

Annual Report and Accounts 2025-2026



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Foreword

This Annual Report reflects a year of continued delivery and important change for Leeds Community HealthCare NHS Trust (LCH). During 2025/26, our colleagues have continued to provide high quality, compassionate care to people across Leeds, despite rising demand, workforce pressures and persistent health inequalities. At the same time, we have been preparing the Trust for the next phase of improvement and closer working across the Leeds health and care system.

Our focus and what we have achieved

This year, we agreed a small number of priorities through our Board, which we call our Wildly Important Goals (WIGs). These goals helped us focus our time, energy and resources on the areas that would make the biggest difference for patients, staff and partners, even when day to day pressures remained high.

A major area of progress has been our role in supporting the development of the Neighbourhood Health Model in Leeds. As a community provider, we play a central role in delivering care closer to people's homes. During 2025/26, we began bringing our services and leadership more closely in line with neighbourhoods, strengthening multidisciplinary working, and expanding services that help people recover at home, avoid admission to hospital, or return home sooner. We have also made better use of digital tools to support care delivery and improve access for patients.

Listening to local people has been an important part of this work. Through engagement led by Healthwatch Leeds, more than 500 residents shared their views on how neighbourhood health should work. We are committed to making sure these insights shape how services are designed and delivered as neighbourhood models develop.

We have also seen early improvement in our performance against the NHS Oversight Framework, moving from segment 4 to segment 3 during the year. While this is a positive step, we are clear that this is not yet where we want to be. Our focus remains on reducing waiting times, improving access to services, strengthening staff engagement, lowering sickness absence and improving productivity. These improvements matter particularly for health equity, as people living in more deprived communities are more likely to wait longer for care or miss appointments.

Our Quality and Value programme has continued to provide a strong foundation for improvement. This programme balances financial sustainability with quality, safety and equity, and has supported us to maintain financial balance while protecting patient care. We are especially proud that this work is led by staff, supporting teams to redesign services and out in place a culture of continuous improvement across the organisation.

Above all, we are proud of our teams. Every day, they deliver compassionate, personalised care in challenging circumstances. Their commitment, professionalism and teamwork are the reason people across Leeds continue to receive high quality community healthcare.

We are also proud of the role LCH plays in supporting the wider health and care system. Our services help reduce pressure on hospitals, support prevention and early intervention, and enable people to manage their health and wellbeing in their own communities.

Our strong partnerships with primary care, the local authority, voluntary and community organisations, and other NHS providers are essential to this work and will be even more important in the years ahead.

What has changed during the year

This year has been a year of transition. As Chief Executive and Chair, we came into post in June and August 2025 respectively. We would like to thank Selina Douglas for her leadership during her time as Chief Executive. Selina brought energy and a strong focus on partnership working to the organisation, helping to strengthen our role across Leeds. We also thank Brodie Clark for his leadership and commitment as Chair since 2020. Brodie provided steady guidance and oversight while supporting the Trust through a period of change. We are grateful to them both for their contribution and stewardship.

The second half of the year has focused strongly on listening and learning, hearing directly from teams, patients, partners and communities to understand what we do well and where we need to do better. This listening has helped shape our shared understanding of the organisation and our approach to future priorities.

We have also continued to respond to increasing expectations around integration and system working across Leeds. These changes reinforce the importance of clear leadership, strong values and a continued focus on what matters most to patients and colleagues.

Looking ahead to 2026/27 and beyond

During 2025/26, we developed our five year Medium Term Plan (2026–2031). This sets out how we will strengthen community health services, reduce health inequalities and contribute fully to the ambitions of the NHS Ten Year Health Plan. The plan aligns closely with the Leeds Health and Wellbeing Strategy and the West Yorkshire Integrated Care Strategy.

Our direction is clear: delivering care closer to home, working in neighbourhoods, using digital tools more effectively, and placing greater emphasis on prevention and early support. The plan recognises the challenges we face, including waiting times, workforce pressures and financial constraints, but builds on strong foundations in quality, governance and financial discipline.

A major priority for the coming years is the Trust Integration Programme and our proposed plan to unite with Leeds and York Partnership NHS Foundation Trust (LYPFT) to form a brand-new organisation. Following an independent strategic review, both trust Boards have approved the development of a Strategic Outline Case. Subject to approval, this would lead to a single, community focused organisation by April 2027, delivering more joined up care, strengthening care pathways and providing better value for money.

The first year of our Medium-Term Plan will focus on preparing carefully and safely for this change, bringing together the strengths of both organisations while maintaining stability for patients and colleagues.

Our thanks

We would like to thank our patients and communities for their trust, our partners for their continued collaboration, and, most importantly, our colleagues for their dedication, compassion and professionalism. As we look ahead to 2026/27, we do so with a clear sense of direction, an honest understanding of the challenges ahead, and confidence in what we can achieve together for the people of Leeds.

Thank you,



Dr Sara Munro
Interim Chief Executive



Helen Thomson
Deputy Lieutenant
Acting Chair

About the Trust

Leeds Community Healthcare NHS Trust (LCH) serves a population of over 800,000 people and delivers care to around 4500 people every day. We are an award-winning Trust, with many of our services and teams recognised locally, regionally and nationally for their achievements.

We employ more than 3,300 people, who provide a range of community healthcare services for the people of Leeds and some specialist care services across the wider Yorkshire and the Humber area. Care is always provided in, or as near to, a person's own home as possible.

Our vision is to provide the best possible care to every community we serve. We do this by working together with other organisations and groups, involving and developing our colleagues, and using our resources wisely to continually improve services. We work in partnership with the wider NHS, social care, the criminal justice system and the third sector.



The Trust was rated 'Good' overall in its most recent inspection by the Care Quality Commission (CQC), and we were pleased to have been rated 'Outstanding' for our Sexual Health Services.

We promote equity throughout the organisation, and we continue to support our staff networks (Race Equality, Disability, Neurodiversity and Long-term Conditions, and LGBTQIA+) to create an inclusive environment for patients and colleagues. We believe that a workforce that reflects its community will serve that community better.

Our services are organised into three business units:

- **Adult Services**
- **Specialist Services**
- **Children and Families Services**

The three business units are supported by Corporate Service teams. A full list of our patient facing services are set out on the following pages 7-9.

Our services

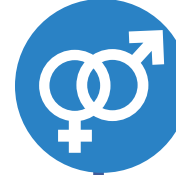
Adult Services

- 13 Neighbourhood Teams
- Triage Hub
- Response Team
- Home Ward Frailty
- Palliative and End of Life Care
- Self-Management
- Neighbourhood Clinics
- Neighbourhood Nursing Out of Hours Service
- Community Discharge Assessment Team
- Bed Bureau
- Transfer of Care
- Healthcase Management
- Active Recovery and Neighbourhood Therapy
- Community Care Beds/ Recovery Beds



Specialist Services

- Community Neurology Team
- Community Stroke Team
- Speech and Language Therapy (SLT) Services and Speech and Swallowing Service
- Leeds Mental Wellbeing Service (LMWS)
- Diabetes Leeds Partnership
- Adult and Children's Nutrition and Dietetics
- Tier 3 Weight Management
- Podiatry (foot health)
- Community Dental Service
- Musculoskeletal Services
- Leeds Community Pain Service
- First Contact Physiotherapy
- Custodial Healthcare (Wetherby Young Offenders Institute, Adel Beck Secure Children's Home and Aldine House Secure Children's Home)
- Police Custody Suites Healthcare Services across West Yorkshire, South Yorkshire, Hull and Humber
- Community Intravenous Antibiotics Service (CIVAS)
- Tuberculosis (TB)
- Homeless and Health Inclusion Team (HHIT)
- Cardiac Service
- Respiratory Service
- Respiratory Virtual Ward
- Leeds Sexual Health
- Community Gynaecology
- Long COVID Community Rehabilitation Service
- Tissue Viability
- Continence, Urology and Colorectal Service (CUCS)
- Falls



Children and Families Services

Integrated Children's Additional Needs Service (ICAN):

- Occupational Therapy
- Physiotherapy
- Community Paediatric Clinics
- Paediatric Neurodisability Clinics
- Growth and Nutrition Clinics
- Adoption and Fostering Service
- Springfield Neonatal Follow Up Clinic
- Audiology Service
- Sudden Unexpected Death in Infancy and Childhood (SUDIC)

Children and Young People's Mental Health Services (CYPMHS):

- Crisis Service
- Core
- MindMate Support
- Crisis Call Line
- Eating Disorders
- Enhanced Support Team
- Medication Support Team
- Therapies Team
- Proactive Support
- Learning Disability Team
- Neurodevelopmental Service

Children's Community Nursing Service

- Continuing Care
- Health Short Breaks
- Hannah House
- Inclusion Nursing Service

Children's Speech and Language Therapy

- Communication Aid Service
- Mainstream
- Dysphasia
- Deaf and Hearing Impairment Team (DAHIT)
- Developmental Language Disorder (DLD)
- School Aged Learning and Dysphagia (SALD)
- Stammering

Infant Mental Health Service

0-19 PHINS Service

School Immunisation Service

Children's Community Eye Service



Case studies

Specialist Business Unit

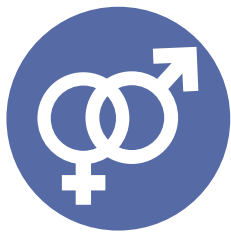
Leeds Sexual Health is delivered by Leeds Community Healthcare NHS Trust in partnership with Leeds

Leedssexualhealth



Teaching Hospitals NHS Trust, Leeds GP Confederation and Volition - Forum Central.

Together we provide a comprehensive range of services including contraception advice and testing for Sexually Transmitted Infections (STIs). We have a flexible approach to the delivery of sexual health services that are responsive to service user need and situation.



We are particularly proud of the work we do in partnership with the Third Sector as they ensure we are accessible to all communities through their outreach work. Volition-Forum Central coordinates our network of 36 voluntary sector partners and community groups. The following case study demonstrates the value of working together with the Third Sector:

In response to a possible resistant STI outbreak in street-based sex workers, an Outreach Control Team was formed which included UKSHA, local authority, stakeholders in street health primary care team, drug and alcohol services, prison health colleagues, VSCE organisations - services working with street-based sex workers.

VCSE organisations had trusted relationships with the client group and offered insight and a flexible, person-centred approach that helped us reach those who may never have accessed sexual health support.

In addition, access to VCSE estates enabled us to support pop-up clinics, targeted screening and tailored care to those most at risk and least likely to engage in standard healthcare settings.



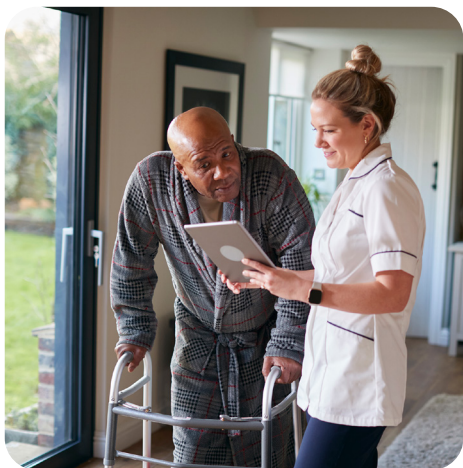
Adult Business Unit

Active Recovery is a partnership between Leeds City Council (LCC) and Leeds Community Healthcare NHS Trust (LCH) to combine our resources to deliver a single, joint, home-based and short-term rehabilitation offer to the people of Leeds.

The vision is to move from two pathways and two services to a single pathway and service delivered by two organisations working in close partnership. Active Recovery is grounded in our shared purpose and vision to bring together all short-term, home-based rehabilitation and reablement functions to create one co-ordinated health and social care delivery model. It brings together colleagues from LCH Neighbourhood Teams and LCC SKiLs Reablement Service into one team and service.



The impact our integrated team has for patients is shown in the case study below:



J is a man in his 70s who was admitted into hospital due to a decline in both his mental and physical health.

When he was discharged in August the Active Recovery Team talked to him about his goals. He had returned home to downstairs living and was mobile with a wheeled zimmer frame. He wanted to mobilise unaided indoors, to manage stairs on his own, to attend to his personal care needs and to access the bath independently.

With the support of both therapists from LCH and the reablement team from LCC, by September he was able to complete stairs and move around indoors independently. He was able to shower independently and after a grabrail was fitted he was able to safely access the bath.

The Active Recovery Team ceased input in mid-September as no outstanding input was required and J was living independently at home.

Children's Business Unit

The ICAN (Integrated Services for Children with Additional Needs) service works with children and young people with disabilities. The large team is made up of doctors, nurses, therapists and support staff.



In this case study a 3-year-old child was referred to paediatric neurodisability services in ICAN after her parents and GP became concerned about frequent falls and some new difficulties with her movement. The child's parents noticed that she was becoming more unsteady, with falls happening around 2–3 times a day, sometimes even when she was standing still. They had also recently noticed a shaking (tremor) in her hands. Although this was worrying, she continued to make progress in her development.



A full developmental history was taken and her examination identified an unsteady, walking pattern, unusual positioning of her limbs, a tremor in her arms and hands and occasional toe-walking. After appropriate diagnostic testing the team diagnosed a rare neurodegenerative condition.

The diagnosis was explained to the family clearly, sensitively, and without delay, and a wide range of support was put in place including

Physiotherapy, Occupational Therapy and Speech and Language Therapy, as well as referrals to the Eye Clinic and the Genetics Team. The child was also enrolled in a clinical trial at Great Ormond Street Hospital, giving access to new and developing treatments.

At follow-up, the child remained active, happy and engaged. Her parents were continuing with physiotherapy exercises and encouraging physical activity at home. This case shows how careful assessment, quick action, and clear communication can lead to both high-quality care and a very positive experience for families.

For more detailed information about any of our services please visit our website:

www.leedscommunityhealthcare.nhs.uk

How we work

The Trust's culture is underpinned by our vision:

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

We have three values that support this vision:

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

We uphold the visions and values through our **how we work** behaviours:



Caring for our patients



Making the best decisions



Leading by example



Caring for one another



Adapting to change and delivering improvements



Working together



Finding solutions

Our strategic goals

The Trust Board agreed five strategic goals for 2025/26:

Work with communities to deliver personalised care.

Enable our workforce to thrive and deliver the best possible care.

Collaborate with partners to enable people to live better lives.

Embed equity in all that we do.

Use our resources wisely and efficiently both in the short and longer term.

Our Wildly Important goals

In response to NHS England's [Fit for the Future: 10 Year Health Plan for England](#) published in July 2025, all NHS Trusts were required to develop a 5-year medium term plan, to show our contribution to the Plan's three shifts:

- Hospital to community.
- Analogue to digital.
- Treatment to prevention.

To support with this, the Trust has developed its Wildly Important Goals - vital priorities that will impact our future:

- Year 2 of our cost improvement approach (Quality and Value Programme).
- Improving waiting lists.
- Supporting Neighbourhood Health.



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



Reduce the backlog of people waiting for our services inline with the national targets for 2025/26.



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

Key risks

We reviewed our strategic risks connected to our goals in Spring 2025, allocating an assigned Lead Director(s) and Lead Committee(s) to each strategic risk. The level of assurance given for the management and mitigation of these risks is reported to the Trust Board at each of its meetings:

Risk 1: Failure to deliver high quality, equitable care and continuous improvement.

