are then likely to be discussions between political groups to agree how an administration should be formed for the next municipal year. These discussions, which may continue up to the Annual Meeting of Full Council on 20th May, will confirm the key leadership and governance arrangements for the next year and elect a new Lord Mayor.

While this is going on, the day-to-day work and full range of Council services continue to be delivered just as they were before the election, and Cllr James Lewis remains in post as Leader of the Council.

4. REASONS TO BE PROUD

Feedback for Armley neighbourhood team and night service

We received some feedback from a family member which highlights the excellent person-centred care delivered by our Armey Neighbourhood team and night service. I have anonymised it for the public paper but wanted to share in full with the board. We have also shared this directly with the teams involved.

"My younger brother sadly died last week. He was learning disabled and had developed dementia. I was his appointee and his Court of Protection appointed Health and Wellbeing Deputy, so was very involved with his day-to-day care. He lived in his own house with a 24-hour staffing package. In recent months his physical health began to fail he had several admissions to SJUH with pneumonia and seemed to fade further following each admission. For the last few weeks, the staff team who look after him have been supported by the Armley Neighbourhood Team and occasionally by the Neighbourhood Night Service. I just wanted to let you know how brilliant those staff have been; they were lovely with my brother and the staff team and very supportive of my family.

"It was very pleasing to observe how the nurses worked alongside the care team as colleagues recognising their expertise and detailed knowledge of my brother whilst augmenting his care with their own unique skills, this was partnership working and

relational care at its best. I would particularly like to commend Rachel and Charlotte and Laura their Matron (I'm sorry I don't have surnames).

"We are led to believe that out of 320 people who died in supported living in the last 12 months my brother is the only person who has been supported to die at home. As a family this made such a difference to us, we are struggling to understand how this can't be the norm. It would seem that your staff alongside Voyage Care (along with a supportive Primary Care Team and some input from the CVAS Team at SJUH) have achieved something remarkable. We sincerely hope this will result in a shift in practice so that our experience is no longer seen as exceptional but as routine care."

Achieving Excellence in our Website Accessibility

Since the launch of the Patient Information Hub just over 12 months ago, the Communications Team, with the support of the Digital Project Team has made significant progress in improving the accessibility of the Trust's website for patients, service users and partners. This work is crucial in ensuring that information about the Trust, its services, and self-management advice is accessible to a wider audience, supporting broader system efforts to reduce health inequalities. It also complements ongoing digital developments to expand the range and quality of information available online.

At launch, an independent accessibility assessment rated the website at 58% compliance against the Web Content Accessibility Guidelines (WCAG 2.2 AA), based on a sample of 125 pages. I am pleased to report that compliance has now increased to 97%. The site is currently ranked as the 14th most accessible NHS website nationally and the 2nd most accessible in the Yorkshire and Humber region.

Digital Inclusion Work – Excellent Feedback

We have worked closely with 100% Digital Leeds to strengthen digital inclusion across our communities. Together, we have developed a digital literacy and ability screening tool for all service users, recognised as a strong example of best practice, alongside joint training and regular partnership working. This has supported the development of digital health support hubs, helping more people access care in ways that work for them. We also use data from our screening and services to track impact and shape ongoing improvement.

The 100% Digital Leeds programme is led by the digital inclusion team in the Integrated Digital Service at Leeds City Council and Leeds Health and Care Partnership NHS West Yorkshire Integrated Care Board. Amanda Jackson our Trust lead recently presented our work Digital Inclusion to the NHS England, Northeast and Yorkshire Digital Inclusion group and this is some of their feedback which we are very proud of and wat to pass on our thanks to Amanda and colleagues for all the work they are doing.

"Love the focus on getting the conversations right. Can make all the difference."

"Amazing presentation and amazing work, could you share your presentation Amanda"

"Just blown away by what you have achieved"

"Shining example of digital inclusion in practice to benefit population"

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
14 May 2026

AGENDA ITEM
2026-27
(6)

Leeds Community Healthcare NHS Trust

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	**Report to:**	Trust Board 21 May 2026
Date of Meeting:	12 May 2026	**Date of next meeting:**	14 July 2026

Introduction

The meeting was quorate, with one member and one presenter attending remotely. Most actions from previous meetings have been closed. Service Spotlight from Podiatry Team who presented the podiatry service's progress in reducing long waiting lists, detailing operational changes, equity considerations, and ongoing challenges

Alert	Action
• Medical Devices position statement - risks associated with not having an accurate list of medical devices, including potential gaps in triangulation with MHRA alerts and recalls, and agreed that only limited assurance can be provided at this stage.	Chief Clinical Information Officer to chase LTHT for updated data and further update to Sep meeting (following discussion at QAIG in Aug) to provide further assurance.
• Incident Management & Investigation Oversight – An update was provided on incident management, revealing delays in reviewing incidents and investigations due to capacity issues, resulting in delays to identifying learning and feeding it back. Similar themes being identified with Learning from Deaths.	Agreed to develop and bring back a high level plan by July, including initial actions and realistic expectations for improvement. PSIRF maturity to be revisited.

Advise

- Service Spotlight – Podiatry. Performance improving with long waits reduced from 40 weeks to 18 weeks, but some concerns remain regarding the impact of some changes on certain patient groups, for which the service is implementing mitigations such as using interpreters, sending targeted communications, and working with Healthwatch.
- NHS Provider Capability Self-Assessment: Quality of Care Report: New 2026-27 National Oversight Framework including the Provider Capability Assessment not yet published. Paper to be brought forward once framework and assessment requirements released, to enable appropriate oversight and assurance.
- Quality live issues – SEND Inspection update. The inspection team had raised concerns about system fragility, leadership, waiting times, and the robustness of education healthcare plans. The report is expected within 30 working days, after which factual accuracy can be addressed and a full action plan will be developed.
- Quality Strategy - Discussed the progress of the 2024-27 strategy, focusing on ongoing actions, assurance frameworks. suggested improvements to reporting, including clearer status indicators and more accessible presentations for non-clinicians, to enhance understanding and oversight. Concerns

Committee Escalation and Assurance Report

were raised about the distinction between operational and strategic assurance, with a call for more explicit reporting on levels of assurance and ongoing implementation.

- Quality Account – Committee reviewed the final draft of the quality account, discussed improvements in structure, the need for service-level reporting, and suggestions for future service annual report templates to enhance data and narrative balance. The group agreed to develop a service-related template for reporting, overseen by the Executive Medical Director and Director of Nursing and AHPs, to ensure consistency and focus on activity, quality, and outcomes. The committee accepted the Quality Account with minor edits, will go to June Board for final approval.
- Essential Clinical skills- Reporting and Recording – 50% of services have submitted a completed matrix, but recording and training are currently reliant on manual, business unit-led processes, limiting organisational assurance. Identified risks related to incomplete data and the inability to pull a whole-Trust dataset. A six-month update to be provided in October meeting, including progress made on exploration of a future platform.
- Quality and Value Report - Equity is emphasised but there is less evidence of post-implementation assurance for classic quality aspects such as safety, effectiveness, and patient experience. It was explained that post-implementation papers are presented to the quality and value board and business committee, with suggestions to include six-month benefits realisation reports for assurance.
- ABU Beds Mobilisation CQC Registration – Focus was on CQC registration options, and the need for clear accountability in shared governance arrangements. LCC to maintain registration for accommodation, LCH for treatment, diagnostics and screening. The Executive Director of Operations to oversee a process of working through scenarios to clarify reporting and accountability prior to mobilisation on 1 July, with an update to be provided in July.
- Integrated Performance Report: Annual Report – The Committee emphasised the importance of including SPC charts in the report to support understanding of performance trends. Annual report would be more beneficial for Board.

Assurance

- Current System pressures - system operating smoothly. No issues to report.
- Feedback on the adequacy of healthcare provision for detainees at Humberside Police Custody Suite following a recent regulatory inspection. Overall findings were adequate assurance, an effective healthcare provision that is safe, well-governed and effectively monitored. No immediate risks or compliance issues were identified.
- HMYOI Wetherby inspection – update on audit and prescribing of controlled drugs. Controlled drug audits showed no patient harm but ongoing record-keeping non-compliance (on risk register), now subject to targeted improvement and repeat audit. Prescribing data provided clear assurance that opiate use was minimal, appropriate and evidence-based.
- NICE Guidance Compliance Update – Six monthly update - Increased assurance in monitoring compliance.
- Mortality Reports – The Quarterly and Annual Mortality Reports were presented. Challenges in data visibility, particularly for LMWS, and described efforts to align mortality review processes with PSIRF and patient safety investigations. Acknowledged the need for stronger thematic learning from deaths review meetings, moving beyond case presentations to shared learning and system improvement.

Committee Escalation and Assurance Report

- QAIG AAA report - discussed capacity constraints within the EQIA process - approval had been received to recruit into a vacant post, which should improve capacity, though short-term pressure remained. Also noted actions arising from Regulation 12 were reported as near-complete, with final confirmation awaited. Impact on services being seen from reduced ICB capacity, including the ICB's Senior EDI Manager no longer being in post.
- Safeguarding AAA report – Children Looked After- noted rising waiting time for initial Health Needs assessments. Solution-focused actions underway. This item was expected to de-escalate by the next meeting.
- IPC AAA report - noted ongoing work regarding the safe transportation of samples, overseen by a working group, and that progress had been discussed previously.

Risks Discussed and New Risks Identified

- The Risk Register report was presented, showing movement in clinical and operational risks scoring 8 and above. The Trust continues to have two extreme risks scored 15 and above. Risk Management Group noted to be scrutinising all static risks. It was suggested to review the threshold to the Committee as 8 and above seemed low.

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	**Risk score (current)**	**Overall level of assurance provided that the strategic risk is being managed (or not)**	**Additional comments** **See above comments in report**
Risk 1 Failure to deliver high-quality, equitable care and continuous improvement: If the Trust fails to identify, deliver, and sustain high-quality care, promote learning, and drive continuous improvement in an equitable manner, there is an increased risk of unsafe or ineffective services. This may lead to preventable harm, poor patient outcomes, and a diminished patient experience.	16 (extreme)	Reasonable	• Incident Management and investigation oversight – Limited assurance provided due to delays reported at all stages and inconsistent data - high level plan required. • Medical Devices position statement – limited assurance provided and work ongoing. Further discussion at QAIG prior to returning to committee in Sep.

Committee Escalation and Assurance Report

			However, reasonable assurance overall, especially as the Trust is sighted on the need for learning and improvement.
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	• Service spotlight – Podiatry. Provided good assurance regarding reduction of 40 week waits but more work to be done on 18 week waits.
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	• Humberside police inspection – Adequate assurance, no immediate risks or compliance issues identified.
Risk 7 Failure to reduce inequalities experienced by the population we serve. If the Trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently delivering unfair access or care and exacerbating inequalities in health outcomes within some cohorts of the population.	12 (high)	Reasonable	

Author:	Helen Robinson/Ian Lewis
Role:	Company Secretary/Committee Chair
Date:	12/05/2026

Leeds Community Healthcare NHS Trust

Agenda item:	2026-27 7
Title of report:	Learning From Deaths – Q4 Report 2025-2026
Meeting:	Public Board
Date:	21 May 2026

Presented by:	Dr Ruth Burnett, Executive Medical Director
Prepared by:	Geraint Jones, CCIO

Purpose of the report:		
This report provides assurance to the Board that the Trust continues to meet the requirements of the NHS Learning from Deaths Guidance (2017) and aligns with the principles of the Patient Safety Incident Response Framework (PSIRF). It summarises mortality activity for Quarter 4, the learning identified through reviews, actions taken in response, and the improvement programme agreed following external review.	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:

- Mortality remains within expected limits, with no evidence of systemic quality failure
- Review coverage and escalation processes are proportionate but not yet universal
- Recurring learning themes indicate persistent improvement opportunities rather than new risks
- Equity assurance is strengthening but data completeness limits confidence
- External review has identified governance and assurance improvements that require sustained oversight

Previously considered by:	Quality Committee 12/05/2026
Outcome of previous discussion/s:	Assurance accepted

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	
Collaborating with partners to enable people to live better lives	X
Embed equity in all that we do	X

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

Recommendation(s)	• The Board is asked to note the contents of this report, receive assurance regarding statutory compliance.

List of Appendices:	None

Learning from Deaths

Summary of Deaths (Statutory Requirement)

Adults

During Quarter 4 2025/26, a total of 847 adult deaths were reported under the Trust's care. Of these, 688 deaths occurred within Adult Business Unit (ABU) services and 159 within Specialist Business Unit (SBU) services. This represents a 13.5% increase compared to Quarter 3, reflecting seasonal variation and activity levels.

Statistical Process Control (SPC) analysis demonstrates that mortality levels within both ABU and SBU remain within expected variation, with reporting trends approaching the lower control limits rather than indicating excess mortality or emerging system concerns.

Children

Between January and April 2026, 12 child deaths were reported. Of these, eight were unexpected deaths (SUDIC) and four were expected. All deaths progressed appropriately through the Child Death Rapid Review process, ensuring timely multi-agency scrutiny and learning.

Mortality Reviews Undertaken (Statutory Requirement)

Adults

62.4% (529) reported adult deaths in Q4 were subject to initial Level 1 screening proportionate to case mix and service type. Where this initial review identified specific triggers, structured Level 2 mortality reviews were undertaken. Triggers included unexpected death, the presence of learning disabilities, mental health needs (LMWS), inpatient or community bed involvement, and any potential concerns in care. In this quarter 77 deaths were reviewed at this higher level, including 14 expected deaths to provide further quality assurance.

During the quarter, four deaths were escalated to Patient Safety Incident Investigations (PSIIs). These comprised two suicide cases (externally led by LYPFT), one fall with harm, and one choking incident. Importantly, no completed mortality reviews in Q4 concluded that a death was more likely than not due to problems in care.

Children

All child deaths underwent 100% rapid review, alongside clinical and quality scrutiny in line with national guidance. No child deaths met the threshold of being more likely than not due to problems in care. There were no cases requiring escalation under Duty of Candour or PSII criteria.

Learning Identified from Mortality Reviews (Statutory Requirement)

Across adult and child mortality reviews, learning themes identified during Q4 were consistent with previous quarters.

Adult Learning Themes

Management of deterioration featured as a recurring area for learning, particularly relating to delayed recognition of deterioration in lower limb wounds and inconsistent application of deteriorating patient frameworks.

Adherence to clinical frameworks was also highlighted, with variable compliance noted in wound infection and lower limb pathways. This learning links to the staged implementation and auditing of updated policies.

Learning related to multidisciplinary communication emphasised the importance of clarity in MDT roles and escalation pathways. This was particularly evident in reviews associated with falls and choking incidents.

Finally, end-of-life care documentation was identified as an area for improvement, with data quality issues relating to preferred place of death, largely associated with system and process changes rather than care delivery.

Positive Practice Identified

Reviews highlighted high-quality care for people with learning disabilities, including strong person-centred end-of-life planning, good Mental Capacity Act documentation, and effective multidisciplinary working. Positive feedback from families was received and relevant learning was shared at a regional level.

Child Death Learning

No LCH-specific learning themes requiring system change were identified through child death reviews. The quarter provided reassurance regarding the robustness of rapid review processes, multi-agency working arrangements, and escalation thresholds.

Actions Taken and Improvement Plans (Statutory Requirement)

Actions Already Completed

Immediate safety actions were implemented following PSIIs, including updates to the syringe driver policy and associated training, as well as amendments to resuscitation policy. Separate mortality processes have been established for Therapy Services and Neighbourhood Response Teams to improve proportionality and clarity.

In addition, Level 1 and Level 2 “not required” options have been fully implemented within S1, improving the accuracy and completeness of mortality data recording.

Actions in Progress

Implementation and audit are underway for the lower limb framework, wound infection prevention framework, and deteriorating patient policy. Work is also ongoing to resolve data discrepancies relating to preferred place of death reporting and to introduce autism identifiers within mortality dashboards to strengthen equity monitoring.

Equity and Reducing Health Inequalities

Equity considerations are embedded throughout the Trust's Learning from Deaths approach.

During Q4, eight deaths involved people with a learning disability, representing an increase compared to Q3. Reviews identified good practice and did not raise concerns relating to quality of care.

A data gap relating to autism status has been identified, with actions already in place to enable routine reporting.

Analysis of deprivation deciles did not identify significant variation in mortality patterns during Q4, and review of ethnicity data did not identify disproportionate mortality at Trust level. Continued monitoring is required due to small numbers and incomplete coding.

Planned actions include the routine inclusion of learning disability, autism, ethnicity and deprivation data in quarterly Learning from Deaths reports, alongside strengthened qualitative review of deaths involving compounded vulnerability.

Improvement Plan Following LYPFT Review of Mortality Process

An external review undertaken by LYPFT identified opportunities to strengthen assurance, consistency and the visibility of learning from mortality reviews. Agreed actions include improving the clarity of review conclusions, ensuring explicit documentation of whether Trust care contributed to, caused, or was not associated with a death.

A scoring approach in line with Structured Judgement Review methodology is being investigated to support consistent assessment of the quality of care delivered. Greater emphasis will be placed on aggregating and reporting thematic learning from mortality reviews and demonstrating how learning informs service improvement.

Governance arrangements will also be strengthened. This includes reviewing Terms of Reference for mortality groups. A workshop has been planned to review current processes and ToR to ensure consistent approach to review, for appropriate check and

challenge with improved visibility of learning outcomes and action plans. Progress will be tracked through QAIG and reported to the Quality Committee.

Assurance and Conclusion

The Trust continues to demonstrate compliance with the NHS *Learning from Deaths* Guidance (2017). The Quality Committee is assured that deaths are identified, reviewed and scrutinised appropriately, learning is identified and acted upon, equity considerations are strengthening, and clear improvement actions are in place following external review.

Recommendations

The Committee is asked to note the contents of this report, receive assurance regarding statutory compliance, and support the improvement plan arising from the LYPFT review.

Agenda item:	2026-27 7b
Title of report:	Learning from Deaths – Annual Report 2025-26
Meeting:	Public Board
Date:	21 May 2026

Presented by:	Dr Ruth Burnett, Executive Medical Director
Prepared by:	Geraint Jones, CCIO

Purpose of the report:		
This report provides the Quality Committee with assurance regarding the Trust's compliance with the NHS Learning from Deaths Guidance (2017), alignment with the Patient Safety Incident Response Framework (PSIRF), and the effectiveness of governance arrangements for identifying, reviewing, and learning from deaths during 2025/26.	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:

- Learning from Deaths arrangements operated effectively in 2025/26, with no evidence of excess mortality and appropriate escalation of care-contributory deaths.
- While identification of learning is strong, assurance over action completion, pace, and demonstrable impact, requires further strengthening.
- Increased PSIIs reflect improved PSIRF-aligned judgement and clarity rather than a deterioration in care delivery.
- No systemic inequity identified, but limitations in ethnicity and autism coding reduce confidence and remain a priority improvement area.
- 2026/27 focus will be on strengthened action tracking, outcome measurement, and more robust equity-focused mortality analysis.

Previously considered by:	Quality Committee
Outcome of previous discussion/s:	Assurance accepted

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	X	What does it tell us?	No significant variation in mortality patterns
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	• The Board is asked to note the contents of this report, receive assurance regarding statutory compliance,

List of Appendices:	None

1. Purpose and Executive Overview

This report provides the Quality Committee with assurance regarding the Trust's compliance with the NHS Learning from Deaths Guidance (2017), alignment with the Patient Safety Incident Response Framework (PSIRF), and the effectiveness of governance arrangements for identifying, reviewing, and learning from deaths during 2025/26.

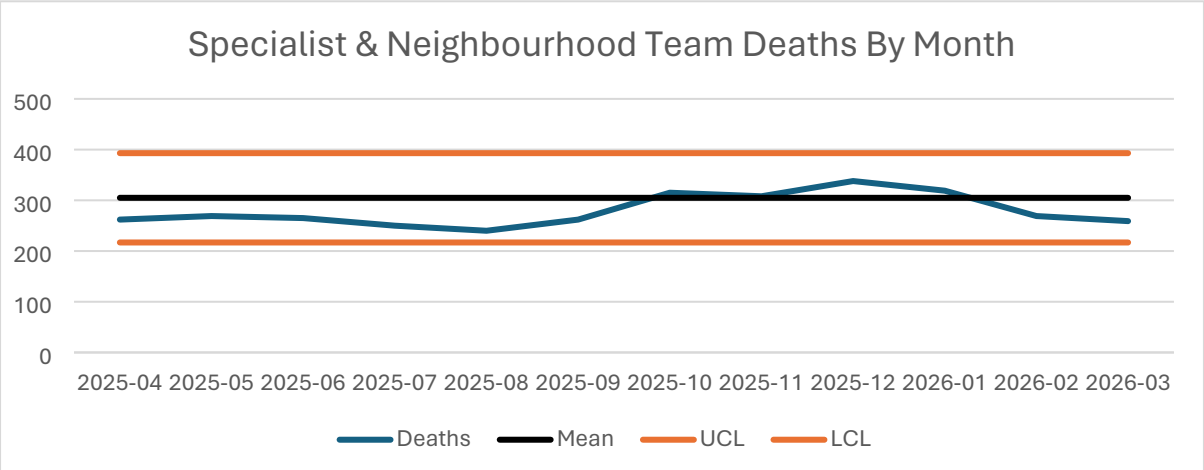
During 2025/26, Leeds Community Healthcare NHS Trust remained statutorily compliant with Learning from Deaths requirements and demonstrated increasing maturity in mortality review, escalation, and application of structured judgement. Mortality remained within expected limits, and deaths more likely than not contributed to by problems in care were appropriately identified and escalated.

The principal risk identified is no longer the identification of learning, but the pace, visibility, and impact of action completion, particularly in community services and for vulnerable and high-risk populations. This risk is partially mitigated through strengthened governance, audit programmes, and dashboard development, but remains an improvement priority for 2026/27.

2. Adult Mortality

- Mortality volumes fluctuated across the year, with seasonal increase during Q3.
- Statistical Process Control (SPC) analysis demonstrated that mortality remained within expected control limits throughout the year, including during Q3, indicating normal variation and no evidence of excess mortality.
- Neighbourhood Teams accounted for the majority of deaths, consistent with the Trust's community-based care model and the demographic profile of people supported.

There is no evidence of unexplained or avoidable excess mortality at Trust level in 2025/26.



3. Children and Young People Mortality

- 100% rapid review compliance was maintained for all child deaths across all quarters.
- Q3 identified a statistically significant spike in child deaths in November, including deaths by hanging, meeting criteria for special cause SPC variation.
- All relevant deaths were escalated appropriately through Child Death Overview Panel (CDOP) and SUDIC processes.
- One child death known to the Leeds Mental Wellbeing Service (LMWS) was escalated to a Patient Safety Incident Investigation (PSII).

Paediatric mortality governance arrangements functioned effectively, including escalation, multi-agency working, and senior oversight. The Q3 clustering highlighted the operational and emotional impact of sudden mortality increases, reinforcing the need for optimising capacity and staff support arrangements.

4. Mortality Review Compliance

The Trust exceeded national minimum requirements by undertaking Level 2 reviews for approximately 12% of expected deaths, in addition to mandatory categories.

Mandatory Level 2 reviews applied to:

- Inpatient deaths
- Unexpected deaths
- Learning Disability deaths
- LMWS deaths

Compliance summary:

Category	Required Level 2	Completed	Compliance
Unexpected deaths	185	160	86.5%
Learning Disability deaths	12	11	91.7%
LMWS deaths	All eligible	Data completeness issue identified	
Overall	196	170	86.7%

Missed Level 2 reviews occurred within:

- Neighbourhood community teams (North, South, West)
- Triage & Neighbourhood Response Service
- A small number of specialist services (e.g. Respiratory, Nutrition & Dietetics)

One Learning Disability death did not receive a Level 2 review.

There is no evidence of systemic or intentional omission. Retrospective reviews are underway where feasible and strengthened oversight has been implemented to improve compliance in community services.

Compliance is high but incomplete. This remains a known risk, with mitigating actions in progress and continued monitoring required.

5. Patient Safety Incident Investigations (PSIIs) relating to mortality

- Q1–Q2: No deaths assessed as more likely than not contributed to by problems in care.
- Q3: Two deaths assessed as care contributory; PSIIs initiated.
- Q4: Four deaths escalated to PSIIs (including suicide, choking, and falls).

System-wide PSII learning themes:

- Syringe driver competency and assurance.
- Multi-agency coordination and handover
- Process and pathway gaps rather than individual staff competence.

The increase in PSIIs during the second half of the year reflects improved consistency and confidence with PSIRF and external review recommendations, rather than evidence of deteriorating care quality.