Risk 2: Failure to respond to increasing demand for services.

Risk 3: Failure to comply with legislative and regulatory requirements.

Risk 4: Failure to deliver financial sustainability.

Risk 5: Failure to maintain business continuity.

Risk 6: Failure to effectively engage staff and leaders as well as to support their health and wellbeing in the current context.

Risk 7: Failure to reduce inequalities experienced by the population we serve.

Risk 8: Failure to collaborate.

The Performance Overview in this report describes how the Trust managed its strategic risks to achieve our goals during 2025/26. These arrangements receive oversight and scrutiny through the Board Assurance Framework.

Risk management, including the Board Assurance, is considered in more detail in our Annual Governance Statement which can be found on [page 101](#) of this report.

Performance report

Performance overview

The Board seeks to make sure we deliver the priorities it agreed for the year and that our operational, and day-to-day, performance meets the expectations of our patients, commissioners, partners, and regulators. It does this through a wide range of formal and informal processes, formal public Board meetings, a committee structure and through engagement with patients, colleagues and stakeholders.

Our operational performance against a range of local and national targets and standards is assessed, and reported on, within the organisation and outside of it. The targets and standards are taken from the NHS Oversight Framework, our contracts, and local priorities.

They are grouped into five domains which work alongside the Care Quality Commission's (CQC) governance framework – we then add a finance domain. By looking closely at individual measures within these domains, we get an overall view of the Trust and our current performance. The Board considers an Integrated Performance Report. This describes our current performance. The Integrated Performance Report is available as part of the Board papers which are published on our website:

www.leedscommunityhealthcare.nhs.uk

In the following sections we look at how we delivered against our priorities for the year and our performance against key performance indicators (KPIs).

How we met our Strategic Goals

At the start of the year, the Board identified a small set of key priorities, known as our Wildly Important Goals (WIGs). These were designed to give a clear sense of direction and help everyone concentrate on the areas that would have the greatest impact for patients, staff and partners. By keeping the focus on a few shared goals, we were able to make meaningful progress despite the ongoing pressures of day-to-day work.

Here are some of our main achievements:

The Quality and Value Programme



This year has been the second year of our cost improvement approach 'Quality and Value' which is all about balancing the need for financial sustainability without compromising quality, safety, equity, and effectiveness. It is underpinned by a 'bottom-up' way of working, where staff are supported to develop ideas that redesign their own services to be more efficient and effective. This year we have had 33 live clinical service redesigns. These have included:

- **Adult Business Unit** - have been reviewing service elements such as Pharmacy Technicians and Self-Management. There have also been success stories with redesigns that were put in place last year, for example eye drop activity has dropped by 20% and reduction is being maintained; and within a review of palliative care early support visits, there has been a reduction of 67% of patients receiving only one visit per month.
- **Children's Business Unit** - has been taking a business unit approach by putting in place 'A Fair Days Work' across all services, this means that referral booking, job planning and productivity is being managed in a standardised and sustainable way.
- **Specialist Business Unit** - continue to take all of their services through a redesign approach with this year's focus being on Leeds Mental Wellbeing Service, Cardiac, Respiratory, Diabetes and Community Neuro-Rehabilitation Team.
- **Corporate and Central Teams and Infrastructure** - over 200 staff have been engaged with as part of the redesign of our administrative services function. The redesign is based on three core components: digitisation, centralisation and prioritisation function aimed at improving quality, patient care and resilience. In addition over 200 leaders have been engaged with to start developing a new leadership model that will better support a Neighbourhood Health way of working. Our estates portfolio has been streamlined to release over £500k of savings - anything we can save in infrastructure costs helps protect frontline clinical services.

As at the end of March 2026 we had identified full year recurrent savings of £12.9m against the £14m target. That's over 92% of our target. The progress around achieving recurrent savings means we take less financial risk into the next financial year and our services remain sustainable.

Our approach to delivery of recurrent savings, through the Quality and Value Programme, means that we ensure that patient safety and experience will not be compromised before making any changes to services.

Plans for the third and final year of Quality and Value are already starting. One of the main aims will be to review learning from staff-leading change, to encourage a culture of continuous quality improvement beyond the programme.

Equity and Quality Impact Assessment (EqIA) Process

The Trust has continued to strengthen its approach to quality, maintaining its importance alongside financial stewardship. Building on previous work, the Equity and Quality Impact Assessment (EqIA) process has been developed so that service and corporate changes are applied consistently with requirements of the Public Sector Equality Duty. As the scale and pace of service transformation increased, the number of EqIAs did too. In response, the Trust introduced more detailed assessment and scrutiny at service and business unit level before proposals went for senior approval. This has improved the depth of understanding of potential impacts and strengthened the quality of decision making.

Working with key system partners has further supported this approach, with a more consistent and informed assessment of how service change may affect patients and communities. This continued progression from last year's position highlights the Trust's commitment to placing equality considerations at the heart of service planning and improvement.

Our Equity and Quality Impact Assessments (EqIA) are firmly fixed into any process of change. To date 52 of our EqIAs are related to the Quality and Value programme, with a further 21 pending. During 2025/26, one EqIA was rejected. This was a request regarding an opt-in referral process for a specific team, but it was felt that a Trust-wide response was required in order to prevent inadvertently increasing barriers to the same groups of people who were awaiting care.

The Patient Safety Incident Framework

The Trust has fully moved to the Patient Safety Incident Response Framework (PSIRF) and has completed a further refresh of the Patient Safety Incident Response Plan (PSIRP) in line with national requirements. Governance arrangements have been strengthened, with dedicated Trust Improvement Groups now reporting directly into the Quality Assurance and Improvement Group, a formal sub committee of the Quality Committee.



Internal Audit has reviewed the revised arrangements and identified several areas for further improvement. The Trust has accepted these findings, and actions to address them are underway, with progress monitored through established governance structures. The Board is assured that appropriate systems of control are in place and that ongoing improvements will continue to increase the strength of the Trust's patient safety governance.

Digital Strategy

In 2025/26, we continued to put in place the Digital Data and Technology Strategy, approved by Board in December 2024. There has been good progress with initiatives for example, the Patient Information Hub (website for patients to access and use information about their care). Making sure our estate remains secure, continuing with plans to become a 'data driven' organisation and new reporting development remain important areas of focus.

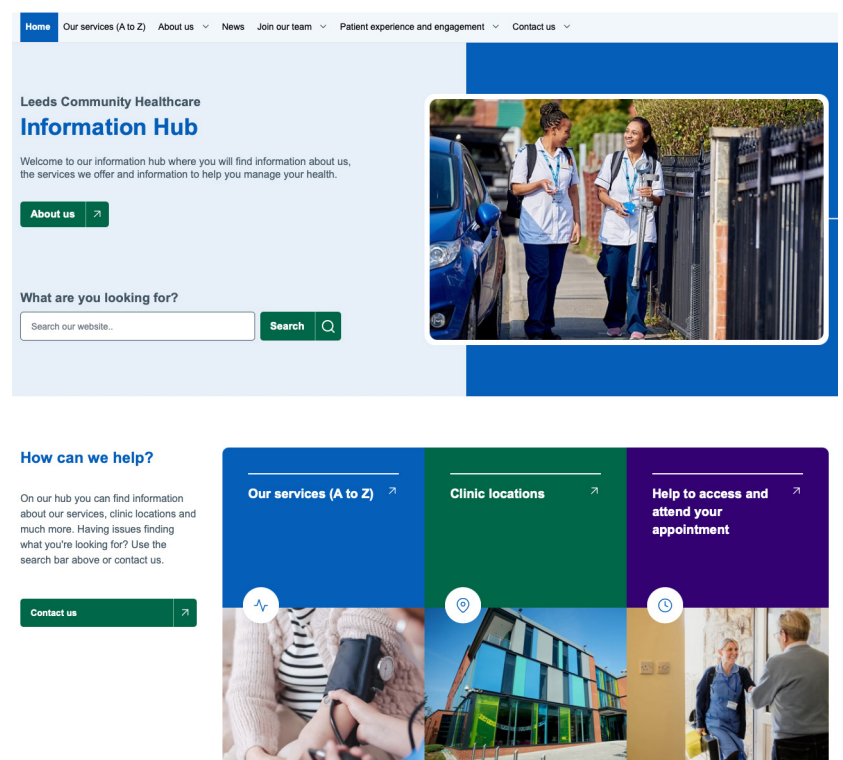


The last financial year has been incredibly busy for digital teams, but there has been a strengthening of engagement from the workforce with a growing Digital and Clinical Champion network. A second Trust-wide digital innovation event was well attended by a cross section of staff from the Trust and, in partnership with Virgin Media / O2, a series of engagement sessions with patients has taken place across several of our health centres to support access to digital resources such as the NHS App and online self-care advice. Feedback from patients gave these sessions high satisfaction ratings.

Notable milestones were reached this year too, with the delivery of the Patient Information Hub, 33 of 43 services are now live with the rest due to be live by the end of June 2026.

Patients have told us that the self-management information was immediately useful, with some already trying recommended exercises and sharing resources with family members. Services are beginning to place use of 'the Hub' within their clinical pathways, sharing links with patients during and after appointments. This reduces the need for printed materials and supports sustainability.

Website analytics show between 35,000 and 40,000 active users on the website, with services such as Children's Speech and Language Therapy, Infant Mental Health and Podiatry regularly achieving high hits on self management pages. The Hub has also risen significantly in NHS website compliance (WCAG) rankings, now placed within the top 50 NHS websites for accessibility and guidance, compared with its previous position of 192.



Within the Leeds Sexual Health service, work has progressed to provide active care records

and progress on its digital inclusion agenda led to shortlisting for a Health Service Journal Award.

In the introduction to this report we referred to the 100% Digital Leeds programme, which is led by the digital inclusion team in the Integrated Digital Service at Leeds City Council and Leeds Health and Care NHS West Yorkshire Integrated Care Board. Screening leads directly to referral and signposting through 100% Digital Leeds and partners, as well as access to our Digital Health Support Hubs. We have a LCH digital network of staff who are key to supporting their colleagues. This ensures digital inclusion is embedded into everyday care, not treated as a standalone project.

100% Digital Leeds have been key with helping us start and continuing our work on digital inclusion.

"We're proud of our partnership with LCH. The Trust is ahead of the curve in embedding digital inclusion into their strategy and priorities ensuring digital inclusion is considered across the whole Trust. 100% Digital Leeds's community-based approach to digital inclusion depends upon bringing together key partners to design interventions that are bespoke, sustainable, and able to scale and flex in response to changing needs. Our partnership with LCH is a perfect example of the strength of cross-sector collaboration.

LCH staff are now more confident in identifying digitally excluded people, helping people to understand the personal benefits of digital, and signposting people to the right support in the community.

Third-sector staff are now more informed of the digital health tools and services available and are better equipped to offer that support.

As a result, people in Leeds have more opportunity and more support to access health services and self-manage their health and wellbeing digitally.

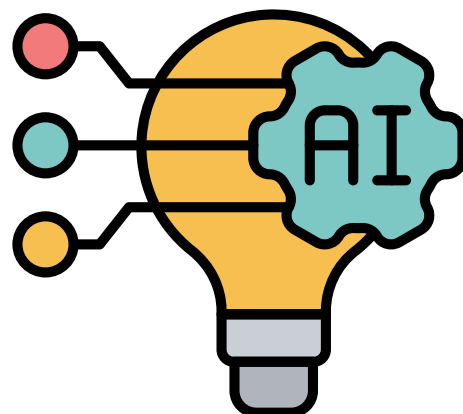
Working closely with Amanda Jackson to implement LCH's Digital, Data and Technology Strategy, has helped 100% Digital Leeds to establish best practice that has informed our work with other health partners in the city. We are thrilled that our work together is now being shared as an example of best practice by NHS England".

Amy Hearn, Digital Inclusion Manager, 100% Digital Leeds.

Artificial Intelligence

This year has marked the beginning of our journey into Artificial Intelligence (AI), laying foundations for safe, ethical and sustainable innovation. We have strengthened our organisational approach through the creation of an AI Specialist Interest Group and the establishment of an AI Governance Board, ensuring that all developments are guided by robust oversight and a commitment to environmentally responsible and equitable use.

We have invested in our people, launching an AI training



programme to build confidence and capability in generative AI. Clear guidance, particularly around the use of Copilot Chat, has enabled staff to embrace these tools responsibly, enhancing productivity and supporting improvements in service delivery.

Alongside this, we have progressed our exploration of Ambient Voice Technology (AVT). A 12 month pilot, in partnership with ICAN and CYPMHS, will test its potential to reduce administrative burden and enrich clinical interactions, allowing staff to focus more on what matters most, patient care.

Innovation has been driven from within. Through 'promptathons', collaborative hackathons, teams have been empowered to experiment, learn and unlock the potential of AI tools. Working with Health Innovation Yorkshire, we have also expanded learning opportunities for both staff and leadership, addressing the growing demand for AI while building understanding of its capabilities, risks and limitations.

Looking ahead, we see significant opportunities to extend the benefits of AI. Subject to successful evaluation, AVT could be scaled further, including into corporate functions. We are also exploring how AI can support clinical pathways, including the potential for intelligent front-door tools that help patients access the right information at the right time, improving both experience and outcomes.

Central to all of this is our focus on equity and inclusion. We are actively working to ensure that AI supports, rather than reinforces, fairness, addressing potential bias and promoting health equity across patient and staff populations. At the same time, we are prioritising digital inclusion, ensuring that no one is excluded from accessing care or contributing to our services as AI becomes more embedded in everyday practice.

Together, these steps represent not just the start of our AI journey, but a clear commitment to harnessing technology responsibly, delivering meaningful improvements for our people, our patients and our communities.

Our digital vision is to:

'Harness digital and data opportunities which allow us to work safely and better together, promoting health and wellbeing and ensuring the best possible care is provided to all those we serve.'

We aim to improve our digital maturity and continue to innovate and transform over the next year, all whilst preparing our digital governance, infrastructure and workforce to become part of a new organisation with Leeds and York Partnership NHS Foundation Trust in 2027.

Thinking about our progress, and the changing healthcare landscape set out in the NHS 10 Year Health Plan, our digital strategy will be refreshed in 2026/27 to focus on priority areas including:

- Potential introduction of Ambient Voice Technology in Neuro-disability pathways to support staff productivity.
- Continued use of 'Digital Letters' to improve access to information for patients about their care.

- Making our Electronic Patient Record System (EPRS) as effective as possible, with a real focus on a Neighbourhood Healthcare way of working as set out in the NHS 10 Year Health Plan.
- The review of EPRS in partnership with Leeds and York Partnership NHS Foundation Trust to find the best solution for the future. One that meets the needs of a combined community and mental health organisation.
- Seeking opportunities to introduce Technology Based Care to support patients to remain well at home.

We will continue to invest in our infrastructure to keep our data 'cyber-safe' and invest in the support and development needs of our staff to make sure we are best placed to take advantage of rapid technological change.

Neighbourhood Health

This year has seen continued progress in the HomeFirst Phase 2 Programme, which focuses on helping people in Leeds



HomeFirst
Programme



**Leeds
Health & Care
Partnership**

to stay independent and supported in their own homes for as long as possible. The programme brings together health and care services to prevent people's health from getting worse and to provide more joined-up, timely support.



Work has continued to build on the HomeFirst approach, improving intermediate care services so that people can avoid unnecessary hospital admissions and return home more quickly after a stay in hospital. This includes a stronger focus on care provided at home, improved discharge processes, and better coordination between teams.

Alongside this, neighbourhood proactive care has been further developed, identifying people who may need additional support earlier. This approach brings together

different professionals to work as one team around the person, helping to prevent crises and support people with long-term conditions or frailty to stay well and connected to their communities.

A Prevention Diagnostic has also been completed, helping to identify how services can better support people to remain independent and reduce future demand for care.

Overall, the programme is helping to reduce avoidable time spent in hospital, improve people's experience of care, and make sure services work more effectively together to support individuals and carers.

Building on these foundations, the team has also made good progress in prevention,

neighbourhood working and digital support. A Frailty and Falls Hub has been set up in Gipton and Armley, along with new training to help both clinical teams and community organisations prevent falls. There have also been improvements in how data is used to identify people most at risk, and a citywide review of prevention work has been completed. At the same time, clear neighbourhood areas have been agreed across the city, with teams aligned to these areas with shared design principles developed to guide how services and local hubs work. Digital work has supported this progress too, including introducing wearable technology, developing a shared ReSPECT care plan, and rolling out recovery care plans to community teams to make transitions between services run more smoothly.

Learning and Development

This year, the Trust has continued to invest in high-quality learning and development opportunities to support career progression, professional excellence and compassionate leadership. Our People Solutions and Clinical Education teams continue to work closely together to make sure colleagues have access to high-quality development, clear career pathways and responsive support. Through the Learning and Development Strategy, we are aligning education and organisational development to help build a more sustainable, skilled and future-ready workforce. Access to training has been expanded through a blended model of in-person workshops, e-learning modules and virtual sessions, supporting colleagues to learn in ways that suit their roles and schedules.

Alongside this, we continue to deliver our in-house LEAD Development Programme, which includes modules on Compassionate Leadership, Manager as Coach and Having Difficult Conversations. We have also invested in a range of Leadership Development Apprenticeships at Levels 3–6 through Manchester University and BPP University, providing colleagues with structured pathways to develop advanced leadership capability.



This year, we introduced two new programmes for colleagues, including the NHS Impact Operational Improvement Training Programme. This programme is open to all Band 6 to 8a (or equivalent) clinical and operational staff, supporting them to develop their skills in operational management with practical tools they can apply in their day-to-day work and future careers. Plus, we have recently joined a collaborative of Trusts to deliver the Mary Seacole Programme in-house, expanding access to nationally recognised leadership development for colleagues at all levels.

We continue to promote system-wide development opportunities through our active membership of the Leeds Health and Care Academy, as well as offers from the North East and Yorkshire Leadership Academy. These partnerships make sure colleagues can benefit from a broad range of high-quality programmes, resources and networks that complement our internal development offer.

Our focus remains on building a skilled, confident and adaptable workforce. By investing in development at every career stage, we aim to support colleagues to reach their potential and deliver outstanding care for our communities.

Racial Equity in Care

Achieving racial equity in LCH services is an active approach, our strategic objective to 'embed equity in everything we do' underlines this, as does our long-term health equity plan that moves us 'from intent to action'.

Our commitment to race equity goes beyond our regulatory duty to deliver an improvement plan for mental health services, we reviewed and aligned 3 anti-racism frameworks:

- [Seven Anti-Racism Principles - NHS - Race and Health Observatory](#)
- [The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf](#)
- [NHS England » Patient and carer race equality framework](#)

From this, we identified 4 key areas of work that the evidence showed could have significant impact in naming racism, identifying how it operates in LCH and acting to address it (Jones, 2018):

- **Leadership:** naming and committing to act on racism.
- **Lived experience:** ethnically diverse community and patient engagement and coproduction.
- Culturally competent service delivery and policy development.
- Data and analysis.

This year, our work has included:

Interpreting and translation

Our new interpreting and translation provision launched in February. It was supported by resources, training and a communications campaign to raise awareness of the need for professional interpreting and translation. The aim is to address racial inequity in access, experience and outcomes and putting this in place works to our delivery of the national improvement framework for community language, translation and interpreting services.



Examples of translated information: our new Patient Information Hub (website) has an accessibility tool including translation and audio versions in community languages, which can be used to provide printed versions of service information for people who do not have access to digital tools. The Information Hub also provides access to self-management videos in a range of languages, including videos made with partners and people in Leeds in Arabic, Bengali, Punjabi and Roma on the signs and symptoms of diabetes and knowing the risks of diabetes, and videos in 10 different languages about children's Speech and Language Therapy.

Improving access to care

The Access LCH improvement programme includes targeted work to find and address barriers to joining or staying on waiting lists. It supports attendance at appointments and in waiting safely, for example, people at risk of worse health outcomes, such as racialised communities, so that they do not experience greater negative impact of waits.

Example: Analysis of data identified that higher rates of missed appointments were contributing to longer waiting times, rather than differences in the rates of being invited to appointments. Earlier recording of communication needs means that support to attend appointments can be provided in the appropriate language prior to the first appointment. Services such as neurology and speech and language therapy have also booked appointments before others in the same waiting cohort. This supports access to interpreters, particularly for rarer languages of which there are many in Leeds.

Data quality

Our new 'About Me' template on the SystmOne health records platform is improving how we record ethnicity and interpreter requirements. We now know if an individual prefers a recording of spoken or a written language, we also record literacy support needs and carers' language needs can be recorded separately.



Cultural Conversations

Our Cultural Conversations programme recognises that cultural humility is ongoing and not achieved through one-off training. We support teams to have the skills and confidence to take part in, and reflect on, learning about different cultures and to build this into everyday practice. We have delivered training to 64 staff, supporting them to begin and lead cultural conversations in their own teams and consider what this means for how they work inclusively with colleagues or patients of different cultures. This work has been supported by a calendar of awareness activities, such as Race Equality Week 2026 theme of #ChangeNeedsAllofUs, aligned to the five pillars of allyship.

Lived experience and community engagement

Alongside our own regular feedback and engagement tools, we work with FRESH (the Forum for Race Equality in Social Care and Health) and use existing insight such as West Yorkshire Insights Library and Healthwatch Leeds, including the How Does It Feel for Me videos to shape how we work.

This year, we commissioned a community engagement project on the future of community health services in Leeds. Our partner, Healthwatch Leeds, intentionally oversampled ethnically diverse communities to make sure we had representation from people who are seldom heard. Feedback about race, ethnicity and cultural diversity highlighted access barriers, trust and communication, service design and health inequality as themes. An engagement event on Black men's mental health, also asked: 'How do you know if care is taking your culture into account?' Community members and health services got together to understand what makes a good, culturally competent conversation about mental health. The learning applied not only to mental health services, but other services who signpost people to mental health support.

Partnership working

Partnerships and the opportunities for shared learning support our racial equity improvement work, including membership of Synergi Leeds and its Exhibition - Remembering What's Forgotten, Leeds Migrant Health Board, Integrated Care Board and Leeds and York Partnership NHS Foundation Trust racial equity in mental health workstreams.

Our Racial Equity in Care steering group oversees this work and is co-chaired by the Director of Nursing, AHPs and Quality and a member of our staff Race Equality Network. Reporting through Quality Assurance and Improvement Group (QAIG) to Quality Committee and Board, this group meets every two months, with a remit to:

- Promote anti-racism principles, that we: name racism; ask 'how is racism operating here'; and organise and strategise to act.
- Be led and informed by the voices of lived experience.
- Ensure we move from intent to action in identifying and addressing racial inequity in our care and pathways.
- Co-ordinate oversight, thinking and action about how we develop racial equity in our service provision.
- Receive updates on the delivery of regulatory requirements to address racial inequity in mental health services and identify wider Trust implications and learning.
- Review work being done on racial equity and whether it's having the desired impact on making our services equitable for racialised communities' access, experience, and outcomes.
- Inform and contribute to workstreams that relate to how we address racial inequity.

Staff Engagement and Staff Networks

Staff engagement remains a central priority. This year we invested in strengthening how colleagues can shape Trust culture and influence decision-making. Insights gathered through engagement activities informed local improvement plans, with a focus on wellbeing, staff safety and inclusion.

Staff networks play a vital role in creating community, amplifying lived experience and supporting organisational change. Each network has delivered a programme of events, awareness campaigns and peer-support activities. Network Chairs have been supported through dedicated development sessions and regular engagement with the Executive Team, making sure their voices contribute directly to strategic priorities and help shape a more inclusive culture.

This year we introduced dedicated Organisation Development support for our staff networks, helping to strengthen their impact, build capability and enhance collaboration across the Trust. We also held our annual Staff Network Celebration Day, recognising the contribution of our networks and providing a space for colleagues to connect, share achievements and showcase their work.

An Engagement Project to strengthen how managers work with teams, drawing on NHS Employers' 'Dozen Dos of Engagement' has also led to the launch of a new engagement toolkit in spring 2026. It supports managers to build stronger relationships, improve communication and foster more inclusive, responsive team cultures.

These approaches are all helping build a more open culture, where we work together to understand colleague experience and place this at the heart of how we learn, develop and deliver care.



The commitment we have made to improving our performance has produced important and positive steps in key areas such as reducing long waits to access our services. This provides a sound platform for the year ahead as we strive to deliver against constitutional standards in all our services.

Dr Sara Munro, Interim CEO

Performance Analysis

This section gives a more detailed analysis of how we performed in key areas during 2025/26.

Our Performance Monitoring Processes

The Trust Board monitored a wide range of Key Performance Indicators (KPIs) across six domains:

- **Safe** - people are protected from abuse and avoidable harm.
- **Caring** - staff involve and treat people with compassion, kindness, dignity and respect.
- **Effective** - people's care, treatment and support achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.
- **Responsive** - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.
- **Well-led** - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.
- **Finance** - our resources are managed well and put to best use.

We have strengthened our performance reporting using the NHS England's 'Making Data Count' methodology to provide a much higher degree of assurance. Where we can we use Statistical Process Control (SPC) charts to track indicators against six domains in our Performance Brief to create a focus on what is changing, the causes, and the actions we are taking. This initiative was part of our Digital, Data and Technology Strategy is designed to deliver insight and intelligence. We have also developed real time data flows designed to assist bed management and more closely aligned our local and national reporting to provide improved insight and allow effective action in response to the NHS Oversight Framework.

The Board was supported in its monitoring of operational performance by the Quality Committee, Business Committee, and the Senior Operations Performance Panel. Each of our three Clinical Business Units provides monthly written reports on their performance, including risks, key initiatives in support of our staff, and plans for improvement to the Senior Operations Performance Panel. These reports covered all six domains.

A summary of these details was reported to committees every two months and then presented to Board for final review.

All the Performance Reports considered by the Trust Board are available as part of the Board papers on our website www.leedscommunityhealthcare.nhs.uk

During the year we undertook a detailed study of our performance and accountability processes, as a result we have started to develop and introduce new ways of working that will ensure we remain governed well. Our developments include:

- A Key Performance Indicator (KPI) library that defines all of our priority measures, and roles and responsibilities in relation to delivery.

- A new Integrated Performance Report format - launched in January 2026.
- A new Performance and Accountability Framework - to be launched in June 2026.

Our Performance against Key Performance Indicators

The Trust's services worked hard to achieve our performance targets in 2025/26 and we are proud of our ongoing commitment to provide high quality services.

Despite growing complexity of demand and service change, we achieved many of our targets this year.

Driven by improvements in waiting times, Children and Young People's Access to Mental Health Services and our Urgent Care Response, we improved our NHS Oversight Framework score from segment 4 to segment 3 in Q3 2025/26 – The NHS Oversight Framework (NOF) is the national system used to assess, monitor, and support the performance of NHS Trusts across England. It drives public accountability and dictates the level of autonomy or support an organisation requires. Organisations are scored against a range of indicators and the scores are translated into public performance league tables placing Trusts into one of five segments, segment 1 being high performing, demonstrating strong autonomy and maximum operational freedom through to segment 4 / 5 being lowest performing, under close regulatory review with maximum intervention and support from NHS England.

We were also able to maintain our staff survey engagement theme score.

We have begun to see significant improvements in the time patients wait to access our services. The majority of services have now eradicated 52+ week waits and a significantly higher proportion of patients are being seen within 18 weeks.

We will continue with focussed work in this area and expect to see further improvements during the coming year.

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.

Safe - means people are protected from avoidable harm.

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.

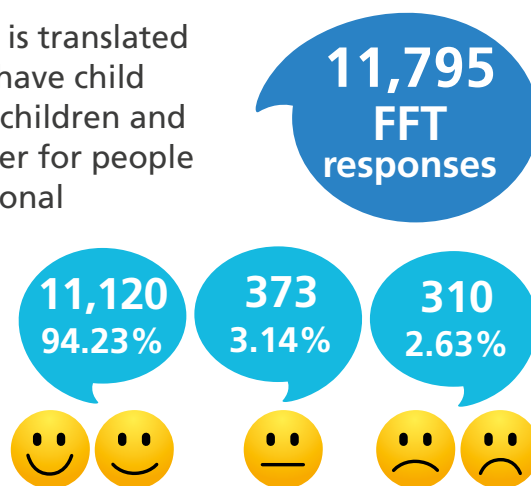
Overdue actions from PSII have also been escalated throughout 2025/26 and the process for managing overdue Patient Safety Incident Investigation (PSII) and Patient Safety Learning Response (PSLR) actions has been reviewed and updated with the aim of strengthening governance and improving the timeliness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

Caring - means staff treat people with compassion, kindness, dignity and respect.

Friends and Family Test (FFT)

We continually seek feedback from people who use our services via the Friends and Family Test (FFT) which can be found through an online link, a QR (Quick Response) Code, paper postcards and SMS message.

The FFT is available in a standard easy-read format and is translated into the five most spoken languages in Leeds. We also have child friendly Friends and Family Tests designed with and by children and young people. Our aim is to make giving feedback easier for people whose first language is not English, or who have additional communication or accessibility needs. Between 1 April 2025 and 31 March 2026, 11795 FFT responses were shared. Of those, 9641 (81.74%) used the online or SMS survey, an increasingly popular option. Despite this, we still received a significant number of responses in writing (2154- 18.26%) which shows the importance of providing different feedback options.



Survey results showed that 11120 (94.23%) of people using our services felt they were good or very good, we received 310 (2.63%) poor or very poor responses. 373 (3.14%) respondents felt the service was neither good nor poor or answered 'don't know'.

Patient and Service User Satisfaction - Concerns, Complaints and Compliments

We embrace all feedback as an opportunity to improve services. We appreciate it can be difficult to speak up when things go wrong but this is important feedback that we learn from to develop our services. We also like to share when things have gone well, to celebrate good practice.

In 2025/26 the Trust received 1427 compliments, concerns, and complaints. An overall 15.1% decrease in feedback (from 1643) the previous year.

This is a 1.5% increase in complaints and concerns and a 16.1% decrease in compliments. Complaint and concern data has been combined because all expressions of dissatisfaction are recorded as a complaint under the Public Health Service Ombudsman (PHSO) standard which some services have piloted this year.