6. Learning Themes Identified

Adult Mortality – Recurrent Themes

- Recognition and management of deterioration (including wound care and limb infection)
- Adherence to clinical pathways during phased implementation
- Multidisciplinary communication and escalation
- Mental Capacity Act (MCA) assessment quality and specificity
- End of life documentation, including Preferred Place of Death and system transition impacts

Learning Disability Deaths

- Strong evidence of person-centred care.
- Identified improvements needed in:
    - MCA documentation specificity
    - Safeguarding prompts
    - Autism status recording
- Learning shared regionally and contributed to “what good looks like” resources.

Children and Young People

- No Trust-specific systemic learning themes identified.

- Ongoing focus on suicide and self-harm risk pathways and cross-boundary working.

Learning themes are stable, well understood, and consistent with previous years. The priority is demonstrable impact rather than further theme identification.

7. Actions and Improvement Activity

Improvements Delivered

- Learning from Deaths and Mortality Policy updated following Internal Audit.
- Medical Examiner reviews embedded in mortality policy.
- Improved accuracy of mortality data in Datix and SystmOne.
- Mortality processes clarified for new service models (e.g. Therapy Services, Neighbourhood Response Teams).
- Learning integrated into SOPs, including LMWS contingency arrangements.

Work in Progress

- Audits of the deteriorating patient framework.
- Lower limb and wound pathway audits.
- Autism identifier integration.
- Strengthened governance links following LYPFT external review.
- Development of dashboards and Business Intelligence alignment.

Delivery activity is strong; however, visibility of action completion and measurable outcome impact at Trust level remains variable and requires further strengthening.

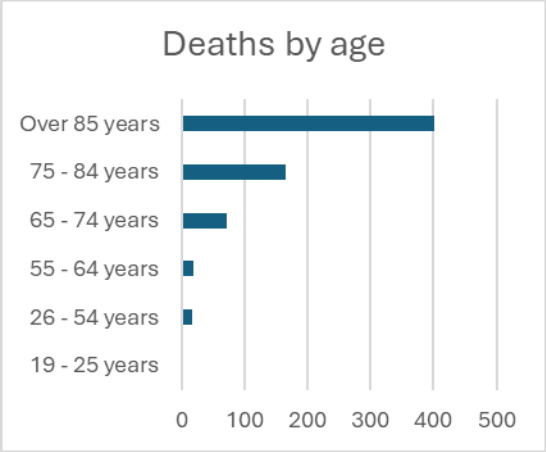
8. Equity and Health Inequalities

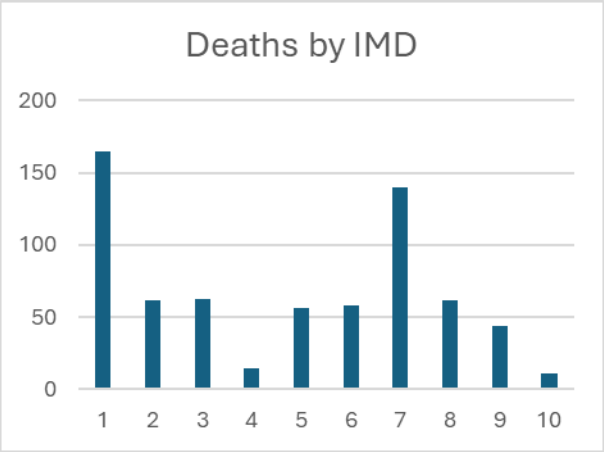
Analysis indicates that mortality patterns broadly reflect the demographic profile of the population served:

- Higher mortality in older age groups (85+)
- Seasonal winter increase
- Deprivation gradient consistent with national population health trends

Ethnicity analysis showed broadly similar outcomes, though small variations in end-of-life care measures were identified. Interpretation is limited by data completeness and small numbers.

Learning Disability deaths represent a small proportion of overall mortality but remain a high-risk group. Reviews demonstrated strong quality focus and commitment to reducing health inequalities.





No evidence of systemic inequity in mortality or access to care has been identified. However, data limitations reduce confidence for some groups. Strengthening data quality, thematic equity analysis, and use of population health intelligence is a priority for 2026/27.

9. Governance and Assurance

- Quality Committee and Trust Board received regular Learning from Deaths assurance reports during the year.
- External LYPFT review strengthened focus on:
    - Explicit care-contribution judgements
    - Clarity of review conclusions
    - Aggregation of learning
- Internal Audit actions have been completed.

Governance arrangements are robust and improving. Further development is required to optimise action tracking, outcome reporting, and use of Structured Judgement Review principles to fully demonstrate sustained improvement.

10. Key Risks and Priorities for 2026/27

Key risks:

- Incomplete Level 2 review compliance in community services
- Limited visibility of actions and impact at Trust level
- Data quality for non-SystmOne units
- Data quality constraints for equity assurance

Priorities:

- Strengthened oversight and assurance of Level 2 review completion.
- Clearer tracking of learning to action to outcome
- Enhanced equity analysis for smaller, high-risk populations
- Continued embedding of PSIRF-aligned judgement.

AGENDA ITEM
2026-27
(8)

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 21 May 2026
Date of Meeting:	21 April 2026	**Date of next meeting:**	19 May 2026

Introduction

The meeting was quorate. The Committee sought assurance with robust discussions across a full agenda – good challenging conversations with the action log and being fully discussed. The Committee welcomed representatives from the Paediatric Neuro Development Team providing an update on the service and waiting lists. The Committee discussed and approved the Early Supported Stroke Discharge Team business case and received updates on the 0-19 Tender Submission and on Short Term Community Beds project (post-contract award).

Alert	Action
• None.	

Advise

- Quality & Value Programme update – included a detailed approach for Year 3 of the programme, the CIP targets with information about each business unit and the monitoring of the grip and control on finances. The Committee applauded the healthy Q&V forecast position early in H1.
- Leeds Provider Partnership Programme (Key Priority) – guidance on financial aspects of Neighbourhood Health were expected from the national team in 2027-28. Issues with capacity and ICB input were discussed. Cross committee work with the People and Culture committee and the maturity index was noted.
- Waiting List Update (Key Priority) – improved position in all areas noted in addition to need for patients to reach specific clinical thresholds before treatment could be considered, including a number of children below threshold. The Committee asked for children below threshold to be included in future reports.
- Neighbourhood Model Update (Key Priority) – national guidance and confirmed Leeds's aligned approach and milestones for the 10 pillars of neighbourhood health noted. The Committee requested a mapping of LCH involvement across each of the pillars (noting involvement already through the well-established Home First Programme). Work ongoing with GP Access and possible income generation; a 24/7 End of Life scheme was being tested; emphasis moving from Home First to Neighbourhood. Data sharing options were still being discussed. The Committee also agreed to share Neighbourhood maturity index and other indices discussion with the People and Culture Committee for potential learning and workforce benefits.
- Financial – Planning Deconstructing the Block templates expected from the national team which would be based on the 2024-25 collect collection data. Update received on draft accounts. The Committee applauded the finance results with an I&E surplus of 951k, against a forecast of £900k. It noted the excellent work done by the finance team and teams across the organisation to achieve this result in challenging conditions nationally.
- 0-19 Public Health Nursing Service tender submitted; post contract update received on Short Term Community Beds project.

Committee Escalation and Assurance Report

- Early Support Stroke Discharge Team Business Case – The Committee noted the collaborative system effort and comprehensive business case for onward review at Trust Board. The Committee also noted for future reference to the Quality Committee potential impact on whole system thinking for Stroke services
- Sustainability and Climate Adaptability Steering Group AAA Report noted with an alert relating to the possible need to restate some carbon emission data.
- Renegotiations around the price for Horsforth site were approved

Assurance

- Segmentation Score 3 – positive move into segment 3 following financial position and waiting list improvements
- Procurement Internal Audit Report – significant assurance and previous discussion at Audit Committee noted.
- Service Spotlight Presentation on the work underway to manage Paediatric Neuro-development waiting lists and the Committee noted there is more work to do, however it welcomed the positive impact the mitigations were having on patients and their families. The Committee suggested this work is showcased in the Annual report.
- Progress made on the Health & Safety Performance and Annual Plan 2026-27 with improvements highlighted in fire and safety. The effectiveness report and Terms of Reference for the Health and Safety Group were approved.
- BAF Sources of Assurance – no gaps in sources of assurance noted.

Risks Discussed and New Risks Identified

- It was considered reasonable assurance had been gained on all the risks associated to the Committee noting robust service-focussed discussions around Risk 2 – Failure to respond to increasing demand for services.

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	

Committee Escalation and Assurance Report

The Committee provides the following levels of assurance to the Board on these strategic risks:	Risk score (current)	Overall level of assurance provided that the strategic risk is being managed (or not)	Additional comments
Risk 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	H&S annual plan update had provided assurance
Risk 4 Failure to deliver financial sustainability: If the Trust cannot manage its resources effectively, ensuring that spending does not exceed available funding, then this could jeopardise delivery of our strategic goals and priorities.	16 (extreme)	Reasonable	Assurance provided around sound grip and control in relation to Q&V programme.
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	ICB structural changes and capacity challenges noted.

Author:	Helen Robinson / Lynne Mellor
Role:	Company Secretary / Committee Chair
Date:	29 April 2026

AGENDA ITEM 2026-27 (9)

NHS Leeds Community Healthcare NHS Trust

Committee Escalation and Assurance Report

Name of Committee:	Audit Committee	**Report to:**	Trust Board 21 May 2026
Date of Meeting:	7 April 2026	**Date of next meeting:**	2 June 2026 (Annual Report – Page Turner)

Introduction

Quorate meeting with a full agenda and good debate on key topics – good challenging conversations with the action log and matters arising being fully discussed.

Alert	Action
• There were no items discussed at the meeting which were considered necessary to escalate to the Board.	

Advise

- Executive responses received on two previous Internal Audit Reports (EPRR and Management of Waiting Lists), noting prior scrutiny at Business Committee.
- Internal Audit Progress Report – one limited assurance final report and two significant assurance draft reports issued since the last meeting. Increased number of reports completed compared to last year, but still room for improvement. Four out of five recommendations validated – Data Security and Protection Toolkit recommendation under further review. Work ongoing to provide meaningful root cause analysis.
- Mental Capacity Act Internal Audit Report (Limited Assurance) noted with gaps discussed. Report previously scrutinised at the Quality Committee.
- Draft Head of Internal Audit Opinion 2025-26 was being updated as work progressed, with two outstanding reports still to be produced – the Quality & Value Programme, and Data Security and Protection Toolkit. Outstanding recommendations were being pursued to enable a final Head of Internal Audit Opinion to be provided by year end, which it was hoped to consider significant assurance had been gained.
- External Audit – the progress update was received noting that no risks of significant weakness had currently been identified from the most recent self-assessments from LCH management. The fieldwork stage was commencing.
- The inclusion of the Valuation report into the asset register and the 2025-26 Annual Accounts was approved with only a slight revaluation provided by the District Valuer.
- The Letter to Those Charged with Governance was explained at the meeting and circulated afterwards for comment.
- The Local Counter Fraud Specialist provided an update, with the risk assessment and workplan agreed. Board training on the updated legislation on Failure to Prevent Fraud was to be scheduled.

Assurance

- The Risk Management Group was now reviewing audit recommendations which further strengthened the process.
- Internal Audit – currently seven reports received significant assurance, four reports with limited assurance and no reports with low assurance.
- Annual Report and Accounts – comments and helpful suggestions provided on the first draft of the annual governance statement, noting any further comments should be provided by the end of April to allow for collation prior to the page turner meeting.

Committee Escalation and Assurance Report

- Audit Committee Annual Report, effectiveness review and Terms of Reference were received and noted, along with the annual reports from all Board Sub-Committees which had been reviewed by each Committee.
- Financial Controls – updates on Losses and Compensation, Tender and Quotation Waivers, and a full Contracts Register received.

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	

Author:	Helen Robinson / Khalil Rehman
Role:	Company Secretary/Committee Chair
Date:	22 April 2026

Agenda item:	2026-27 10
Title of report:	**Charitable Funds Update Report**
Meeting:	Board
Date:	21 May 2026

Presented by:	Sam Prince, Executive Director of operations
Prepared by:	Jodie Collins, Charitable Funds Officer

Purpose of the report:		
This report provides an update to the Board on charitable activities for the period June 2025 – June 2026	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:

- There has been a notable increase in the number and scale of charitable activities
- A communications plan has been drafted to encourage greater participation in the work of the charity
- Work has commenced with LYPFT to explore joint opportunities around the charity and volunteering

Previously considered by:	Charitable funds committee
Outcome of previous discussion/s:	Fundraising plan approved at Charitable funds committee Comms plan not yet seen at committee but has approval from Exec Director of Operations

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

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

Recommendation(s)	The Board is recommended: • Receive the report and note the extend of fundraising activities • Note and approve communications plan Appendix 2

List of Appendices:	Appendix 1 Communications Plan Appendix 2 Impact story from Homeless Health and inclusion

Leeds Community Healthcare Charitable Funds Report

1 Executive Summary

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

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

This paper gives an update on the charity's activities and outcomes. It includes an impact statement from the Homeless Health and inclusion team who have accessed charitable funds demonstrating the importance and benefits of the funds.

The paper also explores the challenges faced by the charity and the new communications plan, aimed at improving participation.

2 An Overview of the Last Year

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

Fundraising activities:

- **Yorkshire three peaks challenge September 2025 –** 7 walkers total raised £1353
- **The big Heartbeat October 2025 –** awareness event at White Rose shopping centre, Throughout the day, **103 people** took part in hands-on CPR demonstrations, including adults, children, college students, and even new and expecting parents. The event created a welcoming space for everyone to learn vital life-saving skills.

- **Christmas November / December 2025 –** The Charitable Funds Officer worked with Dunelm Mill again for a second year - shoppers and members of the public provided around 500 gift bags which were divided and distributed to service users across Leeds, providing presents for patients in the Trust's four recovery hubs, children at Hannah house and their siblings, Homeless Health and Inclusion Team service users, and TB service users. The remaining items, mainly crafts and games, were donated to Adel Beck and Hannah House. Donation were also received from staff members including money raised from Christmas jumper days etc.

- **Race Across Leeds December 2025-** 8 colleagues from LCH took on the challenge to "Race Across Leeds", this event was planned at the request of Andrea North and donations were given in place of retirement gifts. A great day was had and £1074 was raised.

- **London Marathon April 2026–** 2 runners completed the race and raised £4700

- **Leeds Half marathon and relay May 2026 –** 7 runners taking part in the Half marathon and a team of 7 from the 0-19 service running the Marathon relay. At the time of writing, this event was yet to take place.

Corporate fundraising

- The British Contractual Steel Association has chosen LCH to be their charity partner at this year's national dinner which will be held at the royal armouries in Leeds with around 300 – 400 attendees. Previous years they have raised around £6000.
- Hays travel in Rothwell chose to fundraise for Hannah house over the year £261 received.
- Morley Glass supported a gardening day at Hannah house and provided £250 to buy plants

➢ 3 Impact of Fundraising Activities on Service Projects

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

Support for Children at Hannah House

- **Days Out and Special Activities** — Funding enabled children to enjoy memorable days out.
- **Craft Materials and Creative Supplies** — A variety of craft resources were purchased to support sensory play, creativity, and emotional expression.
- **Christmas Presents for Every Child** — Every child who visited Hannah House over the festive period received a Christmas gift, helping each young person feel valued and included.

Support for the Homeless Health & Inclusion Team

- **Gardening Equipment for Patients in Temporary Housing** — Tools and materials supported small gardening projects that promote wellbeing and routine. (See **Appendix 2** for more detail)
- **Care Packs for Patients in Hospital** — Packs included reading books, quiz and colouring books, and essential personal care items for patients who often arrive at hospital with nothing.
- **Bus Tickets for Healthcare Appointments** — Funding removed transport barriers so patients could attend vital medical appointments.
- **Emergency Food Supplies** — Food parcels were provided to patients in crisis, ensuring no one was left without essentials.
- **Christmas Presents for People Experiencing Homelessness** — Gifts were provided to ensure patients felt remembered and supported during the festive season.

Support for the TB Service

- **Bus Tickets for Treatment and Appointments** — Funding helped patients attend essential treatment sessions and medical reviews without financial worry.

- **Christmas Presents for Patients** — Gifts were provided to offer comfort and kindness during what can be a difficult time of year.

Support for the Stroke Rehabilitation Service

- **Refreshments for Service User Focus Groups** — Funding provided refreshments for patients taking part in focus groups, helping create a welcoming environment where they could share experiences and shape future improvements.

Support for Community Care Beds

- **Christmas Presents for Patients** — Over **150 patients** received a Christmas present, ensuring that everyone staying in community care beds over the festive period felt recognised, valued, and included.

Support for Adel Beck

- **Craft Supplies and Board Games** — Adel Beck received new craft materials and board games to support creativity, social interaction, and meaningful activity for the young people staying there.

Support for Staff Across the Organisation

- **Starbucks Cups for Welcome and Celebration Events** — Over **500 Starbucks cups** were gifted to staff at welcome and celebration events as a small gesture of appreciation for their continued hard work and dedication.

Marking Remembrance Sunday

- **Wreath for the Cenotaph** — The charity funded a wreath that was laid at the Cenotaph on Remembrance Sunday, honouring those who served and ensuring our organisation was represented at this important moment of
-
- **Long term conditions service digital app –** remaining funds from Covid grants used to upgrade current software to enable all service users with long term conditions to access App and self-manage conditions were possible.

Over the past year, the LCH charity has continued to make a meaningful difference across our organisation. Thanks to generous donations and the dedication of our teams, we've been able to fund a wide range of resources, activities, and essentials that directly support the wellbeing of the people we care for.

4. Quality

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

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

5. Resources

Due to the merger, it was decided not to purchase any new material, and to wait until the position of the charity, and its new identity was known. This will reduce cost and save stock being wasted.

The new communications plan will help to mitigate this as we plan to grow our presence via digital platforms such as social media, internal and external websites. Where there is no need for printed materials.

6. Risk and assurance

- The merger presents a potential yet small financial risk to the charity as grants are generally offered over a long period of time and it would not be ethical to apply for funding whilst the future of the charity is uncertain.
- The full rebranding of the charity will be result in a financial cost,
- A detailed LCH Charity Communications Plan for 2026–27 is provided at **Appendix 1**. The plan sets out the approach for raising awareness of the Charity, supporting fundraising activity, and demonstrating the impact of charitable funds in line with Trust priorities. It takes a proportionate, primarily digital approach and remains flexible in light of potential organisational changes. The plan provides assurance that communications activity is structured, governed, and focused on maximising benefit for patients, staff and communities.

➢ 7 Next steps

The charity continues to grow, and we are seeing increased engagement on our community.

- With the new fundraising plan and communications plan outlines the activities for the next year.
- The Charitable Funds Officer is working with colleagues at LYPFT to understand more about their charity and its position within the trust.
- The Charitable Funds Officer has spent time with LYPFT'S volunteer service.

Upcoming fundraising events

- Leeds 10k June 2026
- Inflatable 5k June 2026
- Leeds Pride
- The Great Leeds Walk July 2026
- The Yorkshire 3 peaks July 2026
- The Great North run September 2026
- London Marathon April 2027

➢ 8 Recommendations

The Board is recommended:

- Receive the report and note the extend of fundraising activities
- Note and approve communications plan Appendix 2

Jodie Collins
Charitable Funds Officer
May 2026

Appendix 1 - Board Summary: LCH Charity Communications Plan 2026–27

Purpose
The Communications Plan sets out how Leeds Community Healthcare (LCH) Charity will increase awareness of its role and impact, support fundraising activity, and strengthen engagement with staff, patients and the local community over the next 12 months.

Strategic Context
LCH Charity exists to enhance patient care beyond core NHS funding, supporting projects such as improved environments, equipment, staff wellbeing and initiatives addressing health inequalities. The plan aligns with the NHS Long Term Plan and the Trust's emphasis on delivering care closer to communities. It also reflects a one-year timeframe, acknowledging uncertainty linked to potential Trust integration.

Key Objectives
- Increase awareness of LCH Charity among staff, patients and the public
- Grow charitable income through events, challenges and campaigns
- Promote equitable impact by supporting priority areas including:
    - Homeless Health & Inclusion
    - Children and young people
    - Mental health
    - Care of older people
    - End of life care

Key Messages
Communications will consistently focus on:
- Who we are – the official charity of LCH NHS Trust
- Why our work matters – funding the "extras" that transform care
- Our impact – real examples and stories from funded projects
- How to get involved – fundraising, Charity Champions, Microhive
- Stakeholders

Primary stakeholders include:
- Charity Committee and Steering Group
- Trust Board and Finance
- LCH staff (as ambassadors and applicants for funding)
- Patients, service users and the wider community
- NHS Charities Together and civic partners
- Communications Approach

A mix of internal and external channels will be used, with an emphasis on cost-effective digital communications:
- Internal: My LCH Today, Monday Messages, intranet, digital screens
- External: Trust website charity pages, Facebook, press, Enthuse fundraising pages

Printed materials will be used sparingly to avoid unnecessary cost during the merger period.
- Key Activities (High-level)
- Awareness campaign for staff on how to apply for charitable funding
- Story-led impact content ("before and after" case studies)
- Promotion and follow-up of major fundraising events including:
    - London Marathon, Leeds Half Marathon, Leeds 10K, Great North Run
    - Community events (e.g. Royal Armouries event)
- Seasonal campaigns, including NHS Birthday and Winter Appeal

- Quarterly newsletters summarising impact and fundraising activity

A detailed calendar of actions is maintained within the plan.

Governance and Approvals

- Content sign-off by senior leads prior to submission to the Charitable Funds Committee
- Charitable Funds Committee meets quarterly
- Board oversight twice yearly
- Evaluation and Assurance

Effectiveness will be monitored through:

- Website and social media analytics
- Fundraising income linked to campaigns
- Media coverage quality
- Internal engagement indicators (newsletter opens, intranet traffic)
- Key Considerations for the Board
- The plan provides clear assurance that communications activity is structured, proportionate and aligned to Trust priorities
- Delivery is dependent on continued internal engagement and capacity within communications
- The approach remains flexible to respond to organisational change

Appendix 2 - Case Study: Impact of NHS Charitable Funds on a Patient Experiencing Homelessness

Background

A 37-year-old male with a long history of high alcohol and cocaine use, beginning at age 14, presented with complex physical and psychosocial needs. Following a relationship breakdown, he became homeless, leading to escalating instability and frequent ED and hospital admissions.

His Type 1 Diabetes was poorly controlled due to difficulties with functional skills, remembering to eat, sequencing daily tasks, and coping with a persistently "busy mind." Substance use was both a cause and consequence of this instability.

After his most recent hospital admission, he was discharged into one of our Out of Hospital beds for people experiencing homelessness, where intensive support could be provided.

Initial Presentation and Support Provided

During his stay, the team delivered comprehensive, wrap-around support, including:

- Daily structure and routine-building
- Diabetes education and practical management support
- Accompaniment to medical appointments
- Support to complete ADHD assessment
- Assistance with bank accounts, benefits, and essential skills
- Exploration of interests and strengths
- Building confidence and functional living skills

Despite the challenges, he engaged well. A strengths-based approach revealed his love for being outdoors and gardening, something he had not previously had the opportunity to explore in a meaningful way.

Discovery of Meaningful Activity

The shared garden area became a turning point. He began:

- Repairing the greenhouse
- Using existing materials to plant seeds
- Organising the space and caring for plants

This not only gave him enjoyment and a sense of achievement but also:

- Encouraged other tenants to join him
- Helped him build healthy peer relationships not centred around alcohol
- Reduced social pressure by offering a gentle, activity-based context for socialising, which felt less intense and more manageable for him

Role of NHS Charitable Funds

Recognising the therapeutic value of this emerging interest, the team successfully applied for charitable funds to purchase a B&Q voucher.

This funding had a profound impact:

- Affirmed his identity and choices, reinforcing that he had value
- Enabled him to expand the garden project
- Boosted his confidence and sense of purpose
- Provided him with positive, meaningful occupation away from substance use
- Strengthened social connection and community involvement

He described the funding as making him feel "worth something" and that others believed in him.

Progression and Outcomes

Housing
With ongoing support, he successfully bid for and secured his own property, moving on to live independently with some community-based support in place.

Neurodevelopmental Assessment
During his stay, the team supported a referral for an ADHD assessment.
He was diagnosed and commenced on appropriate medication, which helped him significantly with:

- Focus and task completion
- Routine building
- Managing his diabetes

Health
He later contacted the team to share that his Diabetes had stabilised, particularly after receiving an insulin pump, which he was managing well.

Employment
Perhaps the most meaningful milestone:
He had successfully applied for a part-time job at B&Q—the same place where he had used his charitable funds voucher.
He expressed immense pride and excitement at this achievement.
The connection between his funded gardening project and later employment was clear and deeply empowering for him.