Although the data for complaints/concerns combined is stable, services shared that not all locally resolved concerns were being recorded. Recording compliments is a continued area for improvement. We therefore anticipate an increase as the PHSO standards are fully put in place in 2026/27.

Year	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Compliments	982	929	965	933	1064	893
Concerns	366	594	544	342	381	254
Complaints	103	101	145	144	145	116
PHSO pilot						164
Total	1451	1624	1654	1419	1590	1427

Complaints

A complaint is an expression of dissatisfaction made to us either verbally or in writing that requires an investigation. Whether the complaint is found to be justified or not, it must be responded to in writing.



There were 285 complaints received in 2025/26. Of the 285, 272 related to LCH services only, 13 related to LCH and other organisations (multi-sector complaints).

LCH is a provider of NHS funded services, and we comply with the NHS regulations. If people are not happy with the outcome of their complaint, they can ask the Health Service Ombudsman for a further review. In 2025/26 the Ombudsman received one complaint for Leeds Community Healthcare NHS Trust. LCH proactively works with the Ombudsman to resolve complaints. The PHSO highlighted areas for improvement, they acknowledged that the Trust had implemented appropriate actions to remedy the impact and therefore did not need to take any further action for a complaint escalated in 2024/25.

Complaints received within the year by Team/Service:

The teams with the highest complaints have been included. The remaining complaints were received across 34 teams with 29 teams receiving 10 (one team) or less complaints and 14 teams received one complaint.

Service	Complaints
Children's and Young People's Mental Health Service	53
Musculoskeletal and Rehabilitation Service (MSK)	52
Leeds Mental Wellbeing Service	37
ICAN South	16
North 2 Adult Neighbourhood Team	14

Numbers of higher incidence of complaints have increased to those of last year. The team with the most complaints was Children's and Young People's Mental Health Service, with a total of 40 complaints made this year and MSK with 37. Both are an increase from 2024/25 where CYMPHS received 24 and MSK 12.

This data is inclusive of the PHSO pilot whereby all expressions of dissatisfaction are recorded as a complaint rather than being separated into concerns and complaints. Both services were part of the initial PHSO pilot and have moved to this method of recording complaints. In addition, both services received significantly less concerns this year, which pinpoints the increase being in relation to the pilot. Overall, CYMPHS received 76 combined complaints and concerns in 2024/25 with a reduction to 40 in 2025/26, and MSK received 68 combined concerns and complaints in 2024/25 and 63 in 2025/26.

Complaints by subject:

Subject	
Clinical judgement/treatment	64
Appointment	25
Attitude, Conduct, Cultural and Dignity Issues	24
Access and Availability	19

Except for CYMPHS and Podiatry, 64 complaints relating to 'Clinical Judgement/Treatment' were evenly spread across the remaining 21 teams.

Effective - means people's care, treatment and support achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

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.

National Clinical Audit and Patient Outcomes Programme (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.

Research and Development



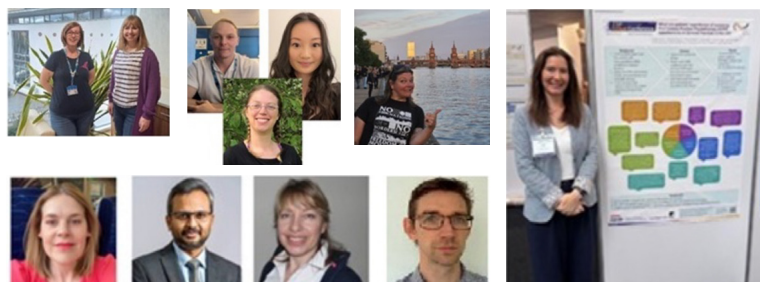
For the third year running, research activity has grown in both the number of studies delivered and breadth of research engagement. In the last 12 months, we have supported 1044 of our patients to access research opportunities, the highest number in five years. Once again, we have had positive feedback from research, with 100% of participants saying they would recommend research at Leeds Community Healthcare NHS Trust.

Our strength as a Community Trust is offering research relevant to the people who use our services and in accessible locations. From schools, health centres and in peoples' homes, we have delivered studies that range from understanding mental health treatments in adults and children, to supporting rehabilitation for children with cerebral palsy (visit www.robust-study.org/about for further information). We've looked at finding the best treatment for working adults with heel pain (visit www.keele.ac.uk/treadon) to improving independence in older adults with heart failure and frailty (visit www.arc-swp.nihr.ac.uk/research/projects/chart-trial). More recently we have been supporting research for people at the end of their lives by exploring daily activity and equitable care.

Our research team has grown in the last 12 months, supported by successful funding applications. We have used this funding to provide an agile and adaptable research approach, offering opportunities to clinical staff on both an ad hoc basis and through our annual research advisor secondment scheme. Having a research team with extensive clinical experience helps us support and deliver research within our clinical services and is a key reason our Trust was the top recruiter in three studies last year.

Our research team is made stronger by colleagues who have won prestigious personal research awards to develop research in Parkinsons, brain injury, first contact musculoskeletal physiotherapy and self-harm. This culture of research is evidenced by the 17 articles published by LCH staff in the last 12 months.

The image opposite shows some of our staff who have taken part in clinical academic development by undertaking internships, research masters, pre-doctoral fellowships, doctoral fellowships and clinical academia.



Get It Right First Time (GIRFT) Programme

The Children and Young People's Mental Health Services (CYPMHS) Get It Right First Time (GIRFT) programme, led by NHS England, helps services improve how they work. Its aim is to reduce unnecessary differences in care, improve access and outcomes for children and young people, and make the best use of resources.

As part of the programme, national clinical experts reviewed our service, including how it is structured, how care is provided, and how staff work. The review found many strengths.

MindMate 
Support Team

It highlighted the effective use of the MindMate Single Point of Access (SPA), which helps make sure referrals are assessed quickly and directed to the right support with clear clinical oversight.

The review also compared our service with others locally and nationally. This showed that while we are performing well in many areas, there are improvements needed in how we record and report data. In some cases, the way information is captured does not fully reflect the work being done or the outcomes achieved.

Positive work to support colleagues was also recognised. This included the Fair Day's Work initiative, which helps teams manage workloads more fairly and supports good job planning. This approach is particularly important given ongoing financial pressures and was highlighted as good practice.

The main recommendations from the GIRFT programme focused on improving how data is recorded and reported, as well as how productivity is measured. Better data will help provide a more accurate picture of the service and support ongoing improvements.

Taking part in the GIRFT programme in 2025 confirmed that the service is providing strong clinical care. It also highlighted areas where improvements are needed. Current systems do not always capture all clinical activity, especially during triage, and do not consistently record outcomes submitted to national datasets. This means waiting times may appear longer than they are, and the level of activity may be underreported.

To address these issues, an action plan has been developed for 2025/26. This includes improving how data flows through systems, strengthening reporting to the Mental Health Services Data Set (MHSDS), and improving how workforce and productivity information is recorded. The plan also includes reviewing how caseloads are managed by looking at approaches used in other services.

These actions will help provide a more accurate understanding of performance, improve the quality of local information, and support further improvements in access, productivity and staff wellbeing across CYPMHS.

Further information on service effectiveness is available in the Quality Account 2025/2026 at www.leedscommunityhealthcare.nhs.uk

Responsive - means services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.

Waiting times

Over the past year, there has been a strong focus on reducing waiting times, with clear improvements across many services. The number of people waiting longer than 18 weeks has reduced by 54%, and those waiting over 52 weeks by 77%, with most services now eliminating long waits of over 40 weeks altogether.

This progress has been driven by targeted action in high-pressure areas, including additional clinics, changes to how referrals are managed, and better use of colleague time, meaning patients have more timely access to services. Although demand remains high in some areas, particularly in the Children's Neurodisability services, plans are in place to continue improving.

Overall, more people are being seen sooner, and services are increasingly able to prioritise those with the greatest need.

Well-led - means leadership, management and governance assure the delivery of high quality person centred care, support learning and innovation, and promote an open and fair culture.

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 sickness 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 2025, in order to support services with maintaining this high level of compliance.

Our 2025/26 Key Performance Indicators

Indicator	Target	2024/25	2025/26
Staff Turnover	14.5%	10.9%	9.2%
Percentage of staff who left the organisation within 12 months	20.0%	21.4%	19.0%
Total sickness absence rate	6.5%	5.9%	6.8%
AfC Staff Appraisal Rate	90.0%	83.5%	80.4%
Statutory and Mandatory Training Compliance	90.0%	88.8%	90.3%
Starters / leavers net movement	0	-12	2
The overall percentage of staff who have identified as BME (Including exec. board members)	14%	13.7%	15.0%
Duty of Candour Breaches	1 per year	5	2
Attributed MRSA Bacteraemia Infections	0 per year	3	0
Clostridium Difficile Infections	3 per year	0	0
Never Event Incidence	0 per year	0	0
CAS Alerts Outstanding	0 per year	1	1
Patient Satisfaction - Percentage of Respondents Reporting a 'Very Good' or 'Good' Experience in Community Care (FFT)	95%	94%	92%
Total Number of Formal Complaints Received	No Target	162	285
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	92%	26.2%	32.6%
Number of patients who waited more than 52 Weeks for a Consultant service	0 per year	1104	448
Percentage of patients waiting less than 6 weeks for a diagnostic test	99%	98.2%	97.5%

Indicator	Target	2024/25	2025/26
Percentage of patients waiting less than 18 weeks for a non-Consultant service	95%	61.6%	81.0%
Compliance in Level 1 and 2 Patient Safety Training	No Target	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 Pressure Ulcers incidents	No Target	145	981
Number of Falls incidents	No Target	106	484
Number of Deteriorating Patient incidents	No Target	11	176
Number of Meatal Tear incidents	No Target	18	47
Number of Clinical Triage incidents	No Target	0	295
Compliance with statutory Duty of Candour	No Target	89.4%	94.4%
Zero tolerance RTT waits over 65 weeks for incomplete pathways	0	851	272
Zero tolerance RTT waits over 78 weeks for incomplete pathways	0	615	198
Community health services two-hour urgent response standard	70%	79.4%	82.7%
Available virtual ward capacity per 100k head of population	No Target	22.9	92.1
Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care	No Target	15	16
% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	95%	50.0%	57.1%
Number of children and young people accessing CAMHS - year to date	No Target	12,585	13,092
Percentage of Children over 5 currently waiting more than 18 weeks for a Neurodevelopmental Assessment	No Target	95.5%	97.8%
No of Patients accessing treatment with LMWS service	No Target	32,364	30,805
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	95%	93.7%	87.4%
'RIDDOR' incidents reported to Health and Safety Executive	No Target	6	6

Indicator	Target	2024/25	2025/26
The overall percentage of staff who have identified as BME (including exec. board members)	14%	13.70%	15.0%
Number of teams who have completed Medicines Code Assurance Check 1st April 2019 versus total number of expected returns	100% by year end	96%	100%
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

Glossary of abbreviations

AfC	Agenda for Change
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Service
CAS	Central Alerting System
FFT	Friends and Family Test
LMWS	Leeds Mental Wellbeing Service
MRSA	Methicillin Resistant Staphylococcus Aureus
PSII	Patient Safety Incident Investigations
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RTT	Referral To Treatment

Sustainability

Progress against the Trust's Green Plan

Achievements

In recognition that the need for healthcare organisations to act on climate change is becoming urgent, the NHS has set two net-zero targets to become the world's first net-zero health service, to achieve carbon net-zero by 2040 for the NHS Carbon Footprint and by 2045 for the NHS Carbon Footprint Plus. From their respective baseline years, NHS organisations are expected to achieve an 80% reduction in their direct carbon emissions by 2032.

We recognise the significant threat climate change poses to our environment and the health of our patients and are committed to be net-zero by 2040. This target will only be achieved with increased focus and determination placed on the sustainability agenda.

The Trust's previous Green Plan (2022-2025) was a foundational plan, with many of the actions and projects aimed at creating a robust sustainability base to measure itself against. Having achieved this, the 2025/28 Green Plan is more ambitious and aims to stop the rise of emissions, stabilise and then facilitate decline by changing the way in which the Trust operates to ensure that sustainability and carbon reduction are considered in every decision and development.

The 2025/28 Green Plan was drafted following a consultation period with staff to gather feedback on the proposed sustainability roadmap and the areas of focus. It was then approved by Trust Board on 10 July 2025.

Aligned to the 'Greener NHS Delivering a Net Zero Health Service' guidance, the Trust's 2025/28 Green Plan remains focused on the Trust's four main CO₂ emitting areas: Estates, Travel, Procurement, and, Waste, however, additional areas have been included that will have a significant impact on emissions. These include Climate Adaptability, Digital, Medicines, and Staff Engagement. Staff are now being encouraged to plan their own sustainability objectives, both as individuals and as teams/services.

The Sustainability and Climate Adaptability Steering Group (SCASG) oversees the implementation of the Green Plan.

You can access our published 2025/28 Green Plan here:

www.leedscommunityhealthcare.nhs.uk/about-us/sustainability/



High impact areas of focus and achievements



During 2025, we have been progressing our Green Plan actions, particularly those that focus on our four main CO₂ emitting areas:

Estate

- A boiler replacement scheme has commenced with two health centres now completed.
- Funding awarded from Greener NHS of £161,834 for LED lighting upgrade across four health centres (Chapelton, Meanwood, Hunslet and Burmantofts). In addition, the Trust has funded LED lighting upgrades across its remaining owned estate.
- Building Management Systems (BMS) have been installed across the estate and will be fully operational by the end of 2025/26.

Travel

- Streamlined specimen collections across multiple sites to reduce the number of collections per day, and utilised existing NHS transport networks to avoid additional vehicle journeys such as taxis.
- Staff held a walking challenge at head office during summer 2025 to encourage staff to walk more during their commute.
- A particular highlight was the Trust being shortlisted for the 2025 National Staff Benefit awards for making electric vehicles more affordable through our salary sacrifice and business lease schemes.

Procurement

- An initial 'Material management' opportunity was explored during 2025, which would reduce the amount of stock (clinical and office products) stored in our buildings and therefore reduce waste. A joint pilot scheme with Leeds and York Partnership NHS Foundation Trust (LYPFT) is now to be considered as part of future business planning. A successful pilot will achieve both financial and sustainability benefits and will provide the rationale for eventual roll out to all sites.
- Supplier commitment: our procurement team completed the evaluation of the top 20 suppliers for LCH and LYPFT, trying to increase the utilisation of suppliers completing the Evergreen questionnaire. For relevant procurements we now request that suppliers provide their carbon reduction plans in line with rule changes described in the Government Commercial Function's document PPN016.
- Identified sites/ services with highest usage of paper, with a targeted approach to reduce usage. Total paper quantity ordered in 2024/25 was 1,069,500 sheets of paper and in 2025/26 is currently 925,000 sheets of paper which is a reduction of 14%.

Waste

There has been improved waste segregation resulting in:

- The reduction in the amount of waste being processed via infectious waste streams.
- Improved methods of off-site waste treatment means that less waste is incinerated (incinerated waste is now 18%) and none goes to landfill.

The Trust has put in place Simpler Recycling, including separating food, waste, and glass for better recycling. A waste batteries collection has also been introduced.

The frequency of waste collections has been closely monitored to identify opportunities to reduce the number of journeys. Our waste contractors are also investing in low-emission vehicles.

Effect on carbon emissions (CO₂e)

All the above are helping to lower carbon emissions and reduced costs. Over the past 12 months, the Trust's carbon emissions have reduced by 9% within categories where the Trust has control: estates, travel and waste. There is an indication that procurement emissions have decreased over the past three years but, as emissions are linked to Trust spend, it is not reflective of true emission decline.

Digital clean-up campaign

The Trust joined in the international 'Digital Clean-up Day' on 21 March 2026 to encourage staff to reduce the Trust's digital carbon footprint by deleting no longer required digitally held information, e.g. old emails, documents and folders, photographs, PowerPoint presentations, etc. Staff were also encouraged to think about their personal digital storage. Posters in our health centre waiting areas offered a gentle prompt for our patients to do the same.

Partnership approach

During 2025/26 we have continued our collaboration with health and care system partners, the NHS West Yorkshire Integrated Care Board and Board level Net-Zero Leads by sharing our objectives, challenges, and best practices, identifying opportunities for scaling improvement initiatives beyond our own organisation.

Conclusion

In the 2025-26 financial year, we recorded a total of 1544.6 t CO₂e emissions (excluding procurement), which is approximately a 14% reduction compared to the baseline year of 2021/22. A combination of a sustainability focus across the Trust, decarbonisation projects with the assistance of external funding, and the full or partial completion of carbon reduction actions in line with the previous and current Green Plan has ensured progress has been made to date and continues to be made into the future.

We remain committed to our 2040 net-zero target and will continue to embed sustainability across all areas of the organisation, seeking funding opportunities where possible.

Task Force on Climate-Related Financial Disclosures (TCFD)

The Group Accounting Model (GAM) follows a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, in line with HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. These TCFD disclosures, as interpreted and adapted for the public sector by the HM Treasury, will be gradually implemented in sustainability reporting until the 2025-26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions, as these are calculated nationally by NHS England. The GAM has also adapted the requirements for scenario analysis in the strategy section of the TCFD disclosures to better fit the needs of the public sector.

The TCFD recommended disclosures, as interpreted and adapted by the GAM are provided below with cross-referencing to relevant sections of the Annual Report and Accounts and other external publications.

Task force on Climate-Related Financial Disclosures (TCFD) Pillars

The Trust's position against the TFCF pillars for climate adaptability is summarised below.

Governance Pillar

The Trust has a clearly defined governance structure to ensure accountability for managing climate-related issues and the implementation of the Trust's Green Plan, which is overseen by the Board, with the Executive Director of Finance and Resources having responsibility for reporting progress and compliance.

The Board formally approves the Trust's Green Plan and receives an annual report on sustainability and climate adaptability progress. This describes the progress made with its objectives and projects, funding opportunities, the Trust's carbon emission data and a comparison against the baseline as well as a trajectory for our net-zero carbon targets, any challenges, and focus areas for the following year.

The Board also receives regular information throughout the year from the Business Committee's assurance reports (see Management role section below).

Management plays an active role in assessing and managing climate-related issues. The Sustainability and Climate Adaptability Steering Group meets quarterly and is chaired by the Executive Director of Finance and Resources, who is the executive sponsor for this programme, with membership including Estates, Procurement, Emergency Planning and Facilities. At every meeting each specialist area provides an update on progress with their various sustainability programmes and projects.

Risks posed by more immediate climate driven extreme weather events continue to be identified, monitored and managed by the Trust's Emergency Preparedness, Resilience and Response (EPRR) function. Actions taken on these risks are reported and discussed at the Sustainability and Climate Adaptability Steering Group.

Following each quarterly Sustainability and Climate Adaptability Steering Group meeting, the Business Committee receives a report that provides a strategic overview of the Trust's performance against its sustainability projects and a report on current carbon emissions.

The Business Committee received the annual report on progress made with the Green Plan, prior to it being presented to the Board.

Strategy Pillar

The Trust is in the early stages of evaluating the impact of climate change on its services and strategies and the challenges associated with measuring the impact of climate change, however it has identified the following climate-related risks and opportunities over the short, medium and long term:

Short-term (1–3 years)

- **Risks:** Increasing fuel prices and unexpected shifts in energy costs, reputation risk of non-compliance or inadequate progress to reduce CO2 emissions. Costs to transition to lower emissions technology. Increased cost of products. Community perceptions of the Trust's contribution to a lower-carbon economy.
- **Opportunities:** Early adoption of energy-efficiency measures along the supply chain, energy efficiency improvements, and cost savings from reduced energy consumption and waste.

Medium-term (3–10 years)

- **Risks:** Not maintaining progress with the movement towards low-emission products. Write-offs and early retirement of existing assets. Potential for mandates on and regulation of carbon-intensive products and services. More frequent and intense weather events.
- **Opportunities:** Sourcing of new products and services aligned with lower carbon emissions to increase the reliability of supply chain and ability to operate under various conditions. Adoption of renewable energy sources reducing exposure to future fossil fuel price increases. A move to more efficient buildings increased value of fixed assets (e.g. highly rated energy efficient buildings).

Long-term (10+ years)

- **Risks:** Severe physical damage to global infrastructure from rising sea levels and extreme temperatures affecting the Trust's premises, operations, supply chain, transport needs, and employee safety and wellbeing.
- **Opportunities:** Building comprehensive resilience throughout NHS services.

The Trust has had limited exposure to climate-related issues. Currently the material impact of risks and opportunities is assessed using the Trust's existing risk management and business planning procedures. The recommended use of scenario analysis to develop the necessary organisational skills and capabilities to assess climate-related risks and opportunities is a key consideration for the Trust to better challenge itself and think more strategically about longer-term risks and their material impact. Climate change will affect performance and the delivery of plans in future years, and the Trust has now utilised the NHS Climate Change Risk Assessment Tool to determine risks in its estate and digital provision:

The Trust's Estates Team has undertaken an assessment of its premises using the NHS Climate Change Risk Assessment Tool to identify physical vulnerabilities, plan mitigation strategies, and to understand how to future-proof the Trust's estate and its facilities against escalating climate risks. Capital planning is already taking account of the changing environment and work has commenced to ensure temperatures in the Trust's owned estate are adequately controlled using building management systems in all buildings and air conditioning installations where appropriate. There are opportunities for the use of emerging technologies such as renewable energy, battery storage, energy efficiency, and carbon capture and storage.

The Digital Department has assessed the impact of climate change on computer hardware systems by utilising the NHS Climate Change Risk Assessment Tool. Controls and mitigation for the identified risks are aligned with the controls the Estates Team has identified for managing changes in buildings temperatures.

With increasingly limited capital to spend, the Trust will prioritise areas of work that will help to reduce its carbon footprint and combat the effects of climate change.

Business continuity plans for all services include planning for adverse weather, loss of building/premises / work environment, loss of information and communications technology (including telephony), utility failure, severe weather, fuel shortage, and supply issues. However, the business continuity plans need to include greater detail on how priority services will be delivered during adverse weather, and plans need to be thoroughly tested using scenario-based assessments..

Risk Management Pillar

The Trust's Annual Governance Statement ([see page 101](#)) provides details of the Trust's risk and control framework within the system of internal control.

This framework provides the methodology employed by the Trust to ensure the consistent and effective management of risk across the Trust. It includes risk treatment options including whether to mitigate, transfer, accept or control risks.

Climate change, emergency planning and business continuity related risks are managed within this framework.

Risks are recorded in the Trust's risk register, along with controls and mitigating actions to manage the risk and these are regularly reviewed by the risk owner and progress is monitored by the Risk Management Committee.

The Trust's risk register contains a risk specifically related to climate adaptability, which currently is described as follows: "Due to the incomplete / inadequate climate adaptability resilience planning across a cross section of the organisation, there is a risk of inadequate response to the impact of flooding, storms and prolonged periods of excessive heat caused by climate change. This could result in the disruption of the delivery of patient care". This risk is currently scored as 'high', which means the Business Committee and Trust Board have oversight.

The Trust's Board Assurance Framework described in Key Risks section and Performance Overview section of the Annual Report, includes the following strategic risk:

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 climate-related risks are currently reflected as a 'high' and aligned to Strategic Risk 5 (Business Continuity), which places them alongside the Trust's highest-rated risks (scores of 16 and 12) in terms of strategic importance. Climate risks are considered to have a system-wide impact due to their cross-cutting nature, escalating likelihood, and ability to compound existing risks.

Collaboration with the Trust's EPRR Team has already been established during the assessment of the climate adaptability preparedness risk. The NHS Climate Change Risk Assessment Tool has been utilised for two major sections of the Trust, digital and estate. Over the next year, there is an aim to further integrate climate adaptability into Trust wide and service specific business continuity plans with input and guidance from the EPRR Team. This action will be monitored by the Sustainability and Climate Adaptability Steering Group.

Metrics and Target Pillar

The Trust's Green plan 2025/28 is the organisation's strategy for achieving progress on carbon reduction, and this is being implemented over a three-year period.

The metrics we have used to develop and assess our carbon footprint, in addition the rationale and methodologies behind their use, are described in detail in our Green Plan.

Here's how we measure our carbon emissions:

Quantitative indicators

We use quantitative key performance indicators for managing climate-related risks and opportunities, including time frames for reaching these targets. More information about our emissions targets is contained in our Green Plan 2025/28.

Qualitative indicators

Ethical sourcing throughout our supply chains helps ensure products are made responsibly and with care for the people behind them.

The Evergreen Sustainable Supplier Assessment is an online tool which enables suppliers to engage with the NHS on their sustainability journey and understand how to align with the NHS net-zero and sustainability ambitions, including those set out in the NHS net-zero supplier roadmap.

The Trust has recently completed an evaluation of the top 20 suppliers to increase the utilisation of suppliers completing the 'Evergreen' questionnaire.

Utilities (gas, electricity, water)

We calculate utilities usage throughout retained and leased estate.

Travel

A calculation of business miles for each vehicle type (petrol, diesel, hybrid, electric) and engine size.

Procurement

The current recommended procurement metrics are linked directly with Trust spend. This does not give an accurate account of carbon emissions but is currently utilised as an indication.

Waste

We calculate tonnage of waste produced for each waste stream (recycle, energy to waste, incineration) and the carbon emissions factors associated with each.

Each of the above quantitative indicators is multiplied by the current published CO₂e factors to measure our tonnage of CO₂ emissions.

By calculating our total carbon emissions (in CO₂e) it has enabled us to:

- Set a baseline for climate action
- Understand the climate impact of our organisation's direct or indirect activities
- Monitor improvements or decline.

Future modelling will include Forward-Looking Metrics: Metrics tracking progress against targets, such as alignment with a 2°C or lower scenario

Performance against targets

The Trust's Green Plan (2025-2028) describes the targets, interventions and trajectory:

2025-2026:

- Installation of LED and BMS Control Systems across estate.
- Refurbishment of Morley Health Centre, ensuring energy saving technologies and fabric upgrades with sustainability in mind. Transition to completely electric, mimicking Seacroft.
- A reduction of petrol and diesel cars on the salary sacrifice by 11%.

2026-2027:

- Solar panel strategy and investment.
- A further reduction of petrol and diesel cars on the salary sacrifice by 11%.

2027-2028:

- Prioritise retained estate for boiler replacement schemes.
- A increase of 5% of EV and ULEV on the grey fleet.

2028-2029:

- Start the transition process away from gas boiler systems throughout retained estate.
- A increase of 5% of EV and ULEV on the grey fleet.

The Trust's carbon emissions are showing a gentle decline over time. In 2025/26 we are slightly ahead of our target for this period (target was projected to be 1650 CO₂ (tonnes), actual emissions were calculated to be 1545 CO₂ (tonnes)).

The decline in emissions is consistent in buildings and estate (from 1165.692968 tCO₂e in 2021/22 to 945.36 tCO₂e in 2025/26), travel (6182598912 tCO₂e in 2021/22 to 945.36 tCO₂e in 2025/26) and waste (24.071 tCO₂e in 2021/22 to 0.518 tCO₂e in 2025/26).

Signed 

Sara Munro, Interim Chief Executive

Date **24 June 2026**

Our Staff

NHS Staff Survey

The annual NHS Staff Survey invites colleagues across the NHS to share their views on working life. It is independently run and provides an important opportunity for colleagues to give feedback on their experience of working in the organisation.

In 2025, 55% of colleagues completed the survey, representing 1,789 responses across the Trust. While slightly lower than the previous year, this continues to demonstrate strong engagement from colleagues across the organisation. This has been supported through coordinated communications and engagement activity, collaboration between teams and services, and visible senior sponsorship from the Chief Executive, directors and general managers.

Results across the seven People Promise themes remained broadly stable compared with 2024. Several themes maintained very similar scores year-on-year, including We are compassionate and inclusive (7.63), We are recognised and rewarded (6.40) and We are safe and healthy (6.26). Other themes showed only small movements, with We each have a voice that counts (6.99) and We work flexibly (6.92) remaining close to last year's scores, and We are always learning (5.93) showing a small improvement. Overall, these results indicate that colleagues' experience across



the core People Promise areas has remained consistent over the past year.

Our Staff Engagement score remained largely stable at 6.92, which is consistent with the previous year, and Staff Morale remained broadly consistent at 6.03, with only minimal movement compared with 2024. These results suggest that overall engagement and morale across the organisation have remained steady.

In comparison to our benchmark group of Community Trusts, our scores across the People Promise themes are generally close to the benchmark averages for similar organisations. For example, We are compassionate and inclusive (7.70) and We each have a voice that counts (6.98) align with the benchmark averages, while other themes sit only slightly above or below those averages. This indicates that overall staff experience here is broadly consistent with that reported across comparable community organisations nationally.

You can find our full results and benchmark reports by visiting the NHS Staff Survey website and searching **Leeds Community Healthcare - Local Results**
www.nhsstaffsurveys.com

Awards and recognition

During the year we were delighted that so many individuals, teams and services received national, regional and local acknowledgement.



External awards

2026 Awards

- David Roberts - winner of the AHP Digital Practice Award 2025, awarded by NHS England.
- Rajbir Sagoo invited to Number 10 for Vaisakhi Event acknowledging her work in for the NHS over the years (representing North East and Yorkshire).
- Sylvester Bolade - shortlisted for Cyber Associates Network (CAN) Rising Star Award.

2025 Awards

- David Roberts nominated for a Chief Officer AHP Award.
- Liz Grogan honoured with silver Chief Nursing Officer Award - Leeds Community Healthcare.
- Leeds' HomeFirst Programme shortlisted for HSJ Award.
- LCH Healthcare support worker receives Chief Nursing Officer Award for Teamwork and Improving Patient Care.
- LCH nominated for Employee Benefit Award.
- LCH Healthcare support worker receives Chief Nursing Officer Award for Compassion.
- LCH adult dietitians shortlisted for HSJ Partnership Award.
- Kirsten Lamb awarded an Education Award.
- Antimicrobial Resistance (AMR) Framework for Roma Communities shortlisted for Antibiotic Guardian Award.

- Dr Jill Halstead-Rastrick awarded a Senior Clinical Research and Practitioner Award.
- Leeds' HomeFirst Programme shortlisted for MJ Achievement Award.
- HomeFirst Programme shortlisted for the LGC Awards.
- Leeds Sexual Health shortlisted for HSJ Digital Award.
- The Homeless Health and Inclusion/Homeless Health Intervention Beds teams won a Leeds Quality and Care Award.