Impact Summary
The charitable funds acted as a catalyst for recovery, stability, and self-worth. They supported:
Psychological Wellbeing

- Increased self-esteem
- A sense of being valued
- Joy, meaning, and purpose in daily life

Behavioural Change

- Reduced reliance on substances through meaningful activity
- Improved routine and executive functioning
- Better adherence to diabetes management

Social Connection

- Healthier relationships with peers
- Confidence in shared activities
- Less social isolation

Long-Term Outcomes

- Independent living
- ADHD diagnosis and treatment
- Improved Diabetes control
- Entry into paid employment
- Sustained engagement in meaningful hobbies

Conclusion
This case illustrates how relatively small charitable investments can have significant, life-changing impacts for people experiencing homelessness with complex health needs.
For this individual, a simple gardening voucher became the foundation for:

- Improved health
- Rebuilt identity
- Social connection
- Purpose
- And ultimately, employment

NHS Charitable Funds played a vital role in enabling a personalised, strengths-based approach that supported a sustainable, hopeful future.

Agenda item:	2026-27 11
Title of report:	Year End Integrated Performance Report
Meeting:	Trust Board
Date:	21st May 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:

- The Trust's services worked exceptionally hard to achieve our performance targets in 2025/26 and we are proud of our ongoing commitment to provide high quality services.
- In Q3 2025/26 we improved out NHS Oversight Framework segmentation from segment 4 to segment 3. This was driven by improvements in waiting times, Children and Young People's Access to Mental Health Services and our Urgent Care Response. We were also able to maintain our staff survey engagement theme score.
- We achieved many of our targets this year despite increasing complexity of demand and service change.
- We have begun to see statistically significant improvements in the time our patients wait to access our services. The majority of services have now eradicated 52+ week waits and approved business cases are in place to eliminate these waits in the coming financial year. We are now seeing improvements in the number of patients waiting more than 18 weeks for care. We will continue with focussed work in this area and expect to see further improvements.
- We have seen maintained improvements in statutory and mandatory training compliance and appraisal rates. But sickness rates have been a challenge in the latter part of the financial year with high rates being reported. A significant programme of work has been implemented in order to address the reasons for this and improvement is expected

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 waits is examined and whilst patients in our most deprived areas wait longer for our services work is in place to deliver improvements and monitor progress.
	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



Integrated Performance Report

NHS
Leeds Community Healthcare
NHS Trust

2025/26

Year End Report



Executive Summary

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We achieved many of our targets this year despite increasing complexity of demand and service change.

We have begun to see statistically significant improvements in the time our patients wait to access our services. The majority of services have now eradicated 52+ week waits and approved business cases are in place to eliminate these waits in the coming financial year. We are now seeing improvements in the number of patients waiting more than 18 weeks for care. We will continue with focussed work in this area and expect to see further improvements.

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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

- Our forecasting shows that we will remain in segment 3 of the NOF in Q4 26/27. The published result is expected in mid-May.
- Further improvements in the number of patients waiting over 52 weeks and number of CYPs accessing mental health services are offsetting a deterioration in our score for sickness absence.
- A PLICs data quality workstream is carrying out a detailed, service level review of the data submitted and improvements in our relative costs for 2025/26 are expected as a result, but this will not affect the 2025/26 NOF segmentation.
- Work has started on reporting on the NOF for 2026/27 and this forecasting model will be updated in due course.

		Q1				Q2				Q3				Q4 (forecast)			
Domain	**Metric**	Value	Score	Rank	Segment	Value	Score	Rank	Segment	Value	Score	Rank	Segment	Value	Score	Rank	Segment
Overall		-	**2.80**	52 of 61	4	-	**2.71**	49 of 61	4	-	**2.58**	43 of 61	3	-	**2.55**	41 of 61	3
Access to Services	Percentage of patients waiting over 52 weeks	7.41%	3.3	32 of 41	3	7.82%	3.32	32 of 41	3	5.72%	3.18	31 of 41	3	2.91%	3.03	30 of 41	3
	Annual change in the number of CYP accessing MH services	-6.48%	3.69	41 of 46	4	-6.98%	3.65	45 of 49	4	4.69%	2.78	31 of 50	3	7.76%	2.07	18 of 49	2
Finance & Productivity	Combined Finance		1		1		1		1		1		1		1		1
	Planned surplus/deficit	0	1	15 of 61	1	0	1	15 of 61	1	0	1	16 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	0.47%	1	9 of 61	1	0	1	26 of 61	1
	Relative difference in costs	122.06	3.74	54 of 60	4	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	80.16%	2.49	27 of 37	2	88.99%	1.83	18 of 38	2	87.82%	1.84	16 of 38	2	88.71%	2.13	18 of 38	2
Patient Safety	NHS Staff Survey - Raising concerns sub-score	7.05	1.4	9 of 61	1	7.05	1.4	9 of 61	1	7.05	1.4	9 of 61	1	6.99	1.4	9 of 61	1
People & Workforce	NHS Staff Survey - Engagement theme sub-score	6.95	3.25	46 of 61	3	6.95	3.25	46 of 61	3	6.95	3.25	46 of 61	3	6.92	3.25	46 of 61	3
	Sickness Absence Rate	6.38%	3.53	49 of 61	4	5.80%	3.51	46 of 61	4	6.29%	3.56	44 of 61	4	7.62%	3.79	54 of 61	4

Safe Domain Summary

Accountable Exec: Heather McClelland

NHS Leeds Community Healthcare NHS Trust

Summary

2025/26 marked the second full year of the implementation of the Patient Safety Incident Response Framework (PSIRF). This included an annual review of data to inform the dedicated and individualised Patient Safety Incident Response Plan (PSIRP) for this year.

In 2025, an internal audit of PSIRF compliance was completed which provided limited assurance, prompting a comprehensive action plan to strengthen patient safety systems and processes across the Trust. In response, LCH have retrained all clinical incident handlers, enhanced our incident management system (Datix), and strengthened Trust-wide training to reinforce Duty of Candour and set clear expectations for high-quality incident closure.

Despite the above interventions there are still challenges for patient safety including delays in incident management and investigation backlogs creating significant risks to statutory compliance such as delays in the identification of Statutory Duty of Candour and the prevention of avoidable harm through the identification of early learning. A paper will be presented to Quality Committee in May 2026 outlining the proposed strategic recovery plan with three key themes: Right Person, Right Time and Right Ownership. This will include strengthening the Integrated Performance Report with incident management related KPI's for 2026/27.

A main priority for Patient Safety is identifying and embedding learning to reduce recurrence. Delays in the completion of Patient Safety Incident Investigations (PSII) have been escalated throughout 2025/26 and a review completed by the Patient Safety Manager concluded that the barrier to PSII completion is not a lack of trained staff, but a lack of protected capacity for lead investigators due to operational demand. A thematic review was completed of recent PSII's which highlighted that despite delays in PSII completion, early learning had been accurately identified and acted upon at Rapid Review, reducing the risk of further harm.

Overdue actions from PSII have also been escalated throughout 2025/26 and the process for managing Overdue Patient Safety Incident Investigation (PSII) and Patient Safety Learning Response (PSLR) actions has been reviewed and updated with the aim of strengthening governance and improving the timeliness of PSII action completion.

Domain Summary Performance

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

Measure	Target	24/25 Financial Year End	25/26 Financial Year End
Compliance in Level 1 and 2 Patient Safety Training	95%	84.6%	89.5%
Number of Patient Safety Incident Investigations (PSII)	No Target	4	17
Number of overdue PSII actions	No Target	3	12
Number of teams who have completed Medicines Code Assurance Check 1st April 2024 versus total number of expected returns	100% by year end	96%	100%
Compliance with statutory Duty of Candour	100%	89.4%	94.4%
Attributed MRSA Bacteraemia - infection rate**	0	3	0
Clostridium Difficile - infection rate**	3	0	0
Never Event Incidence**	0	0	0
CAS Alerts Outstanding**	0	1	1
Data Quality Maturity Index (DQMI) - CSDS dataset score**	No Target	91.2%	TBC
Data Quality Maturity Index (DQMI) - IAPT dataset score**	>=95%	97.0%	TBC
Data Quality Maturity Index (DQMI) - MHSDS dataset score**	>=95%	87.9%	TBC

Caring Domain Summary

Accountable Exec: Heather McClelland

NHS Leeds Community Healthcare NHS Trust

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

Overall, the percentage of respondents reporting a "Very Good" or "Good" experience of community care has remained within the upper and lower control limits throughout the year, showing common cause variation. However, the year-end target of 95% of patients reporting a positive experience through patient satisfaction surveys has not been achieved.

Analysis of Friends and Family Test (FFT) feedback shows that the primary factor contributing to dissatisfaction relates to patient waiting times. Trust-wide improvement work continues with a focus on improving communication and managing expectations to improve patients experience whilst waiting.

The Patient Engagement Manager is undertaking work to standardise the Friends and Family Test across all services and progress towards the introduction of more bespoke, service-specific surveys. This work aims to improve data quality assurance and enable more robust, Trust-wide analysis of both quantitative results and qualitative feedback. The standardisation of FFT is scheduled for completion by the end of Quarter 1 2026/27, with predicted improvements in insight and reporting from Quarter 2 2026/27 onwards. Themes from complaints and FFT feedback are reviewed through established governance arrangements to inform learning and service improvement within the Caring domain.

Total Number of Formal Complaints Received

During the reporting period of 2025/2026, the Patient Experience Team have successfully rolled out a Parliamentary Health and Service Ombudsman (PHSO) complaint process pilot phase 1 and 2. The pilot tested a new approach to managing complaints and resolving complaints as early as possible. Feedback within phase 1 indicated positive outcomes.

A risk identified was reduced capacity within the team, which has impacted delivery and responsiveness to progress complaints. This has had an impact on delivery on training and the role out to the PHSO standards to all services. Which in return has contributed to lack of training and support to new investigators in the trust. There are planned improvements to embed the standards and role out the pilot to all services. Once this has been introduced widely in the trust, this will benefit our patients and families, benefits will include faster outcomes, reduced distress for patients and their families and rebuilds trust. Given the challenges within the team, the pilot has been successful and highlights commitment to provide improvements across the trust that drive improvement.

Sub Domain Summary Performance

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

Measure	Target	24/25 Financial Year End	25/26 Financial Year End
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	>=95%	93.7%	91.5%
Total Number of Formal Complaints Received	No Target	159	285

Effective Domain Summary

Accountable Exec: Ruth Burnett

NHS Leeds Community Healthcare NHS Trust

Summary

Equity in average length of wait:

The end of year position shows a decrease in likelihood of patients in our most deprived areas (MD1) waiting longer for consultant-led services, although non-consultant led services remain above target, with patients in our most deprived areas still likely to wait longer than the rest of the population. This position has not been consistent throughout the year and targeted work has been undertaken to improve access through reducing missed appointments and supporting attendance. We continue to monitor the impact of this work and will complete a deep dive in Q1 to understand if improvements are being sustained and identify further areas of focus.

NICE Guidance

During 2025/26, LCH maintained strong compliance with NICE guidance, achieving full compliance for earlier guidance by year end and showing improvement for more recent publications. Some variation reflects the challenge of embedding and evidencing new standards. Actions are in place to strengthen tracking and timely implementation, supporting sustained alignment with evidence-based practice.

NCAPOP audits

During 2025/26, LCH maintained strong engagement with national clinical audits, with most submissions completed. A small number were partial or delayed due to external system limitations affecting data upload functionality. The Trust has taken all reasonable steps to mitigate this and continues to work with audit providers to enable full participation and maximise assurance and learning.

Clinical Audit

During 2025/26, the clinical audit programme has seen good engagement, with most audits registered and progressing to completion. However, gaps remain between completion and the submission of summaries and improvement plans, limiting full assurance of impact. Learning has informed a strengthened 2026/27 programme, with improved governance and targeted support to enhance completion, learning, and the implementation of improvements in practice.

Domain Summary Performance

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

Measure	Target	24/25 Financial Year End	25/26 Financial Year End
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 18 week standard	<=1.0	1.05	0.96
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 52 week standard	<=1.0	0.97	0.95
Difference in access to services for patients living in IMD1 vs IMD2-10 - Non-Consultant 18 week standard	<=1.0	1.17	1.15
Number of NICE guidelines with full compliance versus number of guidelines published in the year prior to last financial year applicable to LCH	100% by year end	100%	100%
Number of NICE guidelines with full compliance versus number of guidelines published last financial year applicable to LCH	No Target	100%	91%
NCAPOP audits: number started year to date versus number applicable to LCH	100% by year end	40%	88%
Priority 2 audits: number completed year to date versus number expected to be completed in 2021/22	100% by year end	67%	39%
Total number of audits completed in quarter	No Target	80	58

Responsive Domain Summary

Accountable Exec: Sam Prince

NHS Leeds Community Healthcare NHS Trust

Summary

The Trust has delivered significant and sustained reduction in long waits over the financial year. There has been a substantial reduction in 40+ week waits, decreasing from 4,459 on 31 March 2025 to 1,276 on 30 March 2026, representing a 71.4% reduction. Alongside this, 18-week performance has improved to 81%, up from 61.6% at the end of the previous financial year, exceeding the 78% target set within the Medium-Term Planning Framework.

The Access LCH Steering Group has driven a focused programme to eliminate the longest waits. As a result, most services have now eradicated 52+ week waits, including CUCS, Adult SLT, Podiatry, MSK, Diabetes, Tier 3 Weight Management and Children's SLT. A key enabler of this progress has been the introduction of enhanced visibility, trajectory management and predictive modelling across waiting lists.

52+ week waits now only remain in CYPMHS (ND pathway), Community Dental and Paediatric Neurodisability (PND). However, approved business cases are in place to eliminate these waits in the coming financial year. Notably, PND is now the only service contributing to 52+ week waits within the NOF domain, with additional substantive paediatrician capacity expected to further reduce waits below 18 weeks. Early improvements in consultant-led waits are already being observed as the result of this work.

Performance in UCR has also improved, with the Trust's UCR response rate increasing from 79.4% to 82.7%, reflecting sustained operational focus within ABU services because of the NOF. Throughout the year we have maintained our performance on or above target for the DM01 indicator.

These improvements reflect sustained service-level efforts to increase capacity, refine triage processes and prioritise patients based on clinical risk. In parallel, the Trust has strengthened its focus on equity within waiting times, with targeted analysis and actions now embedded within services to address variation across population groups.

Domain Summary Performance

Data Quality : Medium Assurance Performance: Off Track

Measure	Target	24/25 Financial Year End	25/26 Financial Year End
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	>=92%	26.2%	32.6%
Number of patients waiting more than 52 Weeks (Consultant-Led)	0	1104	448
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	>=99%	98.2%	97.5%
% Patients waiting under 18 weeks (non reportable)	>=95%	61.6%	81.0%
Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care	0	15	16
% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	>=95%	50.0%	57.1%
Number of Patients Accessing CAMHS	No Target	12585	13092
Percentage of Children over 5 currently waiting more than 18 weeks for a Neurodevelopmental Assessment	5%	95.5%	97.8%
LMWS – Access Target; Local Measure (including PCMH)	24456 by year end	32364	30805
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	No Target	59.6%	53.1%
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	>=95%	99.4%	98.4%
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	>=75%	93.7%	87.4%
Available virtual ward capacity per 100k head of population	No Target	22.9	92.1
Community health services two-hour urgent response standard	>=70%	79.4%	82.7%

Well-Led Domain Summary

Accountable Exec: Laura Smith and Jenny Allen

NHS Leeds Community Healthcare NHS Trust

Staff Appraisal Rates Compliance

Appraisal compliance improved significantly compared to the previous year, increasing from an average of 76% in 2024/25 to 82% in 2025/26. The trust appraisal rates finished the year on 80.4%. Targeted action at Business Unit level, including the introduction of specific appraisal targets monitored, through local performance panels and reinforcing expectations around timely, and meaningful appraisal conversations, has played a key role in driving this improvement. Collectively, these actions support the Trust's ambition to ensure colleagues are well supported, developed, and equipped to deliver safe and effective care.

The overall percentage of staff who have identified as BME (excluding Exec Board Members)

The proportion of staff identifying as BME increased to 15%, exceeding the 14% target. This improvement reflects targeted action to resolve ethnicity data issues within ESR, proactive engagement with staff to complete declarations, and wider inclusion initiative. Our work to reduce the existing disparities in experience and opportunity, improve engagement and target areas of concern, is ongoing .

Turnover and Net Movement

The overall rate at which colleagues left the organisation has remained healthy, with Turnover at year end for 2025/26 sitting at 9.2%. This continues the pattern of workforce stability seen throughout the year. Net movement for the year has finished with an increase of +2 heads.

Sickness Absence

Sickness rates looked positive in the first six months of the year, averaging 6.0% compared to the previous year's 6.3%. However, a spike in sickness over the winter months took absence levels higher than expected, resulting in a total absence rate this year of 6.8%. The trust sick absence rate finished the year on 7.1%. Over the last twelve months, our approach to sickness absence has evolved into a proactive and preventative model that prioritises early intervention. Key achievements include long-term case reviews and launching "Managing Absence with Confidence" training and Organisational Health reviews in hotspot areas are underway

Statutory and Mandatory Training

Following the improvement in our Statutory and Mandatory training compliance last year, our rates have remained at the 90% target throughout 2025/26. Furthermore, a training dashboard was released at the start of November 25, in order to support services with maintaining this high level of compliance.

Domain Summary Performance

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

Measure	Target	24/25 Financial Year End	25/26 Financial Year End
Staff Turnover	<=14.5%	10.9%	9.2%
Total sickness absence rate (Monthly) (%)	<=6.5%	5.9%	7.1%
AfC Staff Appraisal Rate	>=90%	83.5%	80.4%
Statutory and Mandatory Training Compliance	>=90%	88.8%	90.3%
'RIDDOR' incidents reported to Health and Safety Executive	No Target	6	6
The overall percentage of staff who have identified as BME (including exec. board members)	14%	13.7%	15.0%
Total agency cap (£k)	No Target	1992	2353
Starters / leavers net movement	>=0 in favour of starters	-12	2

Finance Domain Summary

Accountable Exec: Andrea Osborne

NHS Leeds Community Healthcare NHS Trust

Summary

Income & Expenditure: As at the end of March 2026, the Trust is reporting a full-year surplus of £0.951m against its break-even plan. This position has been achieved through a combination of one-off measures, including the release of historic accruals no longer required and underspends within pay budgets. After adjusting for the full-year effect of savings already identified, the underlying financial position at Month 12 is a deficit of £1.093m.

Cash: The Trust's cash position remains strong, with a closing balance of £49.922m, higher than the planned figure by £6.496m. This was due to 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 89 days. Compliance with the Better Payment Practice Code (BPPC), our requirement to pay suppliers within 30 days or by the due date, is above target at 97.5% by both number and value of invoices.

Capital Expenditure: At the end of March 2026, the Trust has reported a spend of £7.2m on owned assets and £3.1m on ROU assets. The Trust has received additional CDEL of £0.6m from NHS England, increasing the CDEL limit to £10.351m. 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: The Trust has delivered recurrent savings in-year of £11.921m, with a full-year effect of £12.907m, representing 92% of the target. The overall savings plan has been achieved in full, supported by £2.079m of non-recurrent measures. The outstanding recurrent savings are expected to be realised in 2026/27, in-line with the implementation of Year 3 of the Q&V programme.

Temporary Staffing: As at the end of March 2026, performance reflects an underspend of £0.513m. Temporary staffing expenditure represents 4.5% of gross staff costs, 0.2% favourable to plan. Full-year temporary staffing costs include expenditure related to waiting list initiatives, as well as one-off pieces of work within the Business Intelligence team, which are non-recurrent and not expected to continue beyond the 2025/26 financial year.

Domain Summary Performance

Prior Year	Key Financial Indicators	YTD Plan	YTD Actuals	YTD Variance	Full Year Plan
(1,943)	Adjusted (Surplus)/Deficit	-	(951)	**(951)**	-
3,600	Underlying (Surplus)/Deficit	-	1,093	**1,093**	
50,908	Closing Cash Balance	43,426	49,922	**(6,496)**	43,426
(7,628)	Capital Expenditure (CDEL)	10,351	10,221	**(130)**	10,351
	Quality & Value Programme				
9,130	Recurrent Savings	14,000	11,921	**2,079**	14,000
6,648	Non Recurrent Savings	-	2,079	**(2,079)**	-
15,778	**Total Savings**	**14,000**	**14,000**	**-**	**14,000**
	Temporary Staffing				
2,408	Agency	2,859	2,329	**(530)**	2,859
5,334	Bank	5,419	5,564	**145**	5,419
7,742	**Total Temporary Staffing**	**8,278**	**7,893**	**(385)**	**8,278**
168,716	**Total Gross staff Costs**	**179,638**	**177,598**	**(2,040)**	**179,638**
4.6%	**Temp Staffing Costs as a % of gross staff costs**	**4.6%**	**4.4%**	**(0.2%)**	**4.6%**

NHS Leeds Community Healthcare NHS Trust

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

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

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

Leeds Community Healthcare NHS Trust

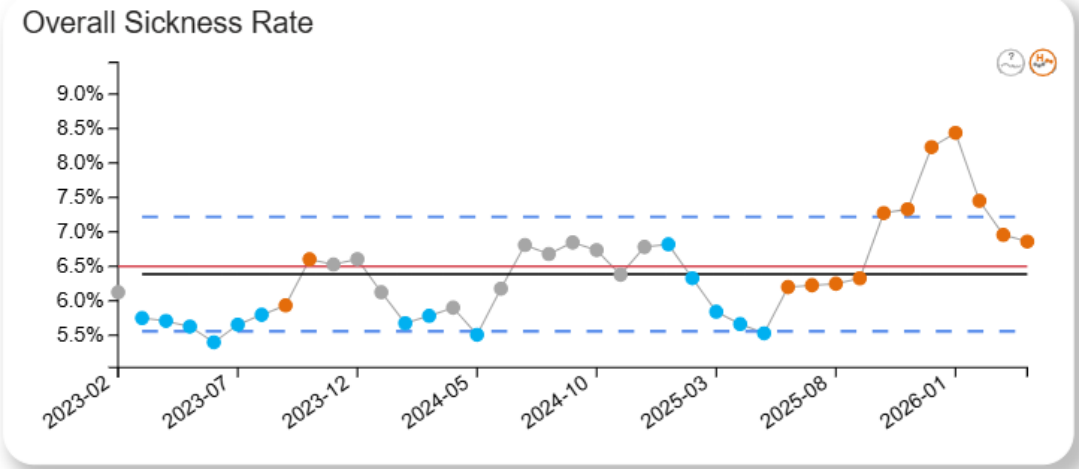
NOF Improvement Project - Sickness Absence Update

Current Position

NHS
Leeds Community Healthcare
NHS Trust

Where we are now

- LCH remains in NOF Segment 4 for sickness absence
- The latest available data is April 2026, with overall sickness absence at 6.9% against a target of 6.2%
- The overall rate is gradually reducing following the winter peak. Short-term sickness has reduced significantly to 1.9%, while long-term sickness remains the main driver at 5.0%
- Anxiety, stress and depression remains the leading reason for absence at 2.3%. Musculoskeletal absence has reduced to 0.9%, but remains the second largest driver of long-term sickness.



What we are doing well

- Managing Absence with Confidence training has been successfully rolled out, with good early evaluations & a waiting list in operation. Feedback indicates the training is landing well and meeting a clear capability need.
- The absence toolkit has been refreshed and uploaded to My LCH, with the intranet content being improved to make guidance more accessible, practical and easier for managers to use.
- EAP awareness and utilisation have improved, supported by well-attended webinars and promotional activity.
- A more structured, data-led support framework is being introduced (the 'intervention compass'), unavailability dashboard and intervention log to direct support to the right teams, track actions and maintain grip on progress.
- Organisational health support is becoming more targeted and proportionate, with full diagnostic reviews available where deeper insight is needed and a lighter-touch approach being developed for earlier supportive conversations with managers.

Where we are focusing next

- The project is now moving from developing tools and interventions into operationalising them through routine management.
- We are continuing to work with 'hotspot' teams using our data driven support framework (the 'intervention compass')
- Further work is required to strengthen the sickness panel process and improve Occupational Health performance, both of which remain important areas of focus.

Key Developments

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 project remains active across four workstreams, with progress now focused on embedding, operationalising and measuring impact.