Details of our awards during the year can be found on our website:

<https://www.leedscommunityhealthcare.nhs.uk/our-news/awards/>

Internal awards

We continue to celebrate colleague achievements through our monthly recognition scheme, Thanks a Bunch. This year, our directors hand delivered surprise bouquets of flowers and certificates to unsuspecting staff members who had been nominated by colleagues for being shining examples of the Trust behaviours.

Our 2025/26 annual staff awards, the Thank You Event, builds upon this monthly recognition scheme, with directors surprising winning and highly commended colleagues and teams at bases and locations across the city. This year we received 88 nominations from across the organisation in the following categories: Leader of the Year, Team of the Year, Kate Granger Patient Care, Making Stuff Better, Project of the Year and Colleague of Year.

Inclusion and belonging

Over the past year, the Trust has continued to strengthen its commitment to creating an inclusive, equitable and compassionate working environment, with a clear focus on ensuring that every colleague feels valued, respected and able to thrive.

Key achievements include improvements to the accessibility of internal systems and the delivery of targeted initiatives to support under represented groups. We have also enhanced our workforce data and insight capabilities, enabling more accurate monitoring of representation and staff experience. These insights have informed refreshed Inclusion Action Plans aligned to the NHS England High Impact Actions, as well as the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap priorities.

The Trust's latest WRES and WDES results show continued improvement, including reductions in bullying and harassment and stronger confidence in reasonable adjustments. While some differences in experience remain for Black and Minority Ethnic and disabled colleagues, particularly in career progression and staff engagement, the overall direction of travel is positive. These findings are shaping targeted actions to strengthen inclusive leadership, improve psychological safety and review recruitment and selection processes to support greater fairness and opportunity, with progress monitored at Board level.

During the year, we have further strengthened staff voice and psychological safety by creating dedicated safe spaces for colleagues to share experiences, raise concerns and help shape inclusion priorities. The Trust's Equality, Diversity and Inclusion (EDI) Forum has also been refreshed, with broader membership to support stronger collaboration between staff

networks, operational teams and senior leaders. Inclusion is now a standing agenda item at the People and Culture Committee, ensuring consistent oversight, accountability and visibility at Board level.

The Trust has continued to champion inclusive leadership, with senior leaders participating in development sessions focused on allyship, No Bystanders and psychologically safe leadership. We have also strengthened partnership working across the Leeds health and care system, contributing to collective efforts to reduce inequalities and improve outcomes for our diverse communities. Together, these actions support our ambition to be an organisation where diversity is celebrated, barriers are reduced and colleagues feel empowered to bring their whole selves to work.

Partnership working

Staffside play an important role in positive and constructive relationships with management, through open communication, mutual respect and shared decision-making. We recognise accredited trade union representatives and professional bodies meeting formally on a quarterly basis at our JNCF and JNC.

Staff health and wellbeing

The health and wellbeing (HWB) of our staff is a key focus of our work and is represented within our annual Trust Priorities. During the last year we have made progress across a wide range of health and wellbeing topics in a variety of ways:

Direct support:

- The Critical Incident Staff Support Pathway (CrISSP) was relaunched in April 2025 following a 3-month gap and has been promoted at business unit celebration days and other LCH events. Referrals have increased over the year, with 36 debriefs conducted to date, across all business units, and three additional facilitators trained over the year. Feedback from staff has been overwhelmingly positive, with participants citing the support, normalisation of the impact of events, and the chance to reflect with their teams as beneficial. Most common themes are patient deaths (expected and unexpected) and safeguarding related cases (adult and child).
- Reflective space, using a variety of psychological and Organisational Development (OD) models, has also been provided to specific teams in both clinical and operational business units. This has helped staff to manage change, navigate new ways of working, wellbeing or distress due to service pressures.
- Approximately 53 individuals have requested psychological support, resulting in psychological consultation and follow up, advice and support or onward referral.
- Following the national protests against asylum seekers and refugees, we have supported a series of safe spaces, led by the Race Equality Network, for all LCH with the aim of hearing from and supporting staff from diverse cultural backgrounds who are affected by the sociopolitical climate, and their allies.



Training and awareness events:

- We have increased awareness of our Employee Assistance Programme and App, hosted an all-service webinar in December 2025 and February 2026, and encouraged use of the programme. Regular reports and liaison with the provider show that we fall into their expected range of uptake (8-12% employees per year).
- We have delivered training on 'Managing Yourself and Your Team through Change' to two cohorts of managers, with a further session planned in March 2026.
- We have delivered an Autism awareness workshop to People Partners and Administrators Operational team to promote understanding of lived experience and the need for individual reasonable adjustments. Work is also underway to coproduce resources for understanding and supporting staff with ADHD.
- As part of our visible commitment to staff wellbeing, we have renewed our Mindful Employer Charter and continue to access and share resources to support staff wellbeing.

Financial Performance

The fantastic operational and clinical achievements described in this annual report are underpinned by the Trust's financial performance for the year. Once again, we have met all our financial targets for the year.

The Trust has statutory financial duties to carry out our functions effectively, efficiently and economically and initially set a financial plan to breakeven in 2025/26. However, work continued across the West Yorkshire Integrated Care System and in response to a challenging system position a revised target surplus of £900k was agreed by the Board in June 2025. Through a combination of one-off measures, including the release of historic accruals no longer required and budget underspends the Trust ended the year with an overall adjusted surplus of £951k.

The financial performance recognised by NHS England excludes a number of technical adjustments such as building impairments and capital grants and donations, this is summarised in the table below.

Summary	2025-26 £000
Operating Income	245,846
Operating Expenses	(247,325)
Operating surplus/(deficit) from continuing operations	(1,479)
Net Financing Costs	1,454
Other gains/losses	(112)
Surplus/(deficit) for the year	(137)
Adjusting items impairment and donated depreciation	1,088
Adjusted financial performance surplus/(deficit) for the year	951

Efficiency Programme

2025/26 is year two of the Trust's quality and value savings programme, which is how we look to deliver our required savings targets through a range of clinical and non-clinical programmes of service transformation. For 2025/26 the overall savings target was £14m. During the year we placed a relentless focus on achieving savings recurrently, identifying almost £12m, 85% of the target.

Efficiency savings	2025/26 £k
Service Pathway Redesign	5.7
Estates Programme	0.5
Business Processes	2.1
Procurement	0.3
Corporate Transformation	1.3
Interest Receivable	2.0
Total Savings 2025/26	11.9

Most savings, £5.7m have been delivered through Service and Pathway Redesign, reflecting progress in the transformation of pathways and care models within the neighbourhood teams, Children and Young People's Mental Health Services and the Leeds Mental Wellbeing Service.

£3.4m was delivered through corporate transformation programmes across Finance, Operational Management and Workforce services and business processes.

Further savings of £0.5m from initiatives as part of the Strategic Estates Programme were achieved through revised rent and security arrangements. Procurement initiatives, driven by improved contract management and a focus on cost avoidance have delivered savings of £0.3m. Our strong cash position meant we were able to generate £1.4m of additional interest receivable, reflecting the favourable interest rates earlier in the financial year.

Service engagement is the cornerstone of our approach to delivery of efficiency savings and so we acknowledged at the outset that there would be some delays in the release of recurrent savings; to mitigate this we maintained our range of grip and control measures on vacancies and discretionary spend which ensured that any shortfalls in-year were supplemented by non-recurrent measures.

This range of financial control measures we had in place throughout 2025/26 meant that we were able to invest more resources, non-recurrently, including supporting a campaign to reduce our waiting lists across a range of our services. Examples of the investments we have made include:

- £0.35m made to enhance the pre-school paediatric neuro disability assessments and establishing a nurse-led intervention whether or not an autism diagnosis had been made.
- £0.55m was spent on increasing the number of dental appointments we offered.
- £0.2m spent on additional medical capacity for the Children's and Young People's Mental Health Services to reduce waiting times for appointments.
- £0.2m was spent on the Urology and Colorectal service additional sessions spread across a longer day.

The impact these investments had on the time patients were waiting for access to our services can be seen at the Responsive Review in the Performance Analysis in this report on [page 27](#).

This was all alongside contributing positively to the West Yorkshire Integrated Care System by delivering our agreed target surplus and by managing the costs of rising demand for our services as Leeds Commissioners were unable to provide financial support for the cost of growth.

Cash and Capital Expenditure

The Trust continues to have a strong cash balance which is a cornerstone to our financial strategy. This enables us to pay staff, suppliers and invest in our estates and clinical equipment effectively. At the end of the year, we had a cash balance of £49.9m. The strong cash position enabled us to exceed the better payment practice code of paying 95% of suppliers' invoices within 30 days.

The Trust's cash position also enabled us to bring forward some of our capital plans from 2026/27 into 2025/26 as the national capital limits going forward are challenging and may curtail our ambition.

We spent £10.2m on capital schemes during 2025/26 as follows:

Scheme	£k
Estates Strategic Developments	1,314
Building Refurbishment and Backlog Maintenance	433
LED Lighting	612
Air Conditioning Units	2,846
Safety Alarms	132
IT Infrastructure	910
Digital Strategy	456
Clinical Equipment	540
Subtotal Operational Capital Expenditure	7,243
Lease Cars	338
Thornton Health Centre	579
Lease Renewals	917
Community Healthcare Partnership Properties	1,797
White Rose Office Park	(328)
Rutland Lodge Health Centre	17
Park Edge Health Centre	83
St Georges Centre	620
Lease Remeasurements	2,189
Subtotal Right of Use Assets	3,106
Owned Asset Disposals	(84)
Right of Use Asset Disposals	(44)
Subtotal Asset Disposals	(128)
Total Capital Expenditure	10,221

Addressing backlog maintenance and refurbishing our properties to a high standard is a key enabler of the Trust's strategic priorities. The Estates team led a wide and varied programme of capital improvements during 2025/26. Key projects included refurbishment at Morley Health Centre, where the roof was replaced with a fully insulated system and all windows and most external doors were replaced, supporting carbon reduction. The reception area was fully renovated to address ongoing issues and improve both patient and staff experience. Communal toilets and staff areas were refurbished, and a new staff breakout area was created from a redundant space at the centre of the building.

Refurbishment work at Burmantofts Health Centre addressed long-standing issues to improve safe circulation around the building, alongside the creation of an alternative reception area and additional clinical space to benefit both staff and patients and improve how the building functions.

Safety and security for patients and staff have been improved with the installation of hard-wired panic alarms to all sites that have been dependent on less reliable mobile systems.

All the Trust's owned buildings are now fully air-conditioned, the £2.8m investment addressing previous variation in provision between sites and individual rooms. This work has improved working conditions for staff and increased comfort for patients.

In addition, we have continued to make progress against our Green Plan and our ambition of achieving net-zero by 2040, LED lighting has been installed across all health centres in line with LCH's green policy at a total cost of £0.6m, this was funded in part by national public dividend capital.

The delivery of the Trust's digital strategy was supported by £0.5m of investment during the year as we seek to modernise how our services work. This included investing in the roll out of digital letters, improving communication and reducing the administrative burden on the organisation. Developing the patient information portal thereby increasing patient access to information about their care and offering an opportunity for self-help initiatives. We revised our care records to update the Yorkshire and Humber single care record system that supports patient safety and ensures our clinicians have access to the right information at the right time. During 2025/26 we have also put in the foundations of a new e-community system which will assist us with the allocation of staffing resources in the future. This digital investment has been alongside continued investment into our IT asset replacement and cyber security programmes.

As required under accounting rules, our capital expenditure includes property leases; during the year we renewed our lease commitments for Thornton Health Centre ensuring we can continue to provide our services in properties accessible to the communities we serve; in addition to this, rent reviews on our existing leases resulted in increases to the leased assets (known as a remeasurement).

Key Financial Performance Targets

We have continued our strong track record of financial performance achieving all our key statutory and regulatory targets.

In addition to the performance already described we were able to maintain our agency costs at planned levels; this is a significant achievement given the challenging labour market and the need to retain an element of flexibility across our workforce as we transformed through quality and value and invested non-recurrently in reducing our waiting lists.

We recognise the importance of our supply chain and throughout the year have consistently paid the majority of our suppliers on time as evidenced below through achievement of the Better Payment Practice Code.

Key Financial Duties	Plan	Outturn	Variance	Achieved
Surplus on income and expenditure	£0k	£951k	£951k	✓
Remain within Capital Resource Limit*	£10,221k	£10,221k	0	✓
Capital Cost Absorption Rate	3.50%	3.50%	0.00%	✓
Agency	£2,859k	£2,833k	£26k	✓
Better Payment Practice Code:				
Non-NHS invoices - number	95%	95%	+2%	✓
Non-NHS invoices - value	95%	97%	+2%	✓
NHS invoices - number	95%	99%	+4%	✓
NHS invoices - value	95%	99%	+4%	✓

*Target confirmed after year end.

Forward look

Like most NHS providers the financial challenges for Leeds Community Healthcare remain significant and the unprecedented structural changes for the wider NHS, bringing together NHS England and the Department of Health and Social Care along with Integrated Care Boards being redesigned, mean the environment we are working in is a little uncertain.

Nevertheless, we recognise and embrace the opportunities these changes can bring to ensuring our services remain financially and clinically sustainable.

During 2026/27 we will be working on the merger with Leeds and York Partnership NHS Foundation Trust, this will result in a larger more resilient organisation better equipped to face the future and deliver on the 10-year health Plan Government's out of hospital, care closer to home agenda.

The merger will build on the strong foundations of both organisations to deliver safe, effective and affordable care to our community.



A handwritten signature in black ink that reads "A. Osborne". The signature is written in a cursive, flowing style.

Andrea Osborne

Executive Director of Finance and Resources

Legal obligations and how we are meeting them

Improving Health Equity, Inclusion and Wellbeing

Annual health equity statement

This is our response to the Statement on Information on Health Inequalities, outlining the extent to which we have exercised our functions in line with the 5 domains:



Understanding health needs:

Draw on local analysis, demographic insight and population health outcomes data to identify risk factors for health inequalities and Core20PLUS population groups.

Use qualitative intelligence and community engagement to challenge quantitative sources.



Understanding healthcare access, experience and outcomes:

Disaggregate data (at a minimum by ethnicity, deprivation, age and sex) and analyse core performance data to identify drivers of unwarranted variation in access and outcomes across population groups and geographies, including PLUS groups.



Improving data quality, collection and analysis:

Address data quality issues by triangulating sources and identifying gaps in datasets (including where key demographic data is recorded as unknown), taking practical steps to make systematic improvements, with a focus on ethnicity, housing and disability recording.



Using information on healthcare inequalities:

Use information on healthcare inequalities to develop actionable insights that inform strategic commissioning and service delivery.

Evaluate impact and embed information routinely into board reporting and governance mechanisms.



Publishing information:

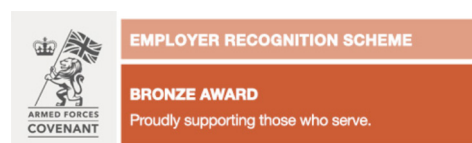
At a minimum, publish information on healthcare inequalities as part of annual reports.