Guidance, policy and process	• Managing absence training has been rolled out and demand is high, with a long waiting list. Early feedback indicates that the training offer needs to support both new managers and more experienced managers, given the variation in baseline knowledge and confidence. • Facilitators are reviewing the approach to make the training more suitable for all managers. Additional psychological input is also being explored to strengthen content on early signs of distress, supportive conversations, absence contact and return-to-work practice. • Work is underway to make the intranet content easier for managers and staff to navigate. • A policy adherence measure is being developed. The agreed initial focus is whether return-to-work conversations are being completed and whether formal meetings are taking place when policy triggers are met. Work is ongoing to confirm whether this data can be extracted reliably. • We are formulating the response to our internal sick absence audit which is looking positive.
Occupational Health	• Occupational Health remains an area of concern as managers are finding it difficult to access the services, and there are concerns over the quality of OH support. This issue has been escalated to the organisational risk register and we continue to work with our OH provider and monitor closely.
Employee Assistance Programme	• EAP engagement has improved following recent awareness events and webinars.
Organisational Health	• Organisational health diagnostic work is being aligned more closely with the data, reporting and intelligence workstream, so that support can be targeted to teams showing early signs of risk or sustained pressure • Work is beginning with Wetherby YOI and Dental, using the same broad methodology applied in Police Custody. • The process is being strengthened through clearer contracting with services at the outset, including scope, leadership ownership, expected outputs and local ownership of recommendations. • Progress will be kept under monthly review through a new engagement report, maintaining line of sight from identification, diagnostic, recommendations, local action and impact. • Where indicators remain a concern, the framework will trigger further check-in and Director discussion on whether additional support is required.
Data, reporting & intelligence	• The data workstream has strengthened since March. The organisational target methodology is being refined for the new financial year, and business unit targets have been defined via the Director of Operations. • The Unavailability Dashboard is live and provides daily updates with weekly absence rates. The next step is to agree how this will be operationalised and used consistently in management routines. • A new structured, monthly, data-driven support framework to manage sick absence has been introduced. A central team reviews trends, assigns graded support levels to services, and provides targeted interventions and oversight. Standardised communication improves consistency, escalates issues appropriately, and aligns support with need while enabling regular feedback and continuous improvement. It was presented at Operations Forum and was well received.

Forward Focus

Leeds Community Healthcare NHS Trust

- **Strengthen operational grip through the support framework**
  - Continue to operationalise the data-led support framework, testing and refining the process through monthly review cycles.
  - Review “hot” and “warm” teams through monthly sickness data meetings, drawing on local intelligence to agree proportionate support.
  - Strengthen engagement with services so the framework is understood as supportive and improvement-focused, rather than punitive.
  - Track actions, support offered and impact through the intervention log.

- **Improve process assurance and adherence to policy**
  - Progress sickness panel improvements, including standards, preparation, chair engagement and reporting.
  - Define policy adherence measures, initially focused on return-to-work completion and formal meetings after triggers.

- **Build manager capability and meet training demand**
  - Continue Managing Absence with Confidence training rollout and refine the training offer to support both new and experienced managers.

- **Look at prevention and earlier support**
  - Pilot psychology input with HR Business Partners to strengthen manager advice on early distress, supportive contact and return to work.
  - Use the support framework and unavailability dashboard to identify “warm” teams earlier and develop targeted action on MSK absence.
  - Maintain Occupational Health as a key area to manage

Agenda item:	2026-27 12
Title of report:	Paediatric Neurodevelopmental (PND) Assessment Pathway Business Case for Investment - **Reducing the increasing number of children and young people waiting for paediatric Neurodisability (PND) assessments in the ICAN service**
Meeting:	Board Meeting
Date:	21 May 2026

Presented by:	Sam Prince, Executive Director of Operations
Prepared by:	Vanessa Hunt, Vicky Hodgson, Laura Ninnes

Purpose of the report:		
This report provides: Setting out the need for investment in the recruitment of three permanent Paediatricians (one per hub) and an additional Advanced Clinical Practitioner (ACPs) to expand capacity for both complex PND and suspected autism assessments, reduce waiting times, and create a sustainable, long-term workforce solution	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:

- Rising demand: Increasing referrals for suspected autism and complex PND since 2019.
- Long waits: 1,328 of 1,641 children have waited over 18 weeks for assessment.
- Limited capacity: Only 47 new PND slots per month available for both autism and complex cases.
- Ongoing pressure: Complex PND patients require long-term follow-up, adding long term pressure
- Risk of inaction: Waiting lists projected to grow due to demand and despite mitigating action and productivity work.

Previously considered by:	Business Committee 25th March 2026
Outcome of previous discussion/s:	Supported

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

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

Recommendation(s)	Support phase 1 - through a combination of recurrent and non-recurrent investment at an annual costs of £700k pa to increase capacity by delivering 240 additional complex PND assessments in the first year and 288 additional autism assessment appointments annually.

List of Appendices:	Appendix 1. PND Risk Assessment

Patient Story

We received a complaint from the parent of a child with complex and multiple medical needs about the lack of support from ICAN paediatricians. The child had been admitted to hospital with sepsis and the parent was struggling to co-ordinate all the child's health needs.

The child is 9 years old with a rare genetic neurological disorder that affects brain development, resulting in severe mental and physical disability. The child is under multiple medical consultants across LCH, LTHT and the national specialist centre.

The child has been accessing the ICAN PND service since 2018. Their named paediatrician retired in April 2025, and they were appointed a new paediatrician. The child was due a follow up appointment in June 2025 which would have been the new paediatrician's first appointment with the family.

Due to the demand on the ICAN PND service, there are increased waits for follow up appointments resulting in appointments being overdue by several months. In this case, the child's planned follow up appointment in June 2025 was delayed and the paediatrician was yet to meet the family at the point of the child's acute hospital admission and subsequent multi-service complaint from the parent in December 2025. The new paediatrician's first appointment with the family was in January 2026. It was difficult for the paediatrician to build rapport and gain trust from the parents when starting from a point of parental frustration and lack of trust in the service alongside significant carer strain from the acute hospital admission. The parent requested a change in paediatrician in February 2026 because they felt unable to build trust in the paediatrician.

We held a complaint resolution meeting with the parent in February 2026 to explain the PND service offer and apologise for the delay in follow up appointment due to current pressures on the service. We have allocated a different named paediatrician and appointed the child to a new patient slot with the paediatrician. We have written to all parents who are awaiting follow up appointments to inform them of the delays and ask that they contact the service should their child require a more urgent review.

Had the new paediatrician been able to review the child as planned in June 2025, the parent would have been able to build rapport and trust with the new paediatrician at a point where the child's condition was stable, and the parent was not under significant strain. The paediatrician would have been able to explain their role and manage parental expectations. The child would have been seen in a follow-up appointment slot, rather than using a longer new patient appointment. The complaint, and the corresponding stress and anxiety for the parent and paediatrician, would have been prevented.

Increasing the PND capacity will enable children to be reviewed more promptly, providing a better experience for parents of children with complex medical needs and reducing the reliance on parents to monitor clinical risk and appropriately escalate their concerns. This will prevent complaints and reduce the associated stress for paediatrician.

Strategic fit

Reducing the increasing number of children and young people waiting for paediatric Neurodisability (PND) assessments in the ICAN service

Summary

- The number of children waiting on the PND list for assessment has increased steadily since 2019. In part, this increase is due to a rise in the number of children being referred because of suspected autism. This reflects both a local West Yorkshire and a national picture.
- There are currently 1,641 children on the PND waiting list for an initial appointment, and 1,328 of these children have been waiting for over 18 weeks (data sourced 10.2.2026).
- The ICAN service has been working hard to address the pre-school autism waiting list to avoid, or at least reduce, a second wait. This wait has been reduced due to investment from the LCH Access Funds.
- In addition, parts of the new pre-school autism assessment pathway are now operational and include:
    - Enhanced pre-school autism assessments
    - A needs-led offer of intervention for children, with or without an autism diagnosis
    - Sole assessor clinics (due to start April 2026)

Current situation

- Currently there are 54 new PND slots available a month. This considers 20% in job plans for study and annual leave. Seven of these slots are required for Complex Developmental assessments (CDA). Leaving a total of 47 new slots a month for both suspected autism and complex PND appointments.

Complex PND appointments

- The current demand for complex PND appointments is 47 appointments per month, accounting for a 5% non-attendance rate.
- This cohort represents CYP with complex needs who are likely to remain under the care of the service until they transition to adult services. Any capacity planning or workforce modelling must account not only for monthly demand but also for the long-term commitment of clinical time required to support this cohort over many years.
- This places a cumulative and sustained pressure on capacity, with demand increasing year-on-year as new patients enter the pathway while existing patients continue to require ongoing support.

Suspected Autism PND appointments

- The current demand for suspected autism PND appointments is 50 appointments per month, accounting for a 5% non-attendance rate.
- This figure also considers the revised acceptance criteria. It is anticipated that approximately 40% of referrals will no longer require a PND appointment and are filtered into the Needs Led Support Pathway.
- This cohort typically requires only one follow-up PND appointment prior to discharge. It is expected that 90% of these follow-up appointments will be delivered by ICAN Advanced Clinical Practitioners (ACPs.)

Assurances in Place

- Complex waiting list is regularly reviewed to mitigate immediate risks

- Paediatricians work to RCPCH-approved job plans with around 60% clinical activity, but vacancies allow plans to be revised to try meet service pressures.
- Newly appointed ACPs now manage all post-autism-assessment reviews and some follow-ups, easing paediatrician workload; an additional ACP is requested to further support new paediatricians rather than recruiting another doctor.
- Non recurrent investment from LCH Access Funds and the introduction of elements of the new pre-school autism pathway have significantly reduced the pre-school autism waiting list and helped minimise the risk of a second wait.
- Key pathway components now in place include enhanced assessments, a needs-led intervention offer regardless of diagnosis, and the planned introduction of sole-assessor clinics from April 2026.

Risk

- Service data indicates that without any action to address the imbalance of the service's capacity and demand, the waiting times will continue to grow by approx. 50 referrals each month. It is expected that waiting lists will quickly returning to pre-initiative levels within 6 months and continue to increase each month thereafter.
- The locum PND Drs cannot take on any child who requires a follow up, as no Paediatricians have the capacity to take on an additional caseload when a locum finishes.
- Clinical risks from significant delays within this pathway are currently mitigated through triage and regular review of waiting lists by the ICAN Paediatricians. This reduces the risk of delays for patients with imminent or deteriorating medical needs but does not eliminate it completely. This is time consuming and resource intensive for the service.

Stakeholders

Key stakeholders include ICAN Paediatricians, Advanced Clinical Practitioners, Service Management, Workforce and Finance teams

Options appraisal:

Option	Description	Summary
Option 1 – Do nothing	Maintain current staffing and capacity arrangements.	Waiting times will continue to grow by approximately 50 referrals per month, with a return to pre-initiative waiting list levels within 6 months.
Option 2 – Continue with locum PND Doctors	Use locum Doctors to increase appointment capacity.	Locum PND Doctors cannot take on any child who requires follow up, limiting effectiveness and sustainability.
Option 3 – Permanent workforce expansion (Proposed option)	Recruit three Paediatricians, one in each hub, alongside ACP workforce expansion.	Provides sustainable capacity, increased new PND assessment availability, improved continuity of care and supports long-term workforce planning.

Proposed Option - Option 3 – Permanent workforce expansion

- There is a requirement for an additional 50 PND appointment slots per month.
- To meet this demand the team would appoint three Paediatricians, one in each hub. A key benefit is that these Paediatricians would not arrive with existing caseloads, allowing their initial activity to focus entirely on complex PND patients.
- For the first six months, each Paediatrician would run complex PND clinics with three new patients per clinic, as there would be no requirement for review appointments during this period.
- For the subsequent six months, clinics would transition to a mixed model of two new and two review appointments per clinic.
- Over the first 12 months, this would result in:
    - 24 new complex cases a month in the first six months, equating to 144 patients seen.
    - 16 new complex cases a month in the subsequent six months, equating to 96 patients seen.
    - A total of 240 additional new complex PND patients seen in the first year.
- In addition, each Paediatrician would provide one autism clinic per week, generating two additional autism assessment slots per clinician. This would create 24 additional appointments per month (288 per year) for the suspected autism cohort.
- Two trainee ACPs are currently in training and are expected to qualify in 2027. Once qualified, they will take on a greater proportion of PND review appointments, enabling Paediatricians to increase capacity for new PND assessments.
- In addition to the two trainee ACPs, there is an intention to recruit one additional Advanced Clinical Practitioner (ACP), with a preference for a fully qualified practitioner.

Proposal Benefits and Assurance

- Delivers direct action to reduce the waiting list/times for PND assessments, including the suspected autism cohort.
- Increases capacity for new PND assessments, enabling earlier diagnosis and timely support supporting prevention and early intervention initiatives.
- Provides dedicated autism clinic capacity to reduce waiting time and support early intervention.
- Reduces reliance on temporary staffing by investing in permanent workforce solutions, supporting sustainability and continuity of care.
- Enables more efficient use of Paediatrician time by moving PND review activity to ACPs, allowing consultants to focus on complex and new cases.
- Supports waiting list recovery and equitable access across hubs by delivering additional capacity within the first 12 months.
- Contributes to improved system flow, experience, and positive outcomes for CPP. Prevent children aging out of ICAN criteria and adding pressure to the CYPMHS.
- Supports the NHS 10 Year Plan to improve access, early identification and intervention for CPY with ND needs.

Digital Opportunities

- EnrichMyCare and Antham are being explored to support paediatric referral, triage, and clinical note-taking, both remain in early stages of evaluation with important functional limitations (e.g. Antham not integrating with SystmOne)
- Whilst pilots have not yet commenced and so there is no evidenced time-saving or efficiency gain a phased approach to investment is recommended to avoid over-commitment of recurrent resources whilst further testing and evaluation are undertaken.

Commercial aspects:

- No external procurement is required.

Affordability: the financial case

Summary of Costing Ref No 0722526CBU - ICAN PND resource to get to 18 week wait

Costing for 1 NR consultant and rest of staff recurrent 2 consultants and 1 B8a

	Non Recurrent	Recurrent	Total
Pay	172,045	421,870	593,915
Non Pay set up costs	1,316	3,948	5,264
Non Pay training and travel costs	3,000	9,200	12,200
Overheads	25,382	62,505	87,887
	201,743	497,523	699,266

Assumptions	
Pay costs	Based on 25/26 payscales costed midpoint and includes Apprenticeship Levy 0.5%
	Consultant costs based on 25/26 ave consultant funded wte
	Consultant costs does not include on-call or CEA, etc
	Pay costs have been uplifted for 3.3% pay award
	Staff work Monday to Friday with no shift work/enhancements
Non Pay set up costs	One laptop and mobile phone per person
Non pay	Travel and training costs included
	Overheads included at 14.5%

Achievability & Evaluation Measurement

Phased Approach

- **Phase 1:** Recruit both non-recurrent and recurrent resource to immediately increase capacity. This will enable rapid workforce expansion to meet current demand while maintaining service continuity.
- **Phase 2:** Include an option to review and potentially reduce longer-term recurrent investment as the impact of AI-enabled efficiency gains becomes clearer and better evidenced.
- **Risks: & Mitigations**
    - A non-recurrent post can clear backlog with no long-term financial commitment, but fixed-term nature may reduce applicant interest and risks service disruption.
    - Relying on AVT assumptions and non-recurrent funding will mean utilising locums who only see autism-related cases, leaving complex PND children who require ongoing specialist care without sufficient permanent provision.
    - Service pressures are shifting, and without permanent staffing, children with complex PND will soon face the longest waits, despite the service already aligning with NHS England guidance.
    - AVT cannot replace essential physical exams, face-to-face assessments, or diagnostic formulation, and is only applicable to autism-specific PND referrals.

Impact Monitoring and Review:

- The service has a robust review process in place, with waiting times and performance monitored through service meetings, Access and Performance cycles, and IBC reporting. The business case proposes a formal six-month review of the phased approach to ensure continuous evaluation of impact and the benefits realisation of the Antham tool before confirming any longer-term recurrent investment.

Conclusions & Recommendations

Conclusion

Demand for Paediatric Neurodisability assessments continue to exceed capacity, leading to sustained waiting list growth and increased risk. Current mitigations are resource intensive and unsustainable. Permanent workforce investment is required to restore balance between demand and capacity and to deliver sustainable reduction in waiting times.

Recommendation

The Board is requested to support recurrent revenue investment of £497,523 per annum, along with non-recurrent investment of £201,743 in Year 1, to deliver additional ICAN PND capacity and achieve an 18 week waiting time standard.

Appendix 1. PND Risk Assessment
Key risks (including probability) are documented below, with identified mitigation to reduce the impact of each should they occur.

1 Owner	2 Risk Description	3 Initial risk score	4 Controls	5 Revised risk score
Operational Lead / Medical Lead	Recruitment Inability to recruit pediatricians/ACP	(4x3) 12	Early advertising, multiple recruitment channels, international recruitment options	(2x1) 2
Operational Lead / Medical Lead / Clinical Lead	Increase in demand Current demand increases and outstrips new capacity causing longer waits, potential for clinical safety incidents	(4x3) 12	Further review of service offers, ongoing capacity and demand modeling, patient safety risk management	(2x2) 4
Operational Lead	High reliance on locum staff Increased financial pressure, inconsistency of patient care for families of children with autism.	(3x3) 9	Recruitment to substantive posts, integrate ACP role. The ACP will provide the families with substantive support if needed.	(2x2) 4
Operational Lead / Clinical Lead	Current infrastructure restrictions Nursing – no additional capacity available for additional paediatricians. Estates - rooms not available .	(3x3) 9	Nurse capacity and demand modeling to release more time for clinical support. Review of estates, room bookings to identify where space can be freed up.	(2x1) 2

Agenda item:	2026-27 13
Title of report:	Business Case: Investment in Stroke Early Supported Discharge Pathway through System Catalyst Fund
Meeting:	Trust Board
Date:	21st May 2026

Presented by:	Andrea Osbourne/Sam Prince
Prepared by:	Helen Knight (Head of Service – Clinical, Community Stroke Rehabilitation Service) Satbir Saggu (Head of Service – Operational, Community Stroke Rehabilitation Service) Nicola Wolstenholme (Business Manager – Specialist Services) Rob Rathbone (General Manager, Neurosciences – LTHT)

Purpose of the report:		
This report provides board with a business case for approval for investment in a consultant therapy lead and phased expansion of the LCH Community Stroke Rehabilitation Service to build community capacity, enable earlier discharge from acute care and deliver improved patient outcomes and experience. This is a coproduced proposal developed between LCH, LTHT and the West Yorkshire Integrated Care Board. The funding source is the Neighbourhood Catalyst Fund Year One Allocation (£525k) agreed recurrently in principle by WY ICB and notice provided to Executive Directors.	Approval	X
	Discussion	
	Assurance	

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

Summary of Key Issues:
• The scheme will be tested and developed over a three-year period, with the aim that from end of Year One (2026/27) the service can demonstrate a return on investment to be cost neutral at a minimum. Recurrent funding of £525k to cover Year One costs (£394k-recurrent) has been confirmed in principle. 2027/28 full year recurrent costs are forecast as £651k and will be subject to further business case approval in Q3/Q4 2026/27.

- After set up in Q1/Q2 it is assumed that the pathway will "go live" from September 2026 with capacity to support a minimum of 5 new starts per week.
- LCH & LTHT partners are confident the model will be at least cost neutral, with the potential for greater savings as the service becomes established and discharge pathways mature. The proposal estimates a full year potential saving of £725k per annum (net £74k) from 2027/28. This is based on achievement of 1,820 saved acute bed days. This excludes other quantifiable socio-economic benefits of supporting patient's earlier return to work
- The key financial risk to LCH is recruitment to permanent roles to assure recruitment to demonstrate the benefits of the opportunity. The scale of this risk will be monitored based on appointed WTE, and some roles are planned from Yr Two only. There are redeployment options for most roles excluding the Therapy Consultant role which is new to the Leeds system and working across the pathway and into LCH & LTHT. Risk share principles are to be agreed as part of project set with system partners to share appropriate financial risks.

Previously considered by:	Business Committee – 15th April 2026
Outcome of previous discussion/s:	Business Committee approved the business case and supported the recommendation to progress recruitment through April and May subject to final approval of this business case by LCH board.

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

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	X	Why not/what future plans are there to include this information?	Health Equity Impact Assessment to be undertaken in project set up phase to inform ongoing development of KPI/Measurement plan

Recommendation(s)	Board are requested to approve the business case based on the assumptions outlined.

List of Appendices:	Appendix One – Cross Organisational Working Group Appendix Two – Workforce Model Appendix Three – Finance Plan & Costing Assumptions Appendix Four - Risks and Mitigations

Patient Story

Stroke is a leading cause of death and disability in the UK. 1500 new stroke patients are treated in Leeds each year and 2% of the Leeds GP population have disability related to a previous stroke. This is higher than national average, likely due to stroke being closely linked to the high indices of deprivation in Leeds. Stroke increasingly impacts working-age adults, with a third of cases occurring in this group and the incidence is increasing year on year (91,162 cases in 2022/23 compared to 85,480 in 2020/21).

The NHS Long Term Plan identifies stroke as a national clinical priority, aiming to improve care across prevention, acute management, and rehabilitation. The Leeds Health and Care Partnership (LHCP) has identified the need for improvement in patient flow through the Stroke Until. Advancements in treatments improve survival and the chances of recovery without disability, but stroke continues to be a major cause of long-term disability, affecting over half of survivors. To quote one stroke patient, "saving lives is one thing, but making them worth living is more important"[1]. Effective rehabilitation is critical to patients regaining good quality of life, independence, reducing burden on NHS and social care and benefits associated with the ability to work.

The Leeds Stroke pathway is across hyper acute, acute, rehabilitation and community services. Services are managed across different Leeds Teaching Hospital Trust (LTHT) clinical service units and the Leeds Community Healthcare (LCH) provided Community Stroke Rehabilitation Service (including sub-contracting of elements of community provision to the Stroke Association). This has led to variability in oversight and implementation of service improvements. All services are supported by clinicians and practitioners with specialist expertise in stroke care; however, care does not appear to be streamlined across the pathway with some patients reporting:

"Lovely people but disjointed care, multiple waits, poor communication, repetition in assessments and not enough therapy[2]."

This includes poor quality stroke care when in the non-stroke LTHT bed base:

"They spoke to me like I was ga-ga because I had aphasia[3]"
"They didn't know I couldn't see through my right side and I couldn't find my lunch[4]"

These challenges highlight the need for improved city-wide stroke infrastructure and service coordination that delivers timely, specialist-led community rehabilitation for appropriate stroke patients who can benefit from individualised rehabilitation in their own environment at an intensity that helps them recover sooner.

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[1] Leeds Early Supported Discharge Service for Stroke, June 2025, LTHT
[2] As previous
[3] As previous
[4] As previous

Summary of the Proposal

Implementation of an early supported discharge pathway for the survivors of stroke within Leeds (Stroke ESD). This expansion of the Community Stroke Rehabilitation Service will provide stroke specific therapy to patients in their own homes, embedded within the developing Neighbourhood Health Model. This will enable people to leave hospital at a much earlier point within their illness.

The scheme will be funded through system "catalyst funding" and be tested and developed over a three-year period, with the aim that from end of Year One the service can demonstrate a return on investment to be cost neutral at a minimum. Recurrent funding of £525k (2026/27) to cover Year One total costs (of which £394k recurrent) has been confirmed in principle. 2027/28 recurrent full year effect costs of £651k will be subject to further investment and business case approval.

This proposal outlines the investment required to recruit and support additional therapy staff to enable more rapid assessment and intervention at home in the community and in LTHT. Required investment to provide for the Activities of Daily Living (ADL) need of patients in the moderate patient cohort is included in the separate Active Recovery 2 Catalyst Fund business case.

This business case is for investment in a consultant therapy lead and phased expansion of the LCH Community Stroke Rehabilitation Service to build community capacity, enable earlier discharge from acute care and deliver improved patient outcomes and experience.

Development will focus on the following patient cohorts in each development year:

- **Year One (2026/27) – mild/moderate with no personal care needs**
  - After a period of set up in Q1/Q2, including recruitment, it is assumed that the pathway will "go live" from September 2026. The aim is to be at capacity to support a minimum of 5 new starts per week from September based on the modelling assumptions outlined in this business case

- **Year Two (2027/28) – mild/moderate including those with personal care needs**
  - Increasing minimum number of new starts per week based on testing of assumptions and assurance of a clinically safe workforce establishment

- **Year Three (2028/29) –** expand to more complex patient cohort. This would be subject to evaluation and would require a separate business for any required investment to expand

Strategic fit

Justification of Population Focus for investment

A review of cases in Leeds has highlighted an increase in the incidence of stroke over winter impacting patient flow. In addition, the Sentinel Stroke National Audit Programme (SSNAP) data cites LTHT stroke services have 1/3 higher MEAN LOS (Length of Stay) for their total in-patient pathway at 28.4 days (2023-24) and 26.7 days (2022-23) compared to a national average in that same period of 19.7 / 19.8 days[5].

The population focus for investment reflects opportunities to improve outcomes for stroke survivors who currently experience unnecessary time in hospital. It is understood more generally across all populations that this can de-skill or limit rehabilitation potential often increasing reliance on long term care. Stroke survivors who receive good rehabilitation are 80% more likely to return to independent living at home. Stroke ESD proposes addressing this gap by supporting additional stepdown of people earlier to home (in line with HomeFirst principles).

This proposal aligns directly with the Healthy Leeds Plan priorities with regards to reducing preventable unplanned care utilisation (responding to what we know about too many people spending more time in hospital than they need) and tackling inequalities. Stroke is a key workstream of the plan under the Long-Term Condition population cohort (Leeds Stroke Priorities)

Strategic Alignment

This proposal strengthens the Neighbourhood Health model, contributing to the wider partnership ambition to shift activity from hospital into community settings, supporting the LCC Prevention Programme and wider strategic aims across NHS and LCC partners.

Stroke ESD aligns with the following national, system and organisation strategies:

- **Healthy Leeds Plan 2023–2028** – reducing preventable unplanned care; stroke priority cohort under long term conditions population (including ambition to develop Stroke ESD pathway (Leeds Stroke Priority Report))
- **Leeds Health & Wellbeing Strategy 2023–2030** – creating strong communities, integrated care, supporting carers, providing care in the right place
- **LCC Adult Social Care Plan 2024–2027** – enabling people to “live in the place they call home”
- **NHS 10-year Health Plan -** identifies stroke as a national clinical priority, aiming to improve care across prevention, acute management, and rehabilitation;

[5] Leeds Early Supported Discharge – 6-month pilot proposal, August 2025, LTHT

"neighbourhood health" model focused on shifting care from hospitals to the community and using digital tools

- **NHS Intermediate Care Framework (2023)** – delivering best practice stepdown care
- **NICE (NG236 Stroke rehabilitation in adults**) – Moving the Leeds system closer to best practice rehabilitative care.
- **Fairer, Healthier Leeds (Marmot)** – reducing inequalities through integration and community-based support
- **LCH ambition to deliver best possible care to every community we service/ LTHT ambition to deliver top quartile holistic healthcare based on a culture of continuous improvement & innovation -** Leeds currently underperform nationally on SSNAP, partly because of a lack of ESD. This proposal will bring us closer in line with peers.
- **Leeds Digital Strategy** – strengthening data sharing, person centred digital records, population health insight

Engagement of Key Stakeholders

This is a coproduced proposal developed between LCH, LTHT and the West Yorkshire Integrated Care Board, that has been clinically led by teams who want to improve their own service. It is based on significant learning in recent years engaging patients, third sector partners and health and social care partners, which will continue as the service is set up.

From late February a cross-organisational working group has been in place including clinical and operational leadership from LTHT and LCH to develop this business case at pace (refer to Appendix One). A key intention of the partnership and planned action over April is to establish the governance steering group to have oversight of the scheme.

This includes action to engage wider with all LCH impacted corporate teams in the development of mobilisation plans. Resource has been costed into the model for administrative support recurrently, and clinical systems & business intelligence support non recurrently (the latter which may be pooled across Neighbourhood Health Catalyst schemes).

Options appraisal:

A full options appraisal has not been undertaken. This is in recognition of the significant work of system partners, noted above, which has led to cross system consensus on the benefits that could be realised from the development of a Stroke ESD pathway in line with national guidance.

In developing this business case proposal the working group has developed modelling assumptions of patient cohorts to be supported from analysis of options appraisals and associated workforce models completed to inform system business cases (June-August 2025), engagement with clinical & operational stakeholders from LTHT and LCH and Active Recovery, and through a snap audit of total acute in-patients, excluding Ward C06 patients, who could go/could have gone home with a Stroke ESD in place on that day/next day (16th March 26). This identified 15 potential patients and their specific support needs.

The proposed model will bring the Leeds system significantly closer to the NHS England Integrated Community Stroke Service model which includes an Early Supported Discharge. It should be acknowledged however that due to lack of confidence at this stage of development of the cost benefit of investment in a service to cover all patient cohorts, complete alignment to national guidance will not be achieved and this will continue to be assessment by the partnership based on evaluation and would inform a future system business case for investment.

Proposed Model

Key components:

Feature	Description
Referral Pathway	Direct referral from inpatient stroke units, 5 days/week (Mon-Fri)
Response Times	Initial contact within 24–48 hours of discharge
Duration of Input	Average of 2 weeks
Expected Transfers to Community	Limited to 5 patients per week (with phased increase year one based on lived experience of patient need)
Therapy Intensity	Average of 10 visits per week (therapist or therapy assistant) – for mild/moderate cohort.
Multidisciplinary Team	MDT includes Therapy / Pathway consultant, Physiotherapists, Occupational Therapists, Speech & Language Therapist, Therapy Assistant Practitioners and Rehabilitation Assistants with support of additional team management and administrative support. • Dietitian, Psychologist and Social Worker/Third sector input to the MDT has been included in costings. This will be considered further with partners as part of the phased implementation and further assessment of the clinical need of the patient cohort to

	assess and readjust the workforce model from Year 2 within the financial allocation. • Specialist neurological nursing needs will be met by existing staff in the Community Stroke Rehabilitation Team (CSRT) • Stroke specialist nursing has not been identified as a requirement as this stage. There may be a small number of patients who require general nursing support not related to their stroke from the Neighbourhood Team. This will be monitored in implementation to assess and readjust the workforce model from Year 2.
Aligned Support for Activities of Dailing Living	The team will also have access to support workers in Active Recovery who will provide support to patients with established treatment goals (from Year 2)
Patient Cohort	Able to support eligible[6] stroke discharges subject to available capacity are from the following cohorts: • Mild/Moderate cohort with no personal care needs (ADLS) that cannot be met by family or existing care • Mild/Moderate cohort with minimal personal care needs (from Year 2)
Staffing Ratios/Workforce Model	• Informed by SSNAP, Cochrane, and NHS England guidance • Refer to Appendix Two for workforce model – noting that this will be subject to ongoing review and refinement based on evaluation
Service Hours	8.30am to 4.30pm, 7 days
MDT Practice	Weekly MDT meetings with shared goal setting and discharge planning; regular therapy ward rounds
Ongoing Care Referral	Seamless handover to CSRT for further interventions
Leadership & Organisational Ownership	LCH will have clinical and operational responsibility for provision of the service offer.

Key aspects of note

- It is a key intention of partners to work towards an integrated stroke pathway, this development being the catalyst to move towards that vision
- The workforce model includes a consultant therapist who will work across the system to identify and embed evidence-based system improvements in relation to rehabilitation and have a pathway overview. This role will allow maximum benefit to be realised from additional investment in the stroke pathway. The role will be directly managed by LCH Deputy Director of AHP's and Clinical Education with a reporting line to LTHT Clinical Director for Neurosciences and the Lead Clinician for Stroke.

[6] There are certain clinical cohorts that will not be able to be supported within the funded workforce model

- This is an extended service offer to patients who are already supported by the Community Stroke Rehabilitation Service, but at an earlier point in their recovery journey. As such it is not a new service but a development of the current service to bring it closer in line with NICE guidance
- The Community Stroke Rehabilitation Team will work with Active Recovery to create trained capacity in each Area to support ADLs for people who have had a stroke. Acknowledging the lead in time for upskilling of Active Recovery the MDT will start by receiving people identified as having 'no personal care' needs while addressing Active Recovery training and work to expand to people with personal care needs from Year Two (2027/28).
- Recognising the need to take a phased approach to improvement, we expect that 2026/27 will incorporate a sub-set of the overall opportunity, aiming to build towards the full opportunity over a multi-year period. Based upon lived experience and evaluation of delivering the service offer, the service will look to support more complex patients to maximize the benefit from the investment subject to available capacity to ensure a safe and responsive service, or subsequent business case for investment where required.
- It is recognised that benefits will benefit one partner more than the other, requiring a system approach to the benefits realisation case over the term of this development, linked to benefits realisation across all Neighbourhood Catalyst Fund Schemes. Project set up includes agreement of the specifics of the partnership agreement between LCH and LTHT to deliver the pathway and will include consideration of risk share principles and management of financial risks, for example regarding the therapy consultant role if the service does not deliver ROI.

Key planned process improvements

- Daily review of stroke ward and any outliers enabled by more staffing, so less delay on onward referrals
- Work with Active Recovery to explore how the team could use the same integrated care record for people who need both therapy and ADLs.
- Explore use of the Recovery Care Plan to streamline the patient pathway and reduce therapist time.
- Review of referral pathways for home care to reduce delays related to social worker allocation and assessment (for those with lower rehabilitation potential). Additional dedicated capacity into the community social work team is provisionally part of the workforce model to realise benefits associated with delays in the current process.

Longer term development considerations

- Consideration of how we safeguard carers to reduce carer strain associated with the delivery of HomeFirst principles. Engagement with the citywide Stroke Delivery Group, on which we have carer and patient representation, will be instrumental in the development and testing of safeguards. This will include

exploring opportunities with current partners including the Stroke Association, Home Comfort, and Enhance partners.

Commercial aspects

There are no commercial aspects to this proposal at this stage of planning. Any development over the course of implementation where this does apply would be approved in line with LCH contract assurance process and subject to a separate business case where required.

Affordability: the financial case

Investment Required & Benefits Case

The source of funding for this business case is the Neighbourhood Health Catalyst Fund. The Senior Finance Executive Group have been consulted throughout the development of this proposal and been reviewed in draft form by the Directors Team Meeting (Leeds place of WY ICB) – 25th March.

Allocation for this proposal has been agreed in principle at West Yorkshire ICB and notice provided to Executive Directors. This is for £525k (recurrent) from 2026/27. The additional funding for full year effect including expansion to all roles proposed in the workforce model will need to demonstrate ROI and a business case will be submitted by end of December in plan to assure required recurrent funds into 2027/28.

Discussion is ongoing with the West Yorkshire ICB to mobilise some of the funding to support project delivery and recruitment in advance to support the pace of required work to demonstrate benefit within Year One. This includes recruitment of the Therapy Consultant who is critical to the success of delivery. As such we recommend and seek approval for progress of recruitment to this, and other roles required for “go live” noting that roles will only be appointed subject to final sign off by LCH board of this business case (refer to Appendix Two – Year One identified roles).

The key long term financial risk to LCH of this business case is the financial risk of any redundancy costs if the scheme does not demonstrate a break-even position on return on investment by Year Two. Refer to “benefits” section below for assurance of confidence level in achieving this. The full scale of financial risk is not confirmed at this point but will be further assessed, managed and shared across the partnership subject to further partnership discussions (LCH/LTHT/WY ICB).

Investment requirements

Modelling indicates the total cost to deliver the Stroke Early Supported Discharge Model is £523k in Year One (2026/27) and £651k FYE from Year Two (2027/28). See below for top-level breakdown of total costs and refer to Appendix Two for further breakdown including costing assumptions.

	2026/27	2027/28	2028/29
Total Recurrent Costs	**£393,608**	**£650,919**	**£671,994**
Total Non-Recurrent Costs	£129,847	£0	£0
Total Overall Costs	**£523,455**	**£650,919**	**£671,994**

Non-recurrent (assuming funded via slippage)

Assuming a collaborative approach to implementation working with related investment and improvement priority Programmes e.g. Active Recovery, Neighbourhood Health

Total investment required £130k to fund:

- Additional project leadership x0.8wte B8a equivalent (working across Active Recovery/Stroke Early Supported Discharge alongside B7 costed into separate Active Recovery Catalyst Fund proposal) – noting there is ongoing discussion regards pooling of project support resource across all catalyst fund schemes
- Contingency fund for clinical systems/BI support (Q2/3/4)
- Contingency fund for independent home care provision set up through Active Recovery (in lieu of Active Recovery if required to enable discharge)

Benefits

Modelling indicates substantial system benefits for implementing this opportunity:

- Based on recent audits and pathway reviews, LCH & LTHT partners are confident the model will be at least cost neutral, with the potential for greater savings as the service becomes established and discharge pathways mature. The proposal estimates full year effect potential savings of £725k per annum from 2027/28 based on 1,820 saved acute bed days. This excludes other quantifiable socio-economic benefits of supporting patient's earlier return to work.

- **Return on Investment Calculation:** Utilising only the primary benefit of reduced bed day costs we estimate a minimum NET potential gain of £74k per annum[7] in 2027/28 from reduction in hospital length of stay by 7 days for the mild and moderate patient cohorts equating to 1,820 saved bed days (refer to Appendix Three for key assumptions for financial calculation).

- At this stage of modelling, it is not possible to estimate a break-even point for return on investment or bed days savings in 26/27. This modelling is planned in

[7] Based on acute bed day saving in 2025/26 of £398.44. This will increase with inflation. Future costs are not yet agreed and will further increase estimated financial benefit which is calculated on 2027/28 full costs

set up phase subject to further assessment of recruitment/start date timelines for minimum MDT members to accept patients and any phased increase. From this we anticipate developing a trajectory for oversight review by the project steering group.

- It is recognised that some benefits will benefit one partner more than the other, requiring a system approach to the benefits realisation case over the term of this development. Development of a bespoke benefits realisation plan, including a measurement plan (KPIs, outcomes), is a key implementation milestone in Q1.

Key tracking KPIs (to be further refined and added to in Q1) include:

- Average acute length of stay for stroke patients (LTHT)
- Reduction in no clinical reason to reside (nCtR) and unplanned bed days not labelled as nCtR) for the patient cohort
- Number / proportion of stroke patients transferred earlier to community rehabilitation
- Readmission rate for patient cohort

Benefits Mapping - This proposal supports several benefits including earlier recovery, reduced risk of institutionalisation and improved patient flow across the stroke pathway. Table One outlines the benefits associated with the proposal, some of which are quantified (i.e. bed day saving) but some which require plans for quantification.

Table One: Benefits mapping

Catalyst Fund Key Tests	Key Benefits
Increased integration	• Clinical leadership of pathway development as a joint appointment (employed/hosted by LCH) with reporting line to stroke consultant
Reduced hospital demand/occupied beds	• Sustainability significant reduction in acute activity and system costs • Reduction in outliers to increase productivity of LTHT stroke service
Strengthened community offer	Gains in efficiency of core offers related to: • improvement of “warm handovers” • reduction in time spent away with outliers • changing risk appetite • relationship building across clinical teams • delivery of efficiencies over time (some at hospital • end and some at community end)
Redesigned existing resources	
Needs to generate added value from core offers	

Plus	
Improved patient experience	• Address inequalities in care • Improved clinical outcomes • Several benefits to the person being supported such as increased independence outcomes, avoidance of longer homecare packages and quicker routes out of hospital. • Socio-economic benefits of supporting return to work

Achievability & Evaluation Measurement

Proposed Timelines

The following implementation approach is proposed with associated key milestones:

Q1 - 2026/27
• Early April 2026 – Contracting arrangements and governance processes agreed with WY ICB, draft contracts drawn- up. • April–May 2026 – Finalisation of contract and internal approvals of business case • May 2026 – Funding transferred • April onwards - Project initiation - recruit project manager, set up governance incl. partnership governance steering group, agree roles/responsibilities of respective partners and risk share principles • April - Recruitment to workforce model – commencing with Consultant Therapist as priority • Health Equity Impact Assessment to inform development of KPI/Measurement plan • Develop Benefits Realisation/KPI Plan and measurement plan • Scoping of plans for recovery plan/integrated care record – confirm BI/clinical systems additional support requirements • Clinical pathway development • Scope requirements for Case for Change in Community Stroke Rehabilitation Service – Non-registered, registered and team leadership workforce / Timeline dependent on recruitment phasing
Q2 – 2026/27
• Clinical pathway development – development of SOPs, service guidelines including pathways with Active Recovery • Appoint roles and train as staff in post • “Go live” – Sept • Set up interim solution to access independent home care (if assessed appropriate) • Training needs analysis – Active Recovery
Q3 & Q4 2026/27
• Ongoing monitoring and review • Review workforce model to inform skill mix planning– including social work, third sector, dietetics and psychology • Update business case/Year Two stage plan (end Q3), seek approvals Q4 • Competency Development – Active Recovery

2027/28
• Ongoing monitoring and review • Map out longer-term development in relation to carer support • Evaluation cycle to inform 28/29 plans including update of business case/Year Three stage plan (Q4)
2028/29
• Full evaluation and business case

Project Owner

SRO not yet confirmed and subject to further discussion on governance for all Neighbourhood Health Catalyst Fund schemes.

Risks and Mitigations

Project risks assessed as high are outlined below. For all other risks please refer to Appendix Four.

Risk	Mitigation
Competing system priorities and limited capacity delay mobilisation and pathway change, reducing early impact	Strong partnership governance, visible executive sponsorship, and dedicated project leadership in Q1 to maintain pace and focus; Step back from Q&V Redesign Project for CSRT
Lack of clinical and operational buy in- limits referrals and undermines the model	Joint Consultant Therapy role to lead pathway design and embed clinical leadership, and assure engagement across acute and community teams
Lack of ADL support to fully realise the opportunity over the 3-year term	Separate AR proposal with funded capacity; project support across Stroke ESD and Active Recovery to support strategic alignment during implementation; small contingency fund in financial planning to access home care from independent contractor (Alliance contract) in Yr1 if required
Provision of sustainable service offer over 7 days dependent on case for change for non-registered staff in CRST	Flexible staffing model utilising registered capacity at service commencement, discussions to scope consultation required in progress with People's Business Partner.
Seasonal demand increases case complexity and volumes beyond planned capacity, impacting safe delivery and outcomes	Phased caseload ramp-up, flexible staffing model, and close coordination with acute wards and discharge teams to manage flow and risk

Recommendations

Trust Board are requested to approve the business case based on the assumptions outlined.

Appendix One – Cross Organisational Working Group

Jo Wood - Director of Operations LTHT
Robert Rathbone - General Manager, Neurosciences LTHT
Ruth Mhlanga - Clinical Implementation Lead, Adult Therapies LTHT
Debbie Gallon – General Manager LCH
Mandy Young – Clinical Lead LCH
Helen Knight – LCH
Satbir Saggu – LCH
Helen Lewis, WYICB
Nicola Wolstenholme, LCH

Plus wider stakeholders across CRST, Specialist Business Unit Leadership Team, Quality & Professional Development, Peoples Teams, Active Recovery, Neighbourhood Teams, LTHT Therapies and Psychology

Though not part of the working group we acknowledge the work of Becky Vickers and Ruby Ali from previous business cases to develop a stroke ESD offer which contributed significantly to this proposal.

Appendix Two – Workforce Model

	WTE			
Role	**2026/27**	**2027/28**	**2028/29**	**Lead employer**
From Year One				
B6 Physiotherapist	1.00	1.00	1.00	LCH
B5 Physiotherapist	0.50	0.50	0.50	LCH
B6 Occupational Therapist	1.00	1.00	1.00	LCH
B5 Occupational Therapist	1.00	1.00	1.00	LCH
B6 Speech Therapist	0.50	0.50	0.50	LCH
B4 Admin	0.50	0.50	0.50	LCH
B3 Rehabilitation Assistant	2.00	2.00	2.00	LCH
B4 Therapy Assistant Practitioner	2.00	2.00	2.00	LCH
B7 Team Lead	0.50	0.50	0.50	LCH
B8B Therapy Consultant	0.80	0.80	0.80	LCH
From Q4 Year One/Year Two*				
B8B Psychology	0.00	tbc	tbc	LTHT
B6 Dietitian	0.00	0.20	0.20	LCH
Social Worker/Third Sector Support Worker	1.00	1.00	1.00	LCC/third sector
	10.80	**11.00**	**11.00**	

Roles not anticipated as required until earliest Q4 2026/27 or into 2027/28. This will be considered further with LCC & LTHT partners as part of the phased implementation and further assessment of the clinical need of the cohort the to assess the cost benefit of addition into the workforce model before recruitment.

Appendix Three – Finance Plan & Costing Assumptions

A. Financial Breakdown

	2026/27	**2027/28**	**2028/29**
Pay	£336,737	£557,755	£576,161
Non-Pay	£7,026	£10,734	£10,734
Overheads	£49,846	£82,431	£85,100
Total Recurrent Costs	**£393,608**	**£650,919**	**£671,994**
Mobilisation	£129,847	£0	£0
Total Overall Costs	**£523,455**	**£650,919**	**£671,994**

B. Costing Assumptions

Pay award included at 3.3% for 26/27 and each year thereafter, assumed contract income in future years will be uplifted to fund pay award
Non-pay inflation included at 2.1% per annum
Unsocial hours enhancements included assuming 1 x Registered and 1 x Unregistered staff member working daytime Saturday and Sunday
Non-pay calculated using an average cost per WTE based upon actual spend on the Stroke cost centre
All roles will be employed by LCH and therefore no uplift for LTHT overheads included.
The 26/27 recurrent costs are mostly based upon an 8-month period (August start date)
No additional estates costs have been included
B6 Dietician included from year 2
B8B Psychologist not included

C. Return on Investment Calculation Assumptions

Financial benefit is modelled on the following key assumptions:

1. 5 new starts per week
2. 10 contacts per week per patient
3. Average length of time receiving increased intensity therapy (as per point 2) of 2 weeks
    - The proposed workforce model can deliver an estimated 99 additional direct contacts per week in Year One from a registered or non-registered therapist which provides assurance that CRST could support an additional 10 people at any one time through the proposed pathway
4. Reduction in hospital length of stay by 7 days for the mild and moderate patient cohorts – total of 1,820 (FYE) in 2027/28.
5. Acute bed day saving in 2025/26 of £398.44 – noting this is anticipated to increase over the term of the development
6. Modelled accounting for 2027/28 costs

Appendix Four - Risks and Mitigations

Risk	Impact	Likelihood	Mitigation Actions
Assumptions in relation to ROI are incorrect leading to inability to demonstrate ROI	Inability to demonstrate value	Low–Medium	Early action to agree measures and set up data flows to capture baseline position and monitor; BI support capacity built into financial planning; Agree approach with Active Recovery for benefits capture and realisation to avoid duplication
Recruitment challenges for specialist posts (fixed term vs permanent)	Delay to service launch, reduced capacity to meet demand	Medium	Offer permanent opportunities with redeployment options; explore joint posts with LCH/LTHT; advertise early with targeted recruitment campaigns
Failure to meet referral/throughput targets	Reduced impact on length of stay, inability to demonstrate value	Low–Medium	Early engagement with inpatient teams; clear transfer criteria; weekly monitoring of transfer numbers; adapt eligibility criteria if safe and appropriate.
Insufficient MDT skill mix due to vacancies or sickness	Reduced therapy intensity; compromised patient outcomes	Medium	Develop a bank/agency cover plan; cross-skill team members; build system resilience through supporting movement of staff across pathways to meet capacity gaps; prioritise high-need cases; use virtual therapy support if required.
Increased readmission rates	Negative patient outcomes; reputational damage; potential incr. hospital pressure	Low	Robust discharge criteria; rapid re-entry pathway for patients needing re-assessment.
Capacity exceeded (more than 10 patients at once)	Staff overload; reduced quality of care	Medium	Demand and capacity modelling at start of process and clearly identified job plans for staff; Implement active caseload management; clear prioritisation framework
Financial Risk associated with permanent contracts for core roles in Year One scheme	Sustainability risk	Low-Medium	Scale of financial risk to be monitored based on appointed WTE; phasing in of some role from Yr Two; Redeployment options for majority of roles excl. Therapy consultant role as new to the system and working across the pathway; Risk share principles to be agreed as part of project set with steering group.

Technology and system access delays (SystmOne/PPM+)	Inability to document or share clinical information effectively	Medium	Submit DIT requests early; have a contingency paper documentation process; provide training immediately on access approval.
Inter-service boundaries between ESD and CSRT	Confusion in referral pathways; delayed handover	Medium	Clear written pathway; joint MDT handovers; shared training and shadowing sessions. Monitoring data on inappropriate referrals and taking required action.
Financial overspend vs budget	Sustainability risk	Low–Medium	Monthly budget tracking; early escalation of variances; adjust resource allocation if required.
Patient non-engagement with home therapy	Reduced effectiveness; lower goal attainment	Medium	Patient and carer education pre-discharge; set shared goals; use motivational interviewing techniques.

AGENDA ITEM 2026-27 (14)

Leeds Community Healthcare NHS Trust

Committee Escalation and Assurance Report

Name of Committee:	People & Culture	**Report to:**	Trust Board 21st May 2026
Date of Meeting:	8th April 2026	**Date of next meeting:**	10th June 2026

Introduction

The meeting was supported by a full agenda and comprehensive set of papers, enabling detailed discussion. The main focus was the deep dive on Inclusion and the Trust Integration Programme, particularly the People and Culture elements. The staff story prompted thoughtful discussion and provided valuable grounding for the meeting.