Embed health inequalities data into other data publications throughout the financial year, such as public board papers, through any relevant channels.



It also demonstrates how we meet our statutory duties relating to health equity:

- **Public Sector Equality Duty** to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out activities. Our Equity and Quality Impact Assessment goes beyond the removal or minimisation of disadvantages on the basis of protected characteristics to align with NHSE Equality and Health Inequality Assessments, including focus on deprivation, health inclusion and other groups at risk of worse health outcomes. These are also included in equity impact assessments in policy development and review.
- **Accessible Information Standard** to identify, record, flag, share, meet and review the communication needs of people with disabilities and sensory impairments which is being delivered through our 'About Me' project and a range of communication improvements, supporting Leeds-wide commitment to improving 'the 3Cs' – communication, compassion and coordination.
- **Equality Delivery System (EDS22)**, the national framework for assessing equality in the NHS, with Domain 1 focused on commissioned services and this year included 0-19 service, Long Covid Rehabilitation Services and, Seacroft and Crossgates respiratory pilot, rated as 'Achieving' and with associated improvement plans relating to data availability and analysis, cultural competency and 3rd sector engagement.
- **Patient and Carer Race Equality Framework (PCREF)**, the anti-racism framework for mental health services, which in LCH relates directly to Leeds Mental Wellbeing Service and Children and Young People's Mental Health Services although our own Racial Equity in Care improvement work has been extended across all services, with improvements focused on lived experience, data and analysis, culturally appropriate service delivery including interpreting and translation.
- **Armed Forces Covenant** to have due regard to the principles of the covenant for currently serving members of the UK Armed Forces (regular and reserve), veterans and family members and ensure they are not disadvantaged as a result of their service. This work is aligned to our Veterans Covenant Healthcare Alliance (VCHA) accreditation and associated workplan, focused on raising awareness of the needs of the Armed Forces community and data quality improvements to enable analysis of key performance metrics.



EMPLOYER RECOGNITION SCHEME

BRONZE AWARD

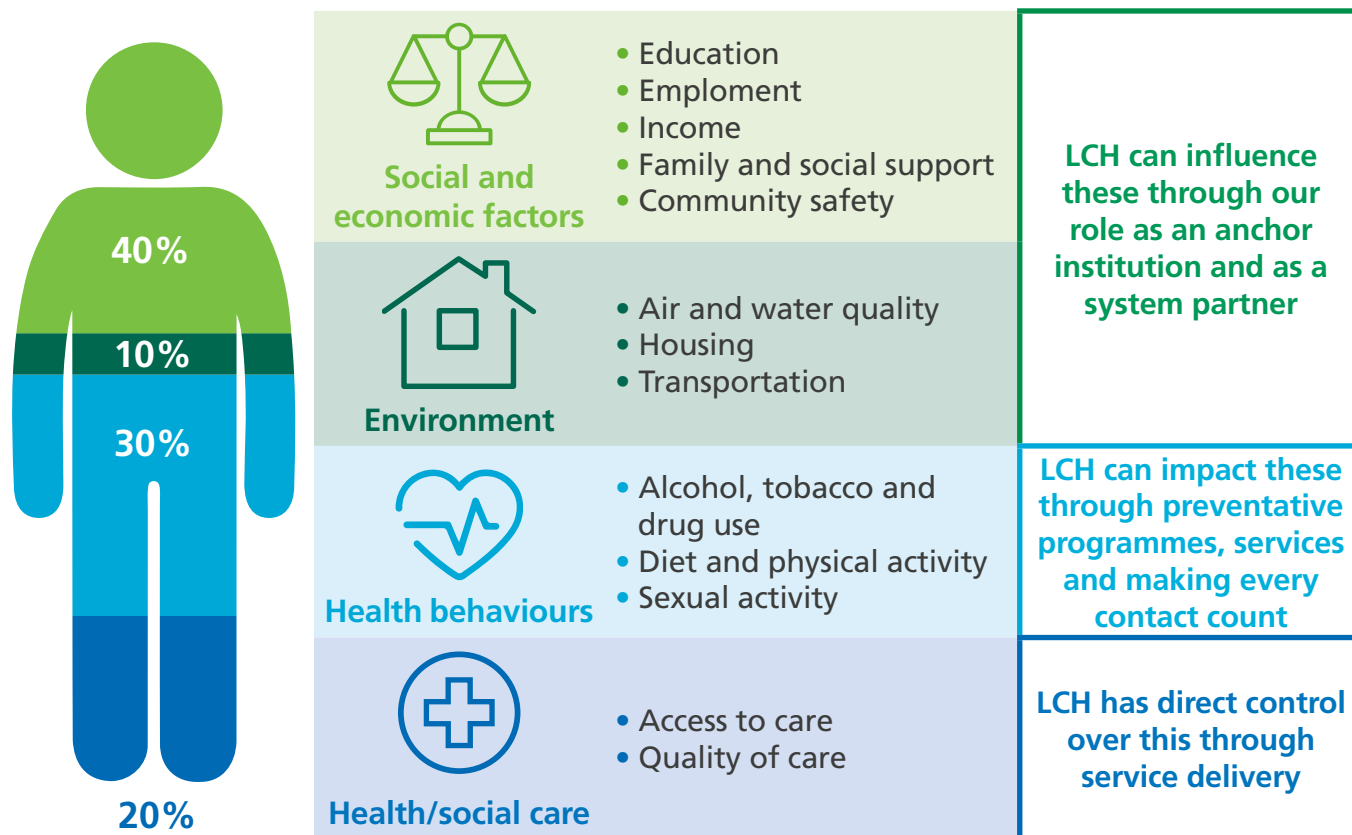
Proudly supporting those who serve.

LCH's commitment to identifying and addressing inequity in care and pathways

Our Health Equity strategy and plans are LCH's response to how we address unfair and avoidable differences in the health of different groups and communities, by working with communities and partners to create equitable care and pathways. We recognise the range of modifiable determinants of health and contribute where we are able (see diagram on next page), for example [Making Every Contact Count](#) conversations can contribute to improvements in social, economic and environmental factors, working with partners as a [Marmot city to create a fairer, healthier Leeds](#), and our equity improvement in children's services contributing to addressing inequity in educational attainment. This report, however,

focusses on our priority to identify and address inequity in care and pathways, being the areas over which we have direct control.

Modifiable determinants of health



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

Our first Health Equity strategy ran from 2021-24, extended with two additional annual plans. In 2025, we developed a new five-year tactical plan for health equity, to sit under the developing trustwide five-year plan.

In 2021 LCH determined that, due to the importance of the health equity agenda in everything that we do, Board should have direct oversight of the health equity programme. Aligned to the decision to make this a fifth strategic goal in 2023, equity risks (BAF7) are managed by Quality Committee and an equity question has been added to the Board and committee cover paper template to support chairs to monitor their committee performance and content against equity. Delivery of statutory equity requirements are reported through Quality Assurance and Improvement Group (QAIG), to Quality Committee and on to Board.

Alongside the inclusion of equity in governance mechanisms, equity is considered in other workstreams. For example, in each Quality and Value Board agenda there is an 'equity, quality and finance pause', adapted from the [Virginia Mason Institute Equity Pause tool](#) that specifically asks attendees to raise any equity implications that have not been discussed or addressed yet in the meeting.

Understanding our population and its health needs

We work with public health colleagues, statutory and third sector providers and communities to develop and use a shared understanding of population needs. This year, this has included a joint presentation to [Leeds Adults, Health and Active Lifestyles Scrutiny Board](#), and using the Director of Public Health Annual Report [‘Heat in our city – our health in a warming Leeds’](#) to focus advice and support for patients most vulnerable to the impact of heat on health. Using national and local data sets such as [Leeds Observatory](#) along with our own equity dashboards, which can be analysed at service, business unit and Trust-wide levels, we are able to identify population groups at risk of worse access, experience and outcomes. This quantitative data is triangulated with qualitative insight through our own feedback and engagement mechanisms, along with sources of existing insight such as [West Yorkshire Insights Library](#) and [Healthwatch Leeds](#), including the [How Does It Feel For Me videos](#).

As a result of this work, we take an approach to equity improvements that recognises that a person’s social identities (such as race, gender class and sexuality) do not exist separately but overlap to create unique and complex experiences. Our initial focus though, is on improvements to access, experience and outcomes for four core groups, aligned to the delivery of key statutory requirements, national, and local priorities.

Population group	Requirements and priorities relating to this group	Inequity for this population	Example achievements in 2025/6
People living in deprivation, incorporating inclusion health groups	Leeds ambition to improve the health of the poorest the fastest Core20PLUS5 (Adults and Children)	People living in deprivation experience poorer health outcomes and face barriers to accessing healthcare. Digital exclusion and low levels of health literacy play a part in this.	Decrease in likelihood of patients in our most deprived areas (IMD1) waiting longer for consultant-led services ‘Support to attend your appointment’ page on Information Hub. Digital inclusion and health literacy screening and recording of needs now included in Electronic Patient Records. Delivery of health literacy training to 49 staff.
Racialised communities	Patient and Carer Race Equality Framework (PCREF) NHS England interpreting and translation improvement framework NHS England ethnicity recording improvement plan.	Racial inequities continue in access, experience and outcomes. People with limited English proficiency can face barriers to receiving care and be at additional risk of patient safety incidents. This can put their health at risk and contributes to health inequalities.	Ethnicity recording at 94.2% Implementation of new interpreting and translation service. Interpreters provided in 58 languages (40% classed as rare languages). Cultural conversations programme support delivered to 64 staff across 23 services.

Population group	Requirements and priorities relating to this group	Inequity for this population	Example achievements in 2025/6
People with disabilities, sensory impairments and Learning Disabilities	Accessible Information Standards Reasonable Adjustments Learning Disability Standards	People may experience barriers to communication and access without appropriate adjustments, impacting experience and outcomes.	'About Me' template and visualisation on SystmOne launched to record and share communication and other reasonable adjustments. Production of Easy-Read patient and carer information.
Armed Forces community	Armed Forces Covenant	The Armed Forces community may have distinct health needs relating to their service or face barriers to access.	Accreditation 1-year review Delivery of national training plan to raise awareness among staff Leeds City Remembrance Day Parade and wreath laying Recording of Armed Forces status on Electronic Patient Record.

You can read the full [Health Equity Report for 2025/26](#) on our website.

You can also read more about this in our 2025/26 Quality Account on our website: www.leedscommunityhealthcare.nhs.uk

Emergency Preparedness, Resilience and Response

Leeds Community Healthcare continues to fulfil its requirements as a provider of NHS-funded healthcare as set out in the Civil Contingencies Act 2004. Additionally, all NHS Trusts are required to adhere to the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework and to take part in the annual assurance audit against the NHSE Core Standards. The purpose of this process is to assess the preparedness of the NHS – both commissioners and providers - against a common set of NHS EPRR core standards to provide assurance that NHS Trusts, NHS Integrated Care Boards and NHS England are resilient and prepared to respond to any form of disruption to normal service provision. This also includes being able to respond to incidents and emergencies whilst maintaining the ability to continue to deliver safe patient care.

For the year 2024/25 the Trust has demonstrated considerable improvement in many of the key areas of the core standards in comparison to 2023/24. The 2024/25 EPRR workplan has focused on the areas of non-compliance to address the outstanding core standards. Of the 58 Core standards relevant to Community Trusts, LCH were able to declare 50 fully and eight partially compliant standards. The final scoring leading to LCH declaring partial compliance. The Trust will however be required to review all core standards ahead of the October 2026 submission.

Plan updates

Throughout the year Emergency Plans and Policies have been reviewed and updated in line with the latest NHSE guidance.

Exercising

All three of the Trust's Business Units have tested their Business Continuity Plans during the year. The Specialist and Children's Business Units focused their exercises on IT Disruption/ Cyber, and the Adult Business Unit selected Adverse Weather in order to address challenges to service delivery experienced during winter 2024/25. The delivery of each exercise was supported by the Emergency Planning Manager, full debriefs were prepared with learning being incorporated into Business Continuity Plans and shared through the Trust Learning and Exercising Group.

Internal Audit review of the LCH NHSE Core Standards Assurance Submission

An Internal Audit review was scheduled to take place ahead of the EPRR Core Standards Submission date in October 2025, however the visit was deferred to December 2025/ January 2026, however the Trust has gained valuable feedback and recommendations which have been incorporated into the EPRR workplan in preparation for the 2026 submission.

Meetings

The Emergency Planning Manager regularly attends the Yorkshire and Humber Mental Health and Community EPRR Forum, the LCH internal Infection Prevention Control Group and the Sustainability and Climate Adaptability Steering Group. The Trust also attends the WY Local Health Resilience Partnership (LHRP).

Trust Learning and Exercising Group

This group, chaired by the Trust's Accountable Emergency Officer (AEO), is now well established and has continued to meet regularly throughout the year. The group is well attended and addresses issues regarding on-call, the development and maintenance of the Trust Business Continuity Management System (BCMS) and arrangements, testing and exercising and EPRR training. The group also provides a forum to share learning from exercises and incidents at national, regional and local level ensuring the Trust is regularly reviewing its emergency plans and demonstrating continuous improvement of its business continuity and emergency response planning arrangements in line with the NHSE Core Standards.

Training

The Learning and Exercising Group provides a valuable learning and training forum for our Trust on-call Managers. The Trust has supported all 2nd on-call managers in undertaking relevant EPRR training in line with NHSE requirements. The Trust focus has been the development of Training portfolios for strategic and tactical commanders which include Principles of Health Command, JESIP and Legal Awareness training.

EPRR and relevant Trust colleagues attended focused workshops organised by NHS NE&Y and the WY ICB in regard to Energy Resilience (May 2025), Cyber Security Resilience (June 2025) and a Winter Resilience Webinar (Nov 2025) in addition to the UKHSA Adverse Weather and Health Plan launch.

National Exercise

Between September and November 2025 the Trust took part in Exercise Pegasus, a phased exercise to test pandemic response preparedness for a simulated novel virus. The exercise was led the UK Health Security Agency (UKHSA) and the Department of Health and Social Care (DHSC) and co-ordinated at a local level by the West Yorkshire Local Resilience Forum.

Chemical, Biological, Radiological and Nuclear (CBRN) Planning

Working alongside Admin/Front of House colleagues the Initial Operational Response (IOR) grab bags have been upgraded and refreshed on reception desks across the LCH estate making them clearly visible and more accessible should they be required to respond to an incident.

Events

The Trust has developed plans for several large events with the potential to impact service delivery during the year. These include the Rob Burrow Marathon, Leeds Festival, Leeds 10K and the Abbey Dash. July 2025 also saw the launch of a new Iron Man event based in the north of the city.

Governance

Emergency Planning has continued to report into the Trust Leadership Team, Business Committee and Trust Board as scheduled throughout the year.

Health and Safety

We are committed to maintaining an environment where the health and safety of staff, patients, visitors, contractors, and the public is assured. This is in line with the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999.

We recognise that putting in place effective health and safety arrangements depends on managers, staff and their representatives working together at all levels.

The Health and Safety Group is the forum that enables staff to be involved in developing and reviewing the Trust's health and safety arrangements. The Group, which met four times in 2025/26 was chaired by the Executive Director of Operations and its membership includes staff side representatives.