Alert

Advise

- Update on impact of contract management on Occupational Health contract – The Committee emphasised the need to review how Occupational Health supported staff in complex situations, such as bereavement, and to ensure the service was appropriate and clearly understood.
- Update on FTSU Training – Feasibility Study – It was agreed that an update on the status of FTSU priority training at LYPFT would be provided to the Committee at its next meeting in June.
- Deep Dive – Inclusion – Committee received an update on key findings from the staff survey indicators linked to the NHS Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), improvements in equality data collection, and the launch of an inclusive recruitment project, with committee members discussing data trends, areas for improvement, and actions to enhance inclusion and address disparities. The implementation of escalation frameworks, behaviour contracts, and the importance of multi-disciplinary approaches and legal considerations were discussed. A five-step escalation plan had been developed for managing serious incidents, including the potential withdrawal of care, and behaviour contracts were introduced to set clear expectations for patients, with flexibility to accommodate individual cases. Discussions collecting data on incidents and responses and using case studies to inform future actions and training. The Committee requested that the 5-step process considered what well-being, psychological safety support for staff would be available for all stages of the escalation process. The Committee suggested a legal review of the letters was considered to mitigate any risks arising from the proposed process when implemented.
- Trust Integration Programme – People and Culture elements - The importance of defining the new organisation's purpose, values, and strategic objectives, ensuring alignment with clinical direction and city-wide healthcare goals, and involving staff and stakeholders in the process were discussed. The Committee was assured an overarching Change Programme was being adopted for the new organisation. The Committee discussed potential risks related to culture change, strategy development. The Committee suggested that capturing the best aspects of both merging organisations as well as lessons learnt could support the culture change. The Committee looked forward to an update including the change approach.

Committee Escalation and Assurance Report

Assurance

- Debbie Gallon, GM Ops Management Team shared her personal journey as a neurodiverse employee at Leeds Community Healthcare, discussing challenges faced, the impact of supportive leadership from senior leaders, and the positive changes in organisational culture towards neurodiversity, with committee members. The discussion highlighted the evolution of the trust's culture, with increased recognition of neurodiversity and a shift towards valuing diverse leadership styles, as well as the importance of reflecting the community in leadership teams.
- Learning and Development – The Committee encouraged benchmarking against other organisations, as well as exploring system advancements e.g. the use of virtual reality and AI and ensuring that any systems adopted were futureproofed and fit for purpose.
- Annual Report Workforce Updates – It was agreed that the key people narrative from Annual Report would be extracted and circulated to the committee members for review before final submission.

Risks Discussed and New Risks Identified

Legal and regulatory compliance risk in relation to sample letters for behaviour contracts to be reviewed.

Trust Integration Programme - Risks were also identified around culture change and alignment to the new organisation's nascent strategy.

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	12 (high)	Reasonable	

Committee Escalation and Assurance Report

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.			

Author:	Helen Robinson/Lynne Mellor
Role:	Company Secretary/Committee Chair
Date:	10/04/26

Agenda item:	2026-27 16
Title of report:	Compliance with the Code of Governance
Meeting:	Public Board Meeting
Date:	21 May 2026

Presented by:	Helen Robinson, Company Secretary
Prepared by:	Helen Robinson, Company Secretary

Purpose of the report:		
This report sets out the Trust's ongoing compliance against the requirements of the new Code of Governance which came into force on 1 April 2023.	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:
• Self-certification of compliance with Provider Licence condition CoS7 • Proposal that Board uses wording 'a', the Trust is compliant.

Previously considered by:	N/A
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	Yes		What does it tell us?	
	No	N/A	Why not/what future plans are there to	

and/or workforce)?			include this information?	

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

List of Appendices:	Appendix 1: Code of Governance Compliance tables

Compliance with the Code of Governance

Executive Summary

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

Main issues for consideration

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

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

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

There is one statement, D 2.5, relating to the Trust having a policy on its purchase

of non-audit services from its external auditor, for which an explanation has been provided. While a stand-alone policy is not in place, the process for the appointment of the External Auditor is included in the Trust's Standing Orders and Standing Financial Instructions (SOs/SFIs) and the NHS England guidance in this respect is also followed.
The Trust can evidence the process for appointing the external auditors through Auditor Panel and Board reports. However, it should be noted that the external auditors have not undertaken any non-audit work during the period of their contract with the Trust.

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

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

Recommendations

The Board is requested to:

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

Helen Robinson, Company Secretary
1 May 2026

Compliance with the Code of Governance

The Board has overall responsibility for the administration of sound corporate governance throughout the organisation. The Code of Governance for NHS Provider Trusts (the Code) was published by NHS England. The purpose of the Code is to assist the boards of NHS trusts and NHS foundation trusts with ensuring good governance and to bring together best practice from public and private sector corporate governance.

The Code is issued as best practice, but also contains a number of main principles, supporting principles and code provisions on a 'comply or explain' basis. The Leeds Community Healthcare NHS Trust has applied the principles of the Code of Governance for NHS Provider Trusts on a 'comply or explain' basis. The Code of Governance for NHS Provider Trusts, most recently revised in October 2022, is based on the principles of the UK Corporate Governance Code and now applies to NHS Trusts in addition to Foundation Trusts.

A full review of compliance with the Code was submitted to the Trust Board to support this statement. A copy of the full report to the Trust Board is available on request from the Company Secretary. The Trust carried out a detailed self-assessment against the requirements of the Code and submitted the assessment to the Trust Board for approval and to support the statement that the Trust complies with the principles of the Code with the exception as listed in the following table.

Table 1: Disclosures required to be reported on in the Annual Report

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

	collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.		
Section A, 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Annual Report NHS Staff Survey Quarterly Pulse surveys	Accountability Report, Annual Governance Statement, Performance Overview and Analysis Report
Section A, 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision- making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Annual Report Standards of Partnership Governance Individual Partnership arrangements	Performance Overview and Analysis Report

Section B, 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent.	Annual Report - NEDs described in Board structure	Accountability Report (Directors' Report)
Section B, 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Annual Report Minutes of Board and Committee meetings	Accountability Report (Directors' Report), Annual Governance Statement (Directors' attendance tables)
Section C, 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	Annual Report Trust website – About the Board	Accountability Report (Directors' Report)
Section C, 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Mersey Internal Audit Agency Report Annual Report	Compliant. A developmental Well-led review was undertaken during 2024/25 and reference made in the Annual Governance Statement.
Section C, 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline	Annual Report Nominations and Remuneration	Annual Governance Statement – Nominations and Remuneration Committee summary, and Equality and Diversity section

	• how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	Committee Annual Report Annual Equality, Diversity & Inclusion Report that evidences compliance with the Public Sector Equality Duty (evidenced through Business Committee and Board minutes)	
Section D, 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans	Annual Report Process for appointment of auditors	Annual Governance Statement

	• where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.		
Section D, 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Annual Report	Statement of Directors' responsibilities
Section D, 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Annual Report Board Assurance Framework Process	Annual Governance Statement
Section D, 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Annual Report Audit Committee risk management reports	Annual Governance Statement

Section D, 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	This is described in the Annual Accounts - Finance	Going Concern Statement
Section E, 2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings	Requirement noted - should this ever be the case this would be described in the Annual Report and Accounts	N/A

Table 2: Comply or explain provisions

Provision	Requirement	Comply
Section A, 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.	Trust vision and values agreed for 2025/26. The Board also agreed its five strategic goals and a number of priorities that are aimed at supporting the delivery of the strategic goals. The strategic goals inform the Trust's Strategic and Operational plans. The Board receives quarterly reports on progress towards achieving its priorities. When setting its strategic priorities, the Board will take account of the ICB's strategic priorities, both at ICB and Leeds Place level.
Section A, 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	The Board regularly review performance using the Performance Brief/Integrated Performance Report in Board Committees and within the Board meeting to measure and monitor the quality, effectiveness and efficiency of healthcare delivery.

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

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

	adequate time is available for discussion of all agenda items, in particular strategic issues.	
Section B, 2.2	The chair is also responsible for ensuring that directors receive accurate, timely and clear information that enables them to perform their duties effectively.	The Chair takes an active role in specifying the format of the information provided to directors. The Chair is clear as to the timeframe in which information should be distributed to the Board of Directors.
Section B, 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	The Chair ensures that there is effective contribution from all members of the Board, in particular the non-executive directors and the opportunity to challenge the executive directors. The Code of Conduct contains information about our values and makes reference to the Nolan Principles. The Chair allows sufficient time for discussion at Board meetings. The Board encourages its sub-committees to look at areas in detail where needed. Board and sub-committee meetings run in accordance with Trust values.
Section B, 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally,	The Chair of the Trust and the Chief Executive abide by the division of responsibilities as set out in the standing orders and standing financial instructions. The roles of the Chair and Chief Executive are undertaken by two different individuals. The Chair of the Trust has completed a declaration as to their independence. Whilst the Chair is required only to do this on appointment we test this (as for all other NEDs) on an annual basis.

	should not be the deputy or vice chair or senior independent director.	The Chair of the Trust has not previously been the Chief Executive of the Trust. The Board has identified a deputy chair and a senior independent director. The Audit Committee is not attended by the Chair of the Trust on a regular basis; however, an invitation is extended for them to attend once a year.
Section B, 2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	The Board comprises 5 non-executive directors excluding the Chair in comparison to 5 executive directors, therefore, at least half the Board comprises non-executive directors. On appointment and annually thereafter the NEDs are required to declare their independence. All the non-executive directors have been determined to be independent.
Section B, 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	This is evidenced through the annual declaration of interest forms.
Section B, 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a	The Board has made a clear determination as to the membership of the committees in the agreed terms of reference. The Trust has two NEDs with clinical backgrounds, other NEDs have a diverse range of skill sets.

	range of skill sets, backgrounds and lived experience.	
Section B, 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Requirement noted and included within the Terms of Reference.
Section B, 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.	The Senior Independent Director undertakes the annual appraisal of the Chair.
Section B, 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the	The CEO reports directly to the Chair, with Executive Directors reporting to the CEO. Appointment of Executive Directors include the relevant NED on the interview panel and inclusion of others with the assessment centre process.

	non-executive directors without the executive directors present.	Annually the CEO reports formally to the Nominations and Remuneration Committee on their appraisal meetings and objective setting with each Executive. The Chair holds a quarterly meeting with the non-executive directors as a group without the executive directors present.
Section B, 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	The expected time commitment is set out in the letter of appointment and in accepting the appointment Directors confirm that they are able to allocate sufficient time to the role.
Section B, 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	Comply – Company Secretary in post.
Section B, 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards	The Board acts as a unitary Board and challenge is made by both the executive and non-executive directors. The non-executive directors will in particular challenge on the performance of the executive directors in achieving the standards, targets and measures set.

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

		this is reviewed annually by the Audit Committee and agreed by the Board to ensure it remains fit for purpose.
Section C, 2.1 (NHS foundation trusts only)	The nominations committee, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.	Comply – use of external recruitment and adherence to recommendations for selection panel. Nominations and Remuneration Committee has received reports on succession planning.
Section C, 3.1 (NHS trusts only)	NHS England is responsible for appointing chairs and other nonexecutive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, nonexecutive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	Requirement noted – appointments conducted in accordance with this.

Section C, 4.1	Directors on the board of directors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	All new Board members are required to sign a self-attestation form. DBS checks are completed for all new Board members, and Board Member References requested where applicable. All Board members are compliant with the revised requirements in the FPPT Framework following the Kark review. This is reported to Board annually.
Section C, 4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.	Comply - At present, two of the NEDs have exceeded six years in post. However, in both cases their terms have been agreed with NHS England.

Section C, 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.	Each member of the Board is subject to an annual appraisal. Each Committee of the Board produces an annual report, reporting delivery against annual work plan and objectives. The Audit Committee reviews the annual reports from Committees.
Section C, 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	All Board members have an appraisal with agreed personal development plan.
Section C, 4.11	The board of directors should ensure it retains the necessary skills across its directors to ensure there is appropriate succession planning.	Requirement noted. The Nominations and Remuneration Committee undertakes succession planning for Director roles.

Section C, 4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	Comply – would adhere to this if ever required.
Section C, 5.1	All directors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	Induction programme and training offered to Board members.
Section C, 5.2	The chair should ensure that directors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board and committees. The trust should provide the necessary resources for its directors and to develop and update their skills, knowledge and capabilities. Where directors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.	Comply – addressed within appraisal and mid year review processes.
Section C, 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	Comply – available to all.

Section C, 5.4	The chair should ensure that new directors receive a full and tailored induction on joining the board. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	Induction programme and training offered to Board members.
Section C, 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Comply – addressed within appraisal and mid year review processes.
Section C, 5.8	The chair is responsible for ensuring that directors receive accurate, timely and clear information. Management has an obligation to provide such information but directors should seek clarification or detail where necessary.	The Chair of the Trust ensures that directors receive information in a format they require and within a timescale that will allow sufficient time to prepare for the meetings. The Chair also allows sufficient time and opportunity for clarification questions to be asked in the meeting. Directors are also encouraged to seek clarification outside of the meeting in order to assist discussion at the Board meetings. There are opportunities to input to how the reports will be presented and the information they contain.
Section C, 5.9	The chair's responsibilities include ensuring good information flows across the board and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	Comply – as above.

Section C, 5.10	The board of directors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	Appropriate papers and reports are presented to the Board of Directors. The Board has an annual business cycle which sets out the standard papers that will be presented to them, and the Board can also agree to receive a report on any matter if it requires. The Board of Directors will from time-to-time ask for information it requires to allow it to carry out its role and to be assured of performance. Any member of the Board of Directors can request any item to be reported to Board meetings and may also ask for this to be looked at in more detail in the Board sub-committee structure.
Section C, 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	The Board of Directors seeks assurance directly and through its committees via assurance and escalation reports. On occasions the Board and its committees invite senior staff to provide presentations to the Board. Non-Executive Directors can request external assurance as appropriate.

Section C, 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of nonexecutive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	All directors have access to professional independent advice at the Trust's expense (including legal advice and access to auditors).
Section C, 5.13	Committees should be provided with sufficient resources to undertake their duties.	Committees are supported by the relevant executive director, senior manager/s and Trust staff.
Section C, 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	This would be explored in appraisal and mid year review and be raised as a separate issue if this was not taking place. The non-executive directors will challenge the executive directors if papers are not sufficiently detailed or clear. The non-executive directors will use their skills and experience to challenge the decisions of the executive in an appropriate and professional manner having due regard to necessary standards of care required in such a role.

Section C, 5.17	The trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Comply – cover is renewed each year and overseen by the Company Secretary
Section D, 2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	Comply. The Trust's Audit Committee comprises three independent non-executives and is chaired by a non-executive director with recent and relevant financial experience. The Trust Chair is not a member of the Audit Committee.

Section D, 2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit	Comply – evidenced in the Audit Cttee annual report to Public Board each year.

	function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities.	
Section D, 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years.	The Trust's external auditors were re-appointed in 2025 following a process overseen by the Auditor Panel. There are no concerns about the performance of the current auditors and there is a high level of experience of the systems in place at the Trust.

Section D, 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	Explain While a stand-alone policy is not in place, the process for the appointment of the External Auditor is included in the Trust's Standing Orders and Standing Financial Instructions (SOs/SFIs) and the NHS England guidance in this respect is also followed. The Trust can evidence the process for appointing the external auditors through Auditor Panel and Board reports. However, it should be noted that the external auditors have not undertaken any non-audit work during the period of their contract with the Trust.

Section E, 2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long term interests of the public and patients. • Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking	The Trust complies with the national guidance on VSM remuneration with respect to bonuses, and has paid these to some VSMs in some years – any decisions about this are made by the Nominations & Remuneration Committee.

	of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	
Section E, 2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Remuneration for the Chair and NEDs set in accordance with this guidance.

Section E, 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	Has not arisen - requirement noted.
Section E, 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	Comply – should this ever be required.
Section E, 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	The Nominations and Remuneration Committee has delegated responsibility for setting all executive director remuneration, and for other senior managers not covered by the Agenda for Change terms and conditions of service. This is evidenced in the Committee's terms of reference and the Standing orders and Standing Financial Instructions.

Table 3: Publicly available information

Provision	Requirement	Comply
Section B, 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.	This is outlined in the Standing orders, standing financial instructions and scheme of reservation and delegation of powers which is available on the Trust's external website.
Section C, 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	Statement on Board of Directors page on Trust's external website.
Section E, 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	The terms of reference of the Nominations and Remuneration Committee are published on Board and Committee Governance page on Trust's external website.

Agenda item:	2026-27 17
Title of report:	Compliance with NHS Provider Licence
Meeting:	Public Board Meeting
Date:	21 May 2026

Presented by:	Helen Robinson, Company Secretary
Prepared by:	Helen Robinson, Company Secretary

Purpose of the report:		
This report outlines the requirement for Trusts to self-certify annually against their compliance with CoS7 of the Provider Licence, and requests that the Board passes a resolution in order to meet the requirements of the provider licence.	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:
• Self-certification of compliance with Provider Licence condition CoS7 • Proposal that Board uses wording ‘a’, the Trust is compliant.

Previously considered by:	N/A
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	Yes		What does it tell us?	
	No	N/A	Why not/what future plans are there to	

and/or workforce)?			include this information?	

Recommendation(s)	The Board is recommended to: Agree that the self-certification against required NHS provider licence condition CoS7 is accurate for 2025/26.

List of Appendices:	N/A

Compliance with NHS Provider Licence

1 Introduction

The provider licence, amended to include all trusts, became operational from 1 April 2023. NHS Trusts are required to self-certify against their compliance with one condition of the provider licence set out under Continuity of Services – CoS7: Availability of Resources, on an annual basis. This report outlines the condition and the action to be taken.

2 *CoS7: Availability of Resources*

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.
2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

Although there is no longer a requirement to submit a certificate to NHS England, Trust Boards are requested to pass a resolution in one of the following forms and keep it on file:

a. "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

b. "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources".
c. "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate"

Summary rationale for using wording 'a': The Trust is compliant. Evidenced through annual contract negotiations, approval of Medium Term Plan and associated financial plan and annual budgets, approval of going concern statement and regular monthly monitoring of performance against plan.

5 Recommendations

The Board is recommended to:
Agree that the self-certification against required NHS provider licence condition CoS7 is accurate.

Helen Robinson, Company Secretary
1 May 2026

Agenda item:	2026-27 18
Title of report:	Audit Committee Annual Report 2025/26
Meeting:	Public Board Meeting
Date:	21 May 2026

Presented by:	Helen Robinson, Company Secretary
Prepared by:	Helen Robinson, Company Secretary

Purpose of the report:		
The purpose of this report is to fulfil the annual review of the Trust's governance processes.	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:
• The Audit Committee agreed the content of its annual report on 7 April 2026.

Previously considered by:	N/A
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	N/A	Why not/what future plans are there to include this information?	

Recommendation(s)	The Board is asked to: • Approve the Audit Committee's annual report.

List of Appendices:	N/A

Audit Committee: Annual Report 2025-26

1 Introduction

1.1 This report aims to provide a summary of the Audit Committee's activities during 2025/26.

1.2 The terms of reference for the Committee require that the Committee's Chair submit an annual report, which demonstrates how the Committee has fulfilled its duties as delegated to it by the Trust's Board and as set out in the terms of reference and the Committee's work plan.

1.3 All committees' terms of reference are reviewed on an annual basis to ensure that they remain up to date and fit for purpose. The Audit Committee's terms of reference were last reviewed in April 2026. A summary of the amends of all committee Terms of Reference is contained in a separate paper.

1.4 The sections below describe:

- Duties of the Committee
- Membership and attendance
- Review of Committee's activities
- Review of effectiveness
- Areas for future development

2 Background: duties of the committee

2.1 The Audit Committee is one of six committees established as sub-committees of the Trust's Board.

2.2 The Committee is well established and has been conducting a portfolio of business on behalf of the Board since the establishment of the Trust. The Committee has shared oversight, with the Business Committee, of one strategic risk on the Board Assurance Framework (BAF). The Committee is responsible for determining whether the controls to manage this strategic risk are working by agreeing the sources of assurance needed, reviewing the evidence (sources of assurance) and indicating to the Board whether those risks are being effectively controlled.

2.3 The Committee provides an overarching governance role and ensures that the work of other committees provides effective and relevant assurance to the Board and the Audit Committee's own scope of work.

2.4 The duties of the Committee can be categorised as follows:

- **Governance, risk management and internal control:** reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.
- **Internal audit:** ensuring that there is an effective internal audit function that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.
- **Counter fraud and security management:** ensuring satisfactory arrangements in place for countering fraud, managing security and shall review the annual plan and outcomes of work.
- **Data security and information governance:** ensuring the Trust has robust information governance processes and that it complies with National Data Security Standards.
- **External audit:** reviewing the work and findings of the appointed external auditor and considering the implications of and management's responses to their work.
- **Financial reporting and annual accounts review:** including: monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance; ensuring that systems for financial reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board; reviewing the annual statutory accounts before they are presented to the Board of Directors to determine their completeness, objectivity, integrity and accuracy and reviewing all accounting and reporting systems for reporting to the Board.
- **Standing orders, standing financial instructions and standards of business conduct**: reviewing the operation of and proposed changes to the standing orders, standing financial instructions and standards of business conduct, the constitution, codes of conduct and scheme of delegation.

2.5 The Information Governance Approval Group (formerly the Data Protection and Cyber Security Panel) is a subgroup of the Audit Committee. The Group discharges a range of duties as delegated by the Audit Committee and recorded in a Committee approved set of terms of reference. The Group is responsible for ensuring that the Trust has effective policies and management arrangements covering all aspects of information governance in line with the Trust's Information Governance Management Framework Policy. Minutes or an assurance report from the Group are received by the Audit Committee.

2.6 Key issues from the Committee are raised at each pursuant public Board meeting through the Committee Chair's assurance report.

3 Membership and attendance

3.1 The terms of reference for the Audit Committee set out the Committee's membership, which is as follows:

- Three non-executive directors, including one non-executive director with significant, recent and relevant financial experience and who serves as the chair of the committee
    - Khalil Rehman (Chair)
    - Professor Ian Lewis
    - Lynne Mellor (Associate Non-Executive Director)

3.2 In addition to the membership, the following participants are required to attend meetings on a regular basis:

- Executive Director of Finance and Resources
- Company Secretary
- Internal audit representative
- External audit representative
- Counter fraud specialist
- Chief Digital Information Officer

3.3 The Chief Executive attends to discuss the process for assurance that supports the annual governance statement, and the annual report and accounts.

3.4 In addition, the Chief Executive, other executive directors and senior managers may attend for discussions when the Committee is discussing areas of risk or operational management that are their responsibility.

3.5 The Committee has met formally six times in the last 12 months and has been quorate on all occasions. In addition, there was one informal meeting. A table recording attendance is shown below.

Attendee	15 April	23 May Page turner informal	23 June (End of Year)	8 Jul	14 Oct	9 Dec	10 Mar	Total (6)
Khalil Rehman	✓	✓	✓	✓	✓	✓	✓	6/6
Ian Lewis	✓	×	✓	×	✓	✓	✓	5/6
Lynne Mellor	✓	✓	✓	✓	✓	✓	✓	6/6
Andrea Osborne	✓	✓	✓	✓	✓	✓	✓	6/6
Helen Robinson	✓	✓	✓	✓	✓	✓	✓	6/6

3.6 In line with its terms of reference, the Committee has had regular private meetings with auditors prior to each formal meeting.

3.7 The Committee has received appropriate administration support to all of its meetings, minutes and a completed list of actions are maintained and monitored at each meeting.

4 Review of Committee's activities

4.1 Work plan

The Committee has an approved annual work plan. Topics scheduled for consideration at each meeting reflect a mix of scheduled items drawn from the work plan and occasionally further items that have arisen because of

specific issues brought to the Committee's attention from internal or external sources. The workplan also considers the assigned strategic risk on the Board Assurance Framework (BAF).

4.2 ***Governance, risk management and internal control***

4.2.1 The Committee reviewed the annual governance statement for 2025-26 on 7 April 2026 prior to it being submitted for approval by the Board. In considering the statement, the Committee reviews assurances from a range of sources including the final Head of Internal Audit opinion which it expects to receive in April 2026.

4.2.2 Annual reports have been received from internal audit, counter fraud, risk management and Board sub-committees during the year. It also received the security management annual report, prior to this item being transferred to the People and Culture Committee in October 2025.

4.3 ***Internal audit and counter fraud services***

4.3.1 The Audit Committee has delegated authority to ensure the trust has an effective internal audit function. Audit Yorkshire, the internal auditors provide an essential part of the trust's system of internal control.

4.3.2 The Committee reviewed and agreed an annual internal audit plan for 2025/26. Topics included a broad mix of financial, governance, operational and quality topics.

4.3.3 As the audit plan progressed, the Committee reviewed a wide-ranging portfolio of reports, considered recommendations, adopted action plans and has overseen progress. The outcome of internal audits was shared with the relevant Board committee, which provided the opportunity to consider the robustness of actions to address recommendations and the associated timescales.

4.3.4 In addition to monitoring progress of the audits, the Committee also regularly monitored progress against internal audit management recommendations and associated actions. The Committee requested and received further explanation and background on the major and moderate recommendations from the audits which have been agreed to be delivered by a certain date but not completed on time. The Committee also reviewed the robustness of the proposed actions and provided feedback.

4.3.5 During 2025/26, a process was introduced whereby the Executive sponsor for any audits with a limited opinion was invited to the Audit Committee to talk to the recommendations and respond to questions posed by Committee.

4.3.6 The Committee closely monitored progress against the internal audit plan in an effort to avoid slippage and over running toward the end of the financial year.

4.3.7 In April 2026, the Head of Internal Audit indicated that their Head of Internal Audit Opinion based on the work carried out was likely to be reasonable assurance that there were adequate and effective management and internal

control processes to manage the achievement of the Trust's objectives. A final opinion would be presented to the Committee in June 2026.

4.4 *Counter fraud and security management*

4.4.1 The Committee received the local counter fraud annual report in July 2025 and the security management annual report in October 2025. The Committee also received quarterly updates on progress against the counter fraud plan for 2025/26, which noted local counter fraud activity, and introduced lessons learnt from fraud incidence from elsewhere.

4.5 *Data Security and Information Governance*

4.5.1 The Committee pursued evidence of compliance with data security requirements and received regular reports, which provided assurance that risks associated with data security were being adequately managed.

4.5.2 Annual and six-monthly reports were received from the Senior Information Risk Officer (SIRO) meetings and Information Governance sub groups.

4.5.3 Updates in relation to information governance and level of compliance with the Data Security & Protection Toolkit were considered by the Committee in March 2026. It was noted that the Trust's previous submission had been upgraded to "standards met" and the next submission in June 2026 was also on track to achieve "standards met".

4.5.4 In October 2025 and March 2026 the Committee received six-monthly updates on the Board Assurance Framework (BAF) activity. The role of the committees that are assigned BAF strategic risks is to check that the controls are working by agreeing the sources of assurance needed, reviewing the evidence (sources of assurance) and inform the Board whether the sources of assurance indicate that those risks are being effectively controlled.

4.6 External audit

4.6.1 In June 2025, Mazar's presented their audit completion report for 2024/25. It stated that the auditors' had issued an unqualified opinion on the Trust's 2024/25 financial statements and concluded that there were no significant matters arising from their 2024/25 audit work.

4.7 *Financial reporting and annual accounts review*

4.7.1 The Committee reviewed the annual report and accounts in detail in May 2025 prior to recommending the annual report and accounts for 2024-25 to the Board for approval.

4.7.2 The Committee reviewed the Charitable Funds annual report and accounts in December 2025 prior to approval by the Charitable Funds Committee and Trustee meeting.

4.7.3 The Committee also discharged a number of further aspects of financial reporting, including: schedules of debtors and creditors, losses and special payments and overpayments and underpayments.

4.8 *Standing orders, standing financial instructions and standards of business conduct*

4.8.1 The Committee reviewed waivers to tendering procedures, the reference costs process, and the register of gifts and hospitality.

4.8.2 Following findings from the Well-Led developmental review, the Committee recommended to the Board the adoption of the proposed changes to the Trust's standing orders and standing financial instructions which were presented in February 2026. These provided an updated set of documents that would better regulate good governance and management.

4.9 Whistleblowing

4.9.1 The Committee has not dealt with any whistleblowing issues during 2025/26.

5 Strategic Risks

5.1 During 2025-26 the Audit Committee was assigned one strategic risk, for which it shares oversight with the Business Committee, to provide assurance to the Board that the risk was being controlled. The Committee reviewed the sources of assurance (papers) that it received against the strategic risk and determined if the sources were of sufficient variety, focus, depth and frequency to enable the Committee to form an opinion of the level of assurance the papers, when presented, would collectively provide:

Strategic Risk 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.

The Committee agreed that the sources of assurance provided over the year provided a reasonable picture of assurance for this risk.

5 Assessment of committee's effectiveness and future developments

5.1 In the April 2026 meeting the Committee was asked to consider the responses from the recent self-assessment questionnaire. Members discussed the key themes arising from the process, which included:

- The timeliness of papers
- The need for Executive Director attendance to speak to final Internal Audit reports.
- The greater involvement from the Internal Auditors during the past year.

6 Recommendation

The Board is asked to:

- Approve the Audit Committee's annual report

Helen Robinson
Company Secretary
1 May 2026

Committee Terms of Reference

Leeds Community Healthcare NHS Trust

Audit Committee

Executive Summary:

The Audit Committee provides an overarching governance role The duties of the Committee are categorised as follows:

- Governance, risk management and internal control
- Internal audit
- Counter fraud and security management:
- External audit
- Financial reporting and annual accounts review
- Standing orders, standing financial instructions and standards of business conduct

Document History:

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Name of author:	Executive Director of Finance and Resources Company Secretary
Name of responsible committee:	Leeds Community Healthcare NHS Trust Board
Review date:	April 2027
Target audience:	Leeds Community Healthcare NHS Trust Board Audit Committee

Contents

Changes made to this version (134)

5.1 Attendees
Added the Chief Digital Information Officer as an attendee.

5.3 Addition of 'Executive Directors, or a nominated deputy, will also be invited to attend for Committee discussion on final internal audit reports for which they have lead responsibility.

Audit Committee
Terms of reference

1. Introduction

1.1. These terms of reference build on original work based around the Cadbury Committee and Combined Code and subsequent guidance and best practice in the private and public sector. They use the model from the NHS Audit Committee Handbook 2011 alongside sector best practice

1.2. The terms of reference reflect the particular nature of Audit Committees in the NHS and the growing role of the Committee in developing integrated governance arrangements and providing assurance that NHS bodies are well managed across the whole range of their activities.

2. Constitution

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

3. Purpose

3.1. The Committee provides an overarching governance role and ensures that the work of other committees provides effective and relevant assurance to the Board and the Audit Committee's own scope of work.

3.2. The duties of the Committee can be categorised as follows:

- Governance, risk management and internal control
- Internal audit
- Counter fraud and security management:
- External audit
- Financial reporting and annual accounts review
- Standing orders, standing financial instructions and standards of business conduct

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

- **Substantial assurance** based on a conclusion that there is a robust system of internal control and governance in place which will deliver the Trust's corporate objectives (clinical, quality or business) and that controls and management actions are consistently applied

- **Reasonable assurance** based on a conclusion that there is a generally sound system of internal control and governance to deliver the clinical, quality or business objectives and that controls and management actions are generally being applied. Some weakness in the design and/or application of controls and management actions put the achievement of particular objectives at risk. Improvements are required to enhance the controls to mitigate these risks.

- **Limited assurance** based on a conclusion that the design and/or application of controls and management actions are insufficient and the weaknesses put the achievement of clinical, quality or business objectives at risk. Significant improvements are required to improve the adequacy and effectiveness of the controls to mitigate these risks.
- **No assurance** based on a conclusion that there is a fundamental breakdown in or absence of controls and management actions which could result (or have resulted) in failure to achieve the clinical, quality or business objectives. Immediate action is required to improve the controls to mitigate these risks.

4. Membership

4.1. The Committee shall be appointed by the Board from amongst the non-executive directors of Leeds Community Healthcare NHS Trust and shall consist of not less than three members, one of which should have significant, recent and relevant financial experience. One of the members will be appointed Chair of the Committee by the Board.

4.2. The Chair of the Trust shall not be a member of the Committee. The Senior Independent Director may not be the Chair of the Committee but may be the Deputy Chair or a member of the Committee.

4.3. The Committee should select one of its remaining two members to be Deputy Chair.

5. Attendees

5.1. The Executive Director of Finance and Resources, Company Secretary, Chief Digital Information Officer, a representative from internal audit and a representative from external audit will normally attend meetings.

5.2. The Chief Executive will be invited to attend and should discuss at least annually with the Audit Committee the process for assurance that supports the annual governance statement. The Chief Executive should also attend when the Committee is discussing the annual report and accounts.

5.3. The Chief Executive, other executive directors and senior managers will be invited to attend for discussions when the Committee is discussing areas of risk or operation that are their responsibility. Executive Directors, or a nominated deputy, will also be invited to attend for Committee discussion on final internal audit reports for which they have lead responsibility.

5.4. The external and internal auditors will be invited to a private meeting with the Audit Committee Chair and members at the beginning of each Audit Committee meeting.

6. Meetings and quorum

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

6.2. A quorum shall be two members of the Committee. If the Committee is not quorate the meeting may be postponed at the discretion of the Chair. If the meeting does take place and is not quorate, no decision shall be made at that meeting and such matters must be deferred until the next quorate meeting.

6.3. Meetings shall be held not less than four times a year. The external auditors or Head of Internal Audit may request additional meetings, through the Chair of the Committee, if they consider that one is necessary.

6.4. Members are expected to attend all meetings.

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

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

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

7. Authority

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

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

7.3. The Committee's delegated decision making will be in accordance with the Trust's scheme of delegation as approved by the Board.

7.4. The Committee is authorised by the Board to establish such sub-groups (duly constituted and operating within approved terms of reference) as it deems necessary to discharge responsibilities of the Committee. The Committee will receive minutes from the sub-group, receive papers on any matters escalated to

the Committee and periodically review the effectiveness of the sub-group in discharging its delegated responsibilities. The sub-group currently constituted is:

- Information Governance Approval Group

8. Duties

The Audit Committee will provide an overarching governance role and review the work of other governance committees within the Trust, whose work can provide relevant assurance to the Audit Committee's own scope of work. The duties of the Committee can be categorised as below.

8.1. Governance, risk management and internal control

8.1.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the organisation's activities that supports the achievement of the organisation's objectives.

8.1.2. The Committee will review the adequacy and effectiveness of:

- The Trust's general risk management structures, processes and responsibilities including all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of strategic risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with the relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to fraud and corruption as required by the NHS Counter Fraud Authority

8.1.3. The Committee will ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance.

8.1.4. The Committee will review the Board Assurance Framework's sources of assurance for strategic risks assigned to the committee, for appropriateness, independence, and frequency, and evaluate whether these can effectively evidence that the controls are working.

8.1.5 Review Board Assurance Framework assurance activity and assess whether the assurance process is being effectively applied.

8.1.6. The Committee will ensure that appropriate governance is in place to ensure that the Trust can comply with its statutory duties relating to information governance.

8.1.7. In addition, the Committee will be the custodian of the Board and sub-committee annual effectiveness process and the review of the adequacy of the governance of the Board sub-committees and their reporting groups. This will include the receipt of annual self-assessments and reports.

8.1.8. In carrying out this work, the Committee will primarily utilise the work of internal audit, external audit and other assurance functions but it will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control. Other external advisers may be called upon where specialist assurance is required, with the prior agreement of the Committee Chair. The Committee will use an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

8.2. Internal audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation or dismissal
- Review and approval of the internal audit strategy, annual audit plan and more detailed organisation as identified in the assurance framework
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Considering the performance of internal audit and undertake an annual review of the effectiveness of internal audit
- Approval of the appointment and termination of the Head of Internal Audit and/or the internal audit service

8.3. External audit

The Committee shall review the work and findings of the external auditor and consider the implications of and management's responses to their work. This will be achieved by:

- Consideration of the appointment of the external auditors, in line with regulations as far as the rules governing the appointment (discharged through establishment of an auditor panel).

- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

8.4. Financial reporting and annual accounts review

The Committee shall:

8.4.6. Monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

8.4.7. Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board

8.4.8. Review schedules of debtors and creditors balances over six months old and over £5,000 and require explanations and action plans

8.4.9. Review, at least annually, all losses and special payments

8.4.10. Review the annual statutory accounts before they are presented to the Board to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes
- Areas where judgement has been exercised
- Adherence to accounting policies and practices
- Explanation of estimates or provisions having material effect
- The schedule of losses and special payments
- Any unadjusted statements
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved
- The letter of representation
- Qualitative aspects of financial reporting.

8.4.11. Review the annual report before it is submitted to the Board to determine completeness, objectivity, integrity and accuracy.

8.4.12. Review all accounting and reporting systems for reporting to the Board including in respect of budgetary control.

8.4.13. Approve the investment policy (as applicable).

8.4.14. Approve the treasury management policy (as applicable).

8.5. Standing orders, standing financial instructions and standards of business conduct

The Committee shall:

8.5.6. Review, on behalf of the Board, the operation of and proposed changes to the standing orders, standing financial instructions and scheme of delegation.

8.5.7. Receive a report on, and review, all instances of waivers to standing orders.

8.5.8. Receive reports on any non-compliance with standing orders and standing financial instructions and any justification for non-compliance and the circumstances around the non-compliance.

8.6. Counter fraud

The Committee shall:

8.6.1 Satisfy itself that the Trust has adequate arrangements in place for countering fraud

8.6.2 Review the annual plan and outcomes of counter fraud work and receive an annual report from the local counter fraud specialist

8.7 Information Governance

The Committee shall:

8.7.1 Receive escalation reports (including significant data breach incidents) as required and minutes from the Information Governance Approval Group.

8.7.2 Receive notification of any significant data security risks (scoring high or extreme) and review controls and mitigating actions in order to provide assurance to the Board.

8.7.3 Provide assurance to the Board that the Trust is compliant with relevant legislation and national guidance.

8.7.4 Review the Data Security and Protection Toolkit prior to submission.

8.7.5 Receive the Information Governance Approval Group's annual report and review and approve proposed changes to the Group's terms of reference as appropriate.

8.7.6 Receive regular cyber security reports, including updates on cyber-related workstreams and activities.

8.8 Other matters

The Committee shall:

- Review any reported incident of fraud, corruption or possible breach of ethical standards or legal or statutory requirements that has a significant impact on the Trust's published financial accounts or reputation.
- Investigate any matter within its terms of reference, having the right of access to any information relating to the particular matter under investigation.
- Receive an annual report from the local security management specialist on the effectiveness of security management arrangements within the Trust.
- Review at least annually, hospitality and sponsorship registers.
- Review at least annually, a register of contracts for services held by the Trust.

8.8. The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where there are implications for the governance of the organisation. The Committee will, wherever it feels necessary, seek reports and assurances from directors and managers focussing on the over-arching systems of integrated governance, risk management and internal control and their effectiveness.

9. Administrative arrangements

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

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

10. Reporting

10.1 The minutes of Audit Committee meetings will be formally recorded for approval at the subsequent Committee meeting prior to being submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

10.2 The Committee will report in writing to the Board through the Committee's Chair's assurance report (produced after each Committee meeting). The report

records key issues, actions and decisions and the level of assurance provided to the Board by the Committee's consideration of the relevant item.

10.3 The Committee will report to the Board annually on its work in support of the annual governance statement.

10.4 As part of the annual report, the Committee will identify specific areas where the Committee has made important positive differences to the governance of the Trust.

10.5 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board.

10.6 The Audit Committee will monitor the effectiveness of the Committee and report this through receipt of an annual report which, once approved, is also presented to the Board.

10.7 The Audit Committee will review the effectiveness of such sub-groups as established by the Committee.

11. Review of terms of reference

11.1 This document will be reviewed annually or sooner if agreed by the Audit Committee or Trust Board.

11.2 Any amended Terms of Reference will be agreed by the Audit Committee for recommendation to a subsequent meeting of the Trust Board for its approval.

Agenda item:	2026-27 18 ii
Title of report:	Committees' terms of reference review
Meeting:	Public Board Meeting
Date:	21 May 2026

Presented by:	Helen Robinson, Company Secretary
Prepared by:	Helen Robinson, Company Secretary

Purpose of the report:		
Between March and April 2026, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness. Minor changes have been proposed by each committee and are detailed in this report.	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:
• The suggested amends proposed by each committee are contained in the tables. • Board is asked to consider whether any further amends are required.

Previously considered by:	N/A
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	Yes		What does it tell us?	

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

Recommendation(s)	The Board is asked to: • Approve the changes to the terms of reference of Board sub-committees.

List of Appendices:	N/A

Committees' reviews of terms of reference

1 Introduction

Between March and April 2026, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness.

The tables below summarise the changes that have been proposed in order to amend and update content. Once approved, an electronic version of the full amended document will be made available to Board members, managers and staff. Use will be made of the Trust's intranet and website to publish the documents.

2 Proposed changes to committees' terms of reference

Quality Committee
Amendment to paragraph 5.1: Chief Digital Information Officer and Chief Clinical Information Officer added to those in attendance. Added an additional bullet in Section 7.4: Recognising Infection Prevention and Control Committee as a sub-group of the Quality Committee. Amendment to paragraph 8,1,1: Added specific reference to the Committee having delegated responsibility from the Board to approve annual reports on safeguarding and infection prevention and control.

Business Committee
Amendments to paragraph 5.1: Associate Director of Digital Transformation replaced with the Chief Digital Information Officer to be in attendance. The Deputy Director Transition and Transformation to be in attendance. Added an extra bullet in Section 7.4 (Authority):

Recognising the Sustainability and Climate Adaptability Steering Group as a sub-group of the Business Committee. Amendment to paragraph 8.2.3 (Resource Management): Added specific reference to the Committee providing assurance to the Board that the Trust is meeting its statutory sustainability and climate adaptability obligations.

Audit Committee
5.1 Attendees Added the Chief Digital Information Officer as an attendee. 5.3 Addition of 'Executive Directors, or a nominated deputy, will also be invited to attend for Committee discussion on final internal audit reports for which they have lead responsibility.

Charitable Funds Committee
Amendment to Membership: 3.1 The Executive Director of Nursing and AHPs is replaced by the Executive Director of Operations. Amendment to those In Attendance: 4.1 The Patient Engagement, Experience and Participation Officer removed from those In Attendance, and the Deputy Director Transition and Transformation and the Head of Business added.

Nominations and Remuneration Committee
Amendment to Other Remuneration Issues section in paragraph 5.3: Removal of reference to the Clinical Excellence Awards.

People & Culture Committee
Amendment to those In Attendance: 4.1 The Associate Director of Strategy, Change and Improvement updated to the Deputy Director Transition and Transformation.

3 Recommendation

The Board is asked to:

- Approve the changes to the terms of reference of Board sub-committees.

Helen Robinson
Company Secretary
11 May 2026

Agenda item:	2026-27 19
Title of report:	Declarations of interest and compliance with fit and proper person requirements made by directors for 2025/26
Meeting:	Public Board Meeting
Date:	21 May 2026

Presented by:	Helen Robinson, Company Secretary
Prepared by:	Helen Robinson, Company Secretary

Purpose of the report:		
This report covers the declarations of interest and fit and proper person requirements for consideration on an annual basis.	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:

- All declarations of interest updated and schedule of disclosures attached
- All Board members have completed a FPPT self-attestation and background checks have been completed
- All Non-Executive Directors have declared their independence.

Previously considered by:	N/A
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	Yes		What does it tell us?	

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

Recommendation(s)	Board is asked to: - Note the declarations of interest made by directors for 2025/26. - Note that the Trust is fully compliant with the Fit and Proper Person Test and Framework as at the date of this report. - Note the statement regarding the independence of Non-Executive Directors.

List of Appendices:	Appendix 1 – Director's declarations of interests for disclosure 2025/26

Board members: declarations of interest

As part of the actions to prepare the Trust's annual report and accounts, the Trust is required to collate the data on any declarations of interest disclosed by directors during the course of the year. The full schedule of disclosures is then included as part of the annual report.

The Trust's policy on declarations of interest requires directors to declare any significant financial or personal interests that each member, or a close relative or associate (such as partner, child, or sibling) has in any business or other activity or pursuit which may compete (or intends to compete) for any contract or agreement to supply goods or services to the Trust. In addition, directors are asked to declare: any other substantial connection or position of trust with related organisations; any other commercial interest; any area of potential conflict and details of hospitality in excess of £25 or gifts in excess of £50.

All directors have reviewed and updated their declarations of interest and a schedule of disclosures for 2025/26 can be found in Appendix 1 to this report.

Board members: fit and proper person requirements

The Health and Social Care Act 2008 (regulated activities) Regulations 2014 set out requirements by which all directors should be, and continue to be, fit and proper persons by nature of the fact they hold positions of significant responsibility and can maintain the confidence of public, patients and staff.

Following the 2019 Kark Review of the original Fit and Person Test, a Fit and Proper Person Test (FPPT) Framework was introduced in Summer 2023 with the aim of strengthening and reinforcing individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. The new framework introduced a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content

whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

The regulations require directors to:

- be of good character
- have the necessary qualifications, competence, skills and experience
- be able by reason of their health (subject to reasonable adjustments) to properly perform tasks intrinsic to the position
- not have been responsible for, contributed to or facilitated any serious misconduct or mismanagement while carrying out a regulated activity
- not to be unfit to hold office on a range of grounds (eg undischarged bankruptcy, criminal convictions, inclusion on barred lists, serious misconduct in the course of carrying out a regulated activity etc).

During March and April 2026, all directors have provided a self-attestation to confirm that they are in adherence with the FPPT requirements. In addition, annual checks have been conducted by Gatenby Sanderson to confirm satisfactory background checks, including Google and social media searches, health and social care regulators' checks, disqualified directors, insolvency and bankruptcy registers. Board Member References have been supplied for departing directors during the year.

Independence of Non-Executive Directors

All NEDs are regarded as independent, evidenced through the Board's Register of Interests, Board & Committee minutes, and their individual annual appraisals.

Recommendations

- Note the declarations of interest made by directors for 2025/26.
- Note that the Trust is fully compliant with the Fit and Proper Person Test and Framework as at the date of this report.
- Note the statement regarding the independence of Non-Executive Directors.

Helen Robinson
Company Secretary
1 May 2026

Board of Directors Declarations of Interest 2025/2026

NHS
Leeds Community Healthcare
NHS Trust

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 any services.	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 Chair Seacole 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 & other ownership interests	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 *[Ceased in this role on 30 September 2025]*	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
Lynne Mellor	Non Executive Director	Executive Business Unit	Outside/Secondary Employment	01/04/2026	2025/26	Board of Directors	NED role similar to LCH NED role & time committment	Leeds and York Partnership NHS Foundation Trust	0
Lynsey Ure	Executive Director of Nursing	Executive Business Unit	Nil Declaration	18/11/2025	2025/26	Board of Directors	*[Individual left LCH on 28 February 2026]*		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. *[Ceased in this role on 31 January 2026]*	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
Heather McClelland	Director of Nursing and AHPs	Executive Business Unit	Nil Declaration	16/03/2026	2025/26	Board of Directors			0

Indicates declaration ceased

Agenda item:	2026-27 20
Title of report:	**Significant Risks and Risk Assurance Report**
Meeting:	Trust Board
Date:	21 May 2026

Presented by:	Dr Sara Munro, Interim Chief Executive
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 30 April 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 (30 April 2026): • There are 123 open risks on the risk register, 22 of which have been managed to the target level. • Two risks score 15 (extreme) and 16 risks score 12 (high) • There is 1 risk that scores 12 or above that has 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 23 April 2026 Quality Committee 12 May 2026 Business Committee 12 May 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 (March 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 (March)
Total Open Risks	123	121
Risks Scoring 15 or above	2	2
New Risks	17	12
Closed Risks	15	8
Risk Score Increasing	0	1
Risk Score Decreasing	10	8

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**	**19**	**Cautious (4 – 6)**
There are currently 588 routine waiters on the list. 20 children/young people have been transferred to West Oaks Clinic and another 6 are pending transfer once new provider capacity is released in the new financial year. The aim is to continue to send as many children who have been waiting over 36 months as capacity allows. A letter to all routine waiters is pending to check-in, signpost to waiting well resources/support and to confirm if an assessment has been undertaken elsewhere, so no longer need to remain on the waiting list. Business case recently approved to increase capacity both recurrent and non to keep priority waits under 18 weeks and to start to address the routine wait backlog. Establishment Control Forms are being written to progress recruitment into new posts and address vacancies/maternity leave in the existing substantive wte. (update 02/04/26)				
1383: Mind Mate Neurodevelopmental Referral Triage Waiting List	**Operational**	**15**	**7**	**Cautious (4 – 6)**
As of April 2026, the following was reported regarding the ND backlog work undertaken by Northpoint. 2500 families who were on the waiting list have been contacted to opt-in to remain on the assessment triage pathway with Northpoint. 972 opted in from 1st letter. Those families who did not respond to the first letter were sent a second letter with a reminder to respond if they still needed to remain on the assessment screening pathway. 326 additional families responded following this to request to opt in. Plus, phone attempts to contact. Oversight of the opt-in process has been maintained by a task and finish group meeting regularly with representation from LCH, Northpoint and ICB. Agreement to look at analysis of demographics for remaining families that have not opted in, to identify any common themes and consider next steps. (Update 06.05.2026)				

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	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-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 →
954	Diabetes Service waiting times	12 ↑	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	12 ↑	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 →
1357	Capacity of PSII trained investigators												12

*Risk 957 – this risk was added to the risk register in 2018 and following review of static risks this risk will be closed and replaced with an up-to-date risk.