The Health and Safety Group reviews and proposes changes and developments of the health and safety management system to make sure there is continuous improvement against health and safety performance.

Counter Fraud, Bribery and Corruption

We do not tolerate fraud and work hard to prevent, deter, detect and investigate it.

We have a Local Counter Fraud Specialist (LCFS) and there are a number of policies in place to support countering fraud, bribery and corruption. This work is overseen by the Trust's Executive Director of Finance and Resources with regular oversight and scrutiny undertaken by Audit Committee. It is our policy that all allegations of fraud must be referred to the Trust's LCFS or Executive Director of Finance and Resources. We raise

awareness of all aspects of fraud and regularly publish newsletters / articles, run training programmes for our staff and teams as well as having a dedicated intranet page that directs staff to key information and contacts so they can refer issues directly to the LCFS.

Our counter fraud work complies with all relevant standards and annually we complete a Counter Fraud Functional Standard Return (CFFSR) which supports us to self-review the counter fraud, bribery and corruption work that we have carried out over the previous twelve months.

We can confirm that the CFFSR shows a green rating across all requirements for 2025/26.

Modern Slavery and Human Trafficking Statement

In accordance with the Modern Slavery Act 2015, Leeds Community Healthcare can confirm that it meets its responsibilities under this act. As an NHS organisation, suppliers are subject to standard NHS terms and conditions.

Disclosure of Personal Data Related Incidents

The UK GDPR and the related Data Protection Act 2018 (collectively 'Data Protection Legislation'), and the Common Law Duty of Confidentiality are the primary legal frameworks under which the Trust processes Personal Data.

These pieces of legislation outline our obligations and responsibilities regarding the Personal Data we hold and use, and the rights that individuals may have over that Personal Data.

Included within these obligations is the requirement that incidents evaluated as being externally reportable due to non-compliance with legislation must be reported to the Information Commissioner's Office (ICO), and in line with NHS requirements this is done through NHS Digital's Data Security and Protection Toolkit (DSPT).

For details of the personal data related incidents reported by the Trust during 2024/25 please see the Annual Governance Statement which starts on [page 101](#).

Safeguarding

Safeguarding means working collaboratively with families and with partner organisations across health and social care to ensure every individual is protected from abuse, neglect, and emotional harm, and supported to live safely and free from harm.

LCH is committed to promoting the safety and wellbeing of our communities through strong multi agency partnerships and meaningful public engagement, in line with our organisation's vision and values. We recognise Leeds City Council's Social Work service as the lead agency for safeguarding in the city.



The Trust's three year Safeguarding Strategy (2023–2026), which sets out our priorities and direction, continues to progress as planned. The strategy reinforces our commitment to making safeguarding a shared responsibility and highlights its central importance in meeting our duty of care. As we begin drafting the Safeguarding Strategy for 2026–2029, we will ensure it fully reflects and incorporates the implications and opportunities arising from our upcoming merger with Leeds and York Partnership NHS Foundation Trust (LYPFT).

LCH safeguarding team work extremely hard to ensure awareness and training where required for new and emerging safeguarding themes.

Duty of Candour

The Quality Committee provides systematic oversight of the Trust's adherence to Duty of Candour requirements. Through regular monitoring, the Committee ensures that all relevant incidents are accurately identified as safety notifiable and that the following statutory obligations are fulfilled:

- A proportionate investigation was undertaken to establish the initial circumstances of the incident, determine what occurred, identify contributory factors, and highlight areas for improvement.
- Each applicable incident was formally considered at a Rapid Review meeting or a Duty of Candour Decision Meeting.
- Individuals affected by the incident were informed in a timely and appropriate manner, offered the necessary apologies, and provided with any immediate learning arising from the event.
- Those affected received a clear explanation of the proposed investigative process and were invited to participate, including the opportunity to raise any questions they wished to be addressed as part of the investigation.

Going Concern Assessment

Going Concern is an accounting principle that requires organisations to consider whether they can continue their operations for the foreseeable future when preparing their Accounts.

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

The Board considered the matter of the Trust as a going concern at its meeting on 27 March 2026. Our formal financial reporting begins on [page 100](#).

Signed  **Sara Munro**, Interim Chief Executive

Date 24 June 2026

Accountability Report

Corporate Governance Report

The Trust Board - What we do and how we do it

Along with all NHS trusts across the country, we have a Board of Directors to guide our work. The purpose of our Board is to govern effectively, and to build patient, public and stakeholder confidence that health and healthcare is in safe hands.

Our Board is accountable to the public and stakeholders for:

- High quality, safe health services.
- Accessible and responsive health services.
- Making sure public money is spent in a way that is fair, efficient, effective and economic.
- Being a good employer.
- Engaging patients and the wider public in shaping health services.

The Board plays a key role in:

- Shaping the strategy, vision and purpose of the Trust.
- Holding the organisation to account for the delivery of strategy.
- Ensuring value for money.
- Working to shape a positive culture.

The Trust's Acting Chair and Interim Chief Executive have led these functions throughout 2025/26.

The Trust Board has both Executive and Non-Executive Directors. It is a unitary Board, which means that both Executive and Non-Executive Directors share the same liabilities and joint responsibility for every decision of the Board. Led by an independent chair and made up of both executive and independent non-executive members, the Board has collective responsibility for the performance of our organisation.

The Board discharges its day-to-day management of the Trust through the Chief Executive, Executive Directors and non-voting Directors, and senior staff through a scheme of delegation which is approved by the Audit Committee.

Board Composition

Taking into account the wide experience of the whole Board, the Board believes that its membership is balanced, complete and appropriate and that no individual or group of individuals dominate the Board. There is a clear division of responsibilities between the Chair of the Trust and Chief Executive which ensures a balance of power and authority. The Board has a wide range of skills and a significant number of members have a medical, nursing or other health professional background. Non-Executive Directors have wide-ranging expertise and experience with backgrounds in finance, digital, healthcare, legal, and third sector.

Here are the people on our Board of Directors as at 31 March 2026

Meet the Board

Non-Executive Directors



Brodie Clark CBE
(Trust Chair to August 2025)

Brodie was appointed as Trust Chair in August 2020 and was previously a Non-Executive director at the Trust since September 2014. He chaired the Nominations and Remuneration Committee and was a member of the Charitable Funds Committee.

Brodie has had extensive public sector experience with 32 years in the Prison Service and nine years in the UK Border Agency. His experience has included governing prisons, responsibility for the high security prison estate and latterly he developed and successfully led the UK Border Force through a modernising programme with security and risk at its core. He is experienced in dealing with large scale complex national and international risk activity and in delivering transformational change agendas within demanding operational settings. He was awarded the CBE in 2010 for his work on UK border security.

He is a strong believer in the power and voice of local communities and seeks to support that through his role with the Trust.



Helen Thomson Deputy Lieutenant
(Vice Chair to August 2025 and then Acting Chair to present)

Helen was appointed as a Non-Executive Director in May 2019. Prior to taking on the role of Acting Chair Helen was Vice Chair of the Trust, chaired the Quality Committee and was a member of the Business Committee. Helen was also the Trust's Senior Independent Director which included duties such as providing support to the Chair, co-ordinating the Chair appraisal process, intervening to resolve issues of concern on the Board, and taking part in the succession planning process for the Chair role where a reappointment or new appointment is necessary.

In August 2025 Helen took over as Acting Chair and chairs the Nominations and Remuneration Committee and is a member of the Charitable Funds Committee.

Helen holds an MA in Leading Innovation and Change from York University and a first degree in management from Leeds University. She is a Registered Nurse and Midwife and a Registered Midwife Teacher as well as a qualified coach.

After beginning her nursing career in Leeds she has held clinical, management and education posts across West Yorkshire. She held a number of NHS Board posts since 1993 as Director of Operations, Chief Nurse and CEO until her retirement in 2014.

Helen is now an independent healthcare consultant and a Trustee of the charity Sue Ryder where she chairs the Health and Social Care Sub-committee.

She was appointed Deputy Lieutenant for West Yorkshire in 2012 and Vice Lord Lieutenant in 2022.



Alison Lowe OBE

Alison was appointed as a Non-Executive Director in December 2020. She chairs the Charitable Funds Committee and is a member of the Quality Committee and Nominations and Remuneration Committee.

Alison has worked for voluntary organisations for nearly thirty years including as Chief Executive of Touchstone, a mental health charity in Leeds and wider West Yorkshire, for nearly 20 years.

Alison is currently the Deputy Mayor for Policing and Crime in West Yorkshire on behalf of the Mayor, Tracey Brabin. Alison has also been involved in local government for 29 years as a local councillor representing Armley and she was Deputy Lord Mayor in 2003-24. Alison was made an Honorary Alderwoman of Leeds in 2020.

Alison has substantial experience in developing inclusive leadership teams and was awarded an honorary Doctor of Laws by the University of Leeds for her contribution to Equality, Diversity and Inclusion across 30 years working in the region.



Professor Ian Lewis

(Acting Vice Chair August 2025 to present)

Ian was appointed as a Non-Executive Director in July 2017. Ian chairs the Quality Committee and is a member of the Audit Committee. He was a senior clinician and was Executive Medical Director of Alder Hey Children's NHS Foundation Trust in Liverpool between 2011 and 2015, having previously been a Divisional Medical Director and Consultant Paediatric Oncologist at Leeds Teaching Hospitals NHS Trust.

He also co-chaired the Children and Young People's Health Outcomes Forum - an independent group of professionals who advised the government, which operated between 2012 and 2016.

He served as a Trustee of The Candlelighters Trust (1985-2011), Martin House Children's Hospice (1990-2010) and Bone Cancer Research Trust (2006-present) within the charitable sector.



Khalil Rehman

Khalil was appointed as a Non-Executive Director in December 2020. He chairs the Audit Committee and is deputy chair of the Business Committee.

Khalil has spent his career at the intersections of finance, social impact and digital innovations across the private, public and third sectors. He brings significant board and corporate governance experience alongside a sense of curiosity, inclusivity and compassion.

Khalil has a background in successfully delivering humanitarian projects, public health and global healthcare services across Africa, South Asia and other developing countries. He was Chief Executive of an international health charity between 2011-18 and Director of Finance and IT of a leading North-West based social care charity previously.

Khalil also spent ten years in investment banking in mergers and acquisitions and corporate finance advisory roles, followed by a stint in academia at one of the world's top universities as a Research Fellow in social care and postgraduate teaching. Khalil is a Board member of the University of Lancashire and until February 2026, Khalil was also a Non-Executive Director and Deputy Chair at East Lancashire Hospitals NHS Trust.



Rachel Booth

Rachel was appointed as an Associate Non-Executive Director in December 2020, and then as a Non-Executive Director in October 2024. Having been previously a member of the Business Committee, she took over the role of Chair of the newly established People and Culture Committee in May 2025. She is also a member of the Nominations and Remuneration Committee, and more recently the Quality Committee.

In August 2025 Rachel took on the role of the Trust's Senior Independent Director which includes duties such as providing support to the Chair, coordinating the Chair appraisal process, intervening to resolve issues of concern on the Board, and taking part in the succession planning process for the Chair role where a reappointment or new appointment is necessary.



Lynne Mellor (Associate Non-Executive Director)

Lynne is passionate about the NHS and supporting the local community.

She has considerable experience at Board level, both in the UK and globally, driving innovation and thought leadership across large multinationals; Lynne has held a number of senior leadership positions most latterly in BT plc as Director of Strategy, Transformation and Operations. She has a demonstrable track record in leading small to complex change in public and private sectors.

Lynne is an experienced Non-Executive Director having served for several years on the Board of York and Scarborough Teaching hospitals, championing improvements for patients and staff with a particular focus on digital, sustainability and culture change.

Having been previously a member of the Business Committee, she took over the role of Chair in April 2025. She is also a member of the People and Culture Committee, and the Audit Committee.

She is a co-owner of a business consultancy which has expertise in transformation, and technology covering for example artificial intelligence and cyber security solutions.

Lynne holds a Master of Business Administration degree together with a number of professional business qualifications.

Executive Directors



Selina Douglas

(Chief Executive 15 April 2024 to 1 June 2025)

Selina took up the role of Chief Executive at LCH from April 2024 until 1 June 2025.

Selina had a strong Adult Care background from operational teams to Director of Commissioning and Enterprise across three London boroughs. As part of this role Selina was the lead Adult Social Care Director for the London Borough of Hammersmith and Fulham. Selina has held senior roles in both Sustainability and Transformation Plans/Clinical Commissioning Groups and provider Trusts, such as North East London NHS Foundation Trust. Selina is committed to the voluntary sector and spent three years as the Managing Director at Turning Point, as well as currently being a Trustee for Waythrough.



Dr Sara Munro

(Interim Chief Executive 1 June 2025 to present)

Sara took up the role of Interim Chief Executive at LCH from June 2025, in conjunction with being the Chief Executive at Leeds and York Partnership NHS Foundation Trust, a role she has held since 2016.

Sara started her career in the NHS as a student nurse and agency nursing assistant. She is a registered mental health nurse, and her clinical work was spent in inpatient mental health settings.

Sara has worked across a range of NHS mental health providers in the North West of England. She has also completed a PhD looking at attitudes of acute mental health nurses and their impact on service users' experience of care. Prior to working at either Trust Sara was the Director of Quality and Nursing/Deputy CEO in Cumbria.



Sam Prince

(Executive Director of Operations)

Born and raised in Leeds, Sam became Executive Director of Operations at the Trust in 2011. Before this, she was responsible for establishing the Trust as an official NHS provider, something she achieved in her role as Managing Director of NHS Leeds Community Healthcare.

Sam brings to the role a wealth of health and social care experience, specifically serving the people of Leeds. She has worked across all sectors of the NHS including community, mental health, commissioning, and acute services. From 2020 onwards, as part of the national drive to protect people against the global pandemic, she successfully led the Covid 19 Vaccination Programme for the City.

Passionate about 'Team Leeds' and working in a way that patients and their families can understand, she has led many partnerships across the city, collaborating with both the public and voluntary sector to improve access and outcomes for people in need of care and support.

Sam holds an MBA from the University of Durham Business School, gained after studying with the Open University. As her leadership career began with few formal qualifications, she remains committed to harnessing potential through workforce training and development and to creating an inclusive culture for all.



Heather McClelland

(Interim Executive Director of Nursing and Allied Health Professionals
(from 16 March 2026 - present)

Heather McClelland joined the Trust in March 2026 with over 35 years of nursing experience, both clinically and corporately. Most recently she was the Chief Nurse at St Gemma's Hospice in Leeds, working with partners in the city to ensure patients receive excellent palliative and end-of-life care.

Heather trained and worked as a Registered Nurse in Belfast, before moving to England and settling in Leeds in 1996, specialising in Emergency Care. She has held posts at the University of Leeds, was editor of a specialist research journal for ten years and travelled to China and the Philippines as part of the national emergency response team.

Throughout her career, Heather's main interests have been based around improving patient care and experience, whether through the development of new, innovative services or by establishing robust learning and improvements in practice. She is passionate about the impact education and continuous development for staff has on patient outcomes.



Dr Ruth Burnett

(Executive Medical Director)

Ruth qualified as a GP in Oxford and, alongside mainstream practice, worked as the Clinical Commissioning Group (CCG) Locality Lead for Urgent Care