**Risk 1221 – the TLT membership in attendance at the Risk Management Group meeting on 23/4/26 agreed that this risk would be tolerated at the current level, above target, acknowledging the extensive controls in operation and the external threat environment. The risk will continue to be managed and monitored.

Ref	Title	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
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
1419	Primary care reduced staffing levels in secure estates										12	12	12
1444	Clinical governance vacancies/absences and increased demand												12
1462	Occupational health support and compliance												12
1467	Clinical And Safeguarding Supervision Portal (CASSP) - Compliance Data												12
1470	Staff shortages and high demand in the Triage Hub and Response Team leads to patients not receiving timely and necessary care.												12
1473	Water Safety												12

3.3 Since the previous report in February the number of risks scoring 12 has reduced from 18 to 16, six new risks scoring 12 have been opened, five risks scoring 12 have reduced to below 12 and three risks have closed.

3.4 In the previous report three risks scoring 12 and above had been at the same score for more than 12 months (static), the number of static risks has reduced to one (Risk 1179).

When risk scores have been static for over 12 months, the detail is escalated to 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 123. Of these there are 51 clinical risks and 72 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	5	6	0	0	12
3 - Moderate	1	26	34	10	1	72
2 - Minor	0	10	17	3	1	31
1 - Negligible	1	2	1	1	0	5
Total	3	45	59	14	2	123

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.

*At the time of writing this report the strategic risks for 2026/27 are in the process of being agreed. The 2025/26 strategic risks have been used for the thematic review below.

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, because of capacity exceeding demand, primary care industrial action, and process transformation. Specifically, 32 risks relate to patient safety[1]	The BAF strategic risks directly linked to patient safety are: BAF Risk 1 Failure to deliver quality of care and improvements BAF Risk 2 Failure to respond to increasing demand for services BAF Risk 3 Failure to comply with legislative and regulatory requirements
Theme Two: Compliance with Standards/Legislation	
The second strongest risk theme is compliance with standards/ legislation[2]. This includes health and safety, compliance with information 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 Three: Demand for Services	
There is also a risk theme relating to demand for services exceeding capacity, due to an increase in service demand and high numbers of referrals[3]	The BAF strategic risks directly linked to demand for services are: BAF Risk 2 Failure to respond to increasing demand for services BAF Risk 6 Failure to effectively engage staff and leaders as well as to support their health and well-being in the current context BAF Risk 7 Failure to reduce inequalities experienced by the population we serve
Theme Four: 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: 1109, 1125, 1168, 1169, 1187, 1196, 1284, 1285, 1307, 1308, 1319, 1335, 1353, 1354, 1356, 1357, 1365, 1366, 1369, 1373, 1374, 1387, 1392, 1393, 1395, 1405, 1414, 1419, 1426, 1437, 1453, 1470
[2] Risks: 902, 1206, 1221, 1242, 1313, 1379, 1400, 1422, 1428, 1434, 1444, 1462, 1463, 1465, 1467, 1468, 1473
[3] Risks: 772, 954, 957, 1098, 1179, 1311, 1383. 1384, 1433
[4] Risks: 1228, 1412, 1413, 1459

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 23 July 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: 6 May 2026

Agenda item:	2026-27 21
Title of report:	Register of Sealings June 2025 – March 2026
Meeting:	Trust Board meeting held in public
Date:	21 May 2026

Presented by:	Sara Munro, Interim Chief Executive
Prepared by:	Helen Robinson, Company Secretary

Purpose of the report:		
This report provides an update on the use of the Trust corporate seal.	Approval	
	Discussion	
	Assurance	x

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

Summary of Key Issues:
• The corporate seal had been used four times in July 2025 and once in March 2026 and a copy of a section of the register is presented to the Board.

Previously considered by:	N/A
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	
Collaborating with partners to enable people to live better lives	
Embed equity in all that we do	

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

and/or workforce)?			include this information?	

Recommendation(s)	The Board is asked to note the use of the corporate seal.

List of Appendices:	N/A

Register of affixing of corporate seal and signatories to legal documents

OCCASION	PARTIES INVOLVED	DOCUMENT APPROVED & SEAL ATTESTED BY	DATE
Licence for Alterations (Automated Door) Building 3, White Rose Office Park Leeds	Munroe K Luxemburg S.A. (landlord) and Leeds Community Healthcare NHS Trust	Executive Medical Director and Executive Director of Nursing and AHPs	09.07.2025
Deed of Rectification of Lease – White Rose Office Park	Munroe K Luxemburg S.A. (landlord) and Leeds Community Healthcare NHS Trust	Executive Director of Operations and Executive Medical Director	23.07.2025
Underlease for part of the Reginald Centre (Non-Dental Service)	Community Health Partnerships Limited and Leeds Community Healthcare NHS Trust	Executive Director of Operations and Director of People	30.07.2025
Underlease for part of the Reginald Centre (Dental Service)	Community Health Partnerships Limited and Leeds Community Healthcare NHS Trust	Executive Director of Operations and Director of People	30.07.2025
Underlease for part of Thornton Medical Centre	Caroline Jayne Porteus, Lindsay Helen Springett, Jessica Ruth Butterworth and Andrew Paul Dickens and Leeds Community Healthcare NHS Trust	Interim Chief Executive and Executive Director of Operations	27.03.2026

Agenda item:	2026-27 (22i)
Title of report:	Board Assurance Framework – Update on Review Process for 2026-27
Meeting:	Trust Board
Date:	21 May 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. This report summarises the process undertaken to review the BAF in readiness for the 26/27 financial year, and shares the draft Strategic Risks with the Board for review.	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:

- Strategic risks for 2026/27 proposed at April's Board workshop
- Detail behind each risk and scoring being worked up with Directors during May
- Committees to receive specific strategic risks in June
- Board to have sight of the full BAF for approval in July 2026.

Previously considered by:	Board workshop – 23 April 2026 Trust Leadership Team – 20 May 2026
Outcome of previous discussion/s:	Strategic risks from 2025/26 reviewed and suggestions for 2026/27 put forward. Detail behind each strategic then worked through with individual directors and discussed collectively at TLT.

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?	Equity remains a strategic risk for the next financial year

Recommendation(s)	• The Board is asked to: • Note the process for review of the strategic risks, gaps in controls and sources of assurance for 2026/27. • Discuss the Strategic Risks for 2026/27 or make recommendations for further amends.

List of Appendices:	Appendix 1 – 2026/27 BAF Summary of Proposed Strategic Risks

Board Assurance Framework – Update on Review Process for 2026/27

1. Introduction

1.1 The contents of the Board Assurance Framework (BAF) require an annual review to ensure the strategic risks remain relevant. At its workshop on 23 April 2026, the Trust Board discussed the Trust's strategic framework for 2026/27. As a result of this discussion, it was agreed that the number of Strategic Risks would increase from 8 to 9, with all risks being developed to reflect the current local, regional and national context.

1.2 All strategic risks will continue to be assigned to an Executive Director and to a Committee(s) for oversight.

2. Review of Strategic Risks

2.1 During May, individual directors are redrafting the Strategic Risks based on the discussions held at the Board workshop, and identifying controls to manage the new or amended strategic risks, the required sources of assurance and any resulting gaps. The output of this will then be reviewed collectively at the Trust Leadership Team on 20 May 2026.

The proposed Strategic Risks for 2026/27 are attached to this report for review and further discussion by Trust Board. Table 2 in the appendix shows the revised Strategic Risks mapped against the Trust's five Strategic Goals.

3. Next Steps

3.1 Once the Trust Leadership Team has undertaken a full review of the strategic risks on 20 May 2026, the oversight Committees (Audit, Business, Quality, and People and Culture) will be asked to review and agree their proposed risks and sources of assurance during June 2026.

3.2 The revised BAF will then be shared at the July Board meeting for final approval and confirmation of the Trust's risk appetite for each strategic risk.

3.3 During 2026/27 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.

3.4 The Committees will continue to be required to report to the Trust Board following each meeting via the Committee Chair's assurance reports on whether the risks to the success of its strategic objectives are being managed effectively.

4 Recommendations

The Board is recommended to:

- Note the process for review of the strategic risks, gaps in controls and sources of assurance for 2026/27.

Helen Robinson
Company Secretary

12 May 2026

Summary of Proposed Strategic Risks as of 12 May 2026

Ref	25/26 Strategic Risk	Proposed Strategic Risk for 26/27	Lead Director(s)	Current Score (May 2026)	Target Score (2026/27)	Key changes agreed at the Board workshop on 23 April 2026
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.	**High-quality care:** If we fail to identify, deliver, and sustain high-quality care, there is an increased risk of unsafe or ineffective services. This may lead to preventable harm, poor patient outcomes, and a diminished patient experience.	Exec Director of Nursing and AHPs	TBC	TBC	• Remove reference to: o Continuous improvement (the suggestion was to move this into SR 3, but when working on SR 3 it was removed – to be discussed further at TLT) o Equitable care (already in SR 7)
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.	**Demand for services:** If we fail to respond to changes in population growth and presentation, and changing delivery models such as Neighbourhood Health, then the impact will be potential harm to patients due to long waits, inability to strengthen equity of access, additional pressure on staff, financial consequences and poor performance as measured through the National Oversight Framework.	Exec Director of Operations	TBC	TBC	• Re-written to include changing demand for services, changing models of delivery through Neighbourhood Health model and inclusion of National Oversight Framework.
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.	**Culture of Engagement and inclusivity** If we fail to foster and support a culture of learning, improvement, inclusivity and speaking up there is a risk that we will not provide high quality safe care for the people who use our services.	Chief Executive	TBC	TBC	• Compliance with legislative and regulatory requirements to be mapped to relevant SRs, e.g. to patient safety, workforce • Risk replaced with a new risk relating to culture and inclusivity, reflecting Well-led domain
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.	**Financial sustainability:** There is a risk that a lack of financial efficiency and sustainability results in the destabilisation of the organisation and an inability to meet our objectives.	Executive Director of Finance and Resources	TBC	TBC	• Risk description aligned with LYPFT finance risk • Efficiency included in the description
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 continuity:** If we are 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	TBC	TBC	• No change to this 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.	**Staff health and wellbeing:** There is a risk that insufficient focus on the health, wellbeing, and engagement of staff will lead to increased sickness absence, burnout, and workforce instability. This may result in reduced capacity and diminished quality of care.	Director(s) of Workforce	TBC	TBC	• Changes to the risk description: o Remove ‘misalignment with key objectives’ o Include career development, learning and progression o Align to LYPFT workforce 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.	**Inequalities experienced by the population we serve:** If we fail to address the inequalities built into our own systems and processes, there is a risk that we are inadvertently delivering unfair access or care and exacerbating inequalities in health outcomes within some cohorts of the population.	Medical Director	TBC	TBC	• No change to this risk

Ref	25/26 Strategic Risk	Proposed Strategic Risk for 26/27	Lead Director(s)	Current Score (May 2026)	Target Score (2026/27)	Key changes agreed at the Board workshop on 23 April 2026
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.	**System change (including Trust Integration Programme)** There is a risk that the Trust is unable to deliver on its medium-term plan if it cannot adequately engage in, influence and adapt to the significant changes that are taking place within NHSE/DHSC, the West Yorkshire ICB and the Trust Integration programme with LYPFT.	Chief Executive	TBC	TBC	• Risk amended to reflect: ○ The significant degree of change in the health and care system ○ Ability to adapt and collaborate ○ Trust integration programme
9		**Infrastructure** If the Trust is unable to provide access to safe and fit for purpose digital and estate infrastructure, then there is a risk that the quality and continuity of service provision will be compromised which may further impact achievement of all of the Trusts strategic goals and priorities.	Executive Director of Finance and Resources	TBC	TBC	• New risk added in relation to estates and digital infrastructure

Proposed Strategic Risks for 2026/27 mapped to the Strategic Goals

Strategic Goals	1. Work with communities to deliver personalised care	2. Use our resources wisely and efficiently both in the short and longer term	3. Enable our workforce to thrive and deliver the best possible care	4. Collaborating with partners to enable people to live better lives
	5. To embed equity in all that we do			
Strategic Risks	**Risk 1 High-quality care:** If we fail to identify, deliver, and sustain high-quality care, 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 Financial sustainability:** There is a risk that a lack of financial efficiency and sustainability results in the destabilisation of the organisation and an inability to meet our objectives. **Business Committee** (Executive Director of Finance and Resources)	**Risk 6 Staff health and wellbeing:** There is a risk that insufficient focus on the health, wellbeing, and engagement of staff will lead to increased sickness absence, burnout, and workforce instability. This may result in reduced capacity and diminished quality of care. **People and Culture Committee** (Director(s) of Workforce)	**Risk 8 System change (including Trust Integration Programme)** There is a risk that the Trust is unable to deliver on its medium-term plan if it cannot adequately engage in, influence and adapt to the significant changes that are taking place within NHSE/DHSC, the West Yorkshire ICB and the Trust Integration programme with LYPFT. **Trust Board** (Chief Executive)
	Risk 2 Demand for services: If we fail to respond to changes in population growth and presentation, and changing delivery models such as Neighbourhood Health, then the impact will be potential harm to patients due to long waits, inability to strengthen equity of access, additional pressure on staff, financial consequences and poor performance as measured through the National Oversight Framework. **Quality Committee and Business Committee** (Exec Director of Operations)	**Risk 5 Business continuity:** If we are 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 9 Infrastructure: If the Trust is unable to provide access to safe and fit for purpose digital and estate infrastructure, then there is a risk that the quality and continuity of service provision will be compromised which may further impact achievement of all of the Trusts strategic goals and priorities. **Business Committee** (Executive Director of Finance and Resources)		
	Risk 3 Culture of Engagement and inclusivity: If we fail to foster and support a culture of learning, improvement, inclusivity and speaking up there is a risk that we will not provide high quality safe care for the people who use our services. **People and Culture Committee** (Chief Executive/*Director(s) of Workforce*)			
	Risk 7 Inequalities experienced by the population we serve: If we fail to address the inequalities built into our 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)			

GLOSSARY

AGENDA ITEM 2026-27 (24)

Leeds Community Healthcare NHS Trust

A

ACP	Advanced Clinical Practice
AfC	Agenda for Change
AGM	Annual General Meeting
AHP	Allied Health Professional
AI	Artificial Intelligence
AIS	Accessible Information Standard
AR	Active Recovery

B

BAF	Board Assurance Framework
BME	Black and Minority Ethnic

C

CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CBT	Cognitive Behavioural Therapy
CDS	Community Dental Service
CE+	Cyber Essentials Plus Accreditation
CEO	Chief Executive Officer
CIO	Chief Information Officer
CIP	Cost Improvement Plan
CIVAS	Community Intravenous Antibiotics Service
CMHT	Community Mental Health Team
CQC	Care Quality Commission
CrISPP	Critical Incident Staff Support Pathway
CUCS	Continence, Urology and Colorectal Service
CYPMHS	Children and Young People's Mental Health Services

D

DBS	Disclosure Barring Service
DHSC	Department of Health and Social Care
DNLTC	Disability, Neurodiversity and Long-Term Conditions
DoLS	Deprivation of Liberty Safeguards
DPA	Data Protection Act
DPO	Data Protection Officer
DSPT	Data Security and Protection Toolkit

E

EAP	Employee Assistance Programme
EDI	Equality, Diversity & Inclusion
EPMA	Electronic Prescribing & Medicines Administration
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
EQIA	Equality & Quality Impact Assessment
ESIB	Estates Strategy Implementation Board
ESR	Electronic Staff Record

F

FBC	Full Business Case
FFT	Friends and Family Test
FoI	Freedom of Information
FPPT	Fit and Proper Persons Test Framework
FTSUG	Freedom to Speak Up Guardian

G

GDPR	General Data Protection Regulation
GIRFT	Getting It Right First Time
GoSWH	Guardians of Safe Working Hours

H

HHIT	Homeless and Health Inclusion Team
HSJ	Health Service Journal
HSW	Healthcare Support Worker
HWB	Health and Wellbeing

I

IAPT	Improving Access to Psychological Therapies
ICAN	Integrated Children's Additional Needs Service
ICB	Integrated Care Board
ICO	Information Commissioner's Office
ICS	Integrated Care System
IFRS	International Financial Reporting Standards
IG	Information Governance
IMD	Index of Multiple Deprivation
IMHS	Infant Mental Health Service
IPR	Integrated Performance Report

K

KLOEs	Key Lines of Enquiry
KPI	Key Performance Indicator

L

LA	Local Authority
LCC	Leeds City Council
LCFS	Local Counter Fraud Specialist
LCH	Leeds Community Healthcare NHS Trust
LD	Learning Disability
LeDeR	Learning from Lives and Deaths - People with a Learning Disability and Autistic People
LHCP	Leeds Health and Care Partnership
LIFT estate	Local Improvement Finance Trust Estate

GLOSSARY

LMWS	Leeds Mental Wellbeing Service
LOS/ LoS	Length of Stay
LSH	Leeds Sexual Health Service
LTHT	Leeds Teaching Hospital NHS Trust
LYPFT	Leeds and York Partnership Foundation Trust

M

MARS	Mutually Agreed Resignation Scheme
MDT	Multi-Disciplinary Team
MSK	Musculoskeletal

N

NAO	National Audit Office
NED	Non-Executive Director
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NOF	National Oversight Framework

O

OFSTED	Office for Standards In Education, Children's Services and Skills
OOH	Out of Hours
OPEL	Operational Pressures Escalation Levels

P

PALS	Patient Advice and Liaison Service
PCN	Primary Care Networks
PFI	Private Finance Initiative
PHINS	Public Health Integrated Nursing Service
PIP	Performance Information Portal
PND	Paediatric Neuro Disability
PPE	Personal Protective Equipment
PSED	Public Sector Equality Duty
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Response Framework

Q

QA	Quality Assurance
QAIG	Quality Assurance and Improvement Group
QIA	Quality Impact Assessment
QOF	Quality and Outcomes Framework

R

RAG	Red Amber Green
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RMN	Registered Mental Health Nurse
RN	Registered Nurse
RTT	Referral to Treatment

S

SAR	Subject Access Request
SEND	Special Educational Needs & Disability
SFI	Standing Financial Instructions
SI	Serious Incident
SID	Senior Independent Director
SIRO	Senior Information Risk Owner
SLA	Service Level Agreement
SLT/SaLT	Speech and Language Therapy
SMART	Specific, Measurable, Achievable, Relevant and Time bound
SME	Subject Matter Expert
SOP	Standard Operating Procedure
SPC	Statistical Process Control
SUDIC	Sudden Unexpected Death in Childhood

T

TLT	Trust Leadership Team
TOR	Terms of Reference
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981

V

VCS	Voluntary and Community Sector
VfM	Value for Money
VSM	Very Senior Manager

W

WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
WYH&CP	West Yorkshire Health and Care Partnership

Y

YAS	Yorkshire Ambulance Service
YOI	Young Offenders Institute
YTD	Year to Date

Leeds Community Healthcare NHS Trust

Trust Board Workplan April 2026 -March 2027
Version: 5 30 April 2026

Agenda Item
2026-27
(25)

Topic	Frequency	Lead Officer	BAF Strategic Risk	21 May 2026	24 June 2026 (End of Year Sign Off)	23 July 2026	17 September 2026	19 November 2026	21 January 2027	18 March 2027
STANDING ITEMS										
Declaration of interests	Each meeting	CS	N/A	X	X					
Minutes of previous meeting	Each meeting	CS	N/A	X					X	X
Action log	Each meeting	CS	N/A	X						
Patient Led Experience	Each meeting	EDN&AHPS	N/A	X						
STRATEGY AND PARTNERSHIPS										
Chief Executive's report	Each meeting	CEO		X		X	X	X	X	X
Organisational Strategy Development	Annual (November)	EDO						X		
Medium Term Plan/Operational Priorities		EDFR					X			
Estate Strategy	Six monthly (May/November)	EDFR		X				X		
Learning and Developement Strategy	Annual (March)	EDN&AHPS								X
Health Equity Strategy	Annual (September)	EMD					X			
Quality Strategy	Six monthly (July/ January)	EDN&AHPS				X			X	
People Headlines and Strategy update	3 X per year (March, July and November)	DOP				X		X		X
QUALITY AND SAFETY										
Quality Committee Chair's Assurance Report	Each meeting	CS		X		X	X	X	X	X
Quality account	Annual (June)	EDN&AHPS			X					
Mortality reports	Quarterly (May + annual report, July, September and January)	EMD		X + Annual Report		X	X		X	X
Patient safety (including patient safety incident investigations) update report	Six monthly (September and March)	EDN&AHPS					X			X
Infection prevention control assurance framework	Annual (May)	EDN&AHPS		X						
Infection prevention control annual report	Annual (September)	EDN&AHPS					X			
Care Quality Commission inspection reports	As required	EMD								
Safeguarding -annual report	Annual (September)	EDN&AHPS					X			
FINANCE PERFORMANCE AND SUSTAINABILITY										
Business Committee Chair's Assurance Report	Each meeting	CS		X		X	X	X	X	X
Audit Committee Chair's Assurance Report	Quarterly (May, July, November and January)	CS		X		X		X		X
Charitable Funds Annual Report and Acccounts TRUSTEES	Annual (January)	EDFR								X
Charitable Funds Committee Chair's Assurance Report	Quarterly (July, Sept, Jan and March)	CS				X	X		X	X
Charitable Funds 6 monthly Update Report	Six monthly (May and Nov)	EDN&AHPS		X				X		
Emergency Preparedness, Resilience & Response Statement of Compliance	Six monthly (July - Annual Report and January)	EDO				X +Annual Report			X	
Integrated Performance Report - with sub-headings of Sickness rate trajectories and waiting list trajectories	Each meeting	EDFR/EDO/DoP		X		X	X	X	X	X
Performance brief: High Level Performance Indicators for inclusion in the performance brief	Annual (March)	EDFR								X
Financial Plan	Annual (March)	EDFR								X
Annual report	Annual (June)	EDFR			X					
Annual accounts	Annual (June)	EDFR			X					
Letter of representation (ISA 260)	Annual	EDFR			X					
Audit opinion (Internal)	Annual	EDFR			X					
National Oversight Framework -Segmentation Update	Each meeting	CEO		X		X	X	X	X	X
Sustainability (Green) Plan	Six monthly (July, and January)	EDO				X?			X	
WORKFORCE										
Staff survey	Annual (March)	DOP								X
Freedom to speak up report	2 x year (March and September)	FTSUG								
Guardian for safe working hours report	Quarterly (May, July , September + Annual Report and January)	GoSWH		X		X + Annual Report				X
Medical Director's annual report	Annual (September)	EMD					X			
People Inclusion Improvement Plan 2025 – 2026(incorporating WRES / WDES and Pay Gap reporting)	Annual (November)	DW						X		
GOVERNANCE										
Code of Governance Compliance	Annual (March)	CEO		X						
Provider Licence Compliance	Annual (May)	CS		X						
Audit Committee annual report inlcluding Committee terms of reference review	Annual (May)	CS		X						
Standing orders/standing financial instruction	Annual TBC	CS								
Going concern statement	Annual (March)	EDFR								
Declarations of interest/fit and proper persons test	Annual (March)	CS								
Register of sealings	As required	CS								
Significant risks and risk assurance report	Each meeting	CS		X		X	X	X	X	X
Board Assurance Framework -quarterly update report	Quarterly May, September, January and March	CS		X			X		X	X
Risk appetite statement	Annual (May)	CS		X						
Management of Risk Policy & Procedure (3 yearly)	(Next due for review in Nov 2028)	CS								
Declaration of interests - information from declare	Annual (September) - from 2025	CS					X			
Board Members Service Visits Report	3 x year (TBC)	CEO								
Business Continuity Management Policy	As required	EDO								
Policy for the Development and Management of Policies (3 yearly)	(Next due for review Feb 2026)	EDN&AHPS								
Health and Safety Annual Plan	Annual	EDFR								
Health & Safety Policy (3 yearly)	(Next due for review Feb 2026)	EDFR								
Senior Information Risk Officer - Annual Report	Annual (May)	EDFR		X						
Work plan	Each meeting	CS	X	X		X	X	X	X	X
ADDITIONAL ITEMS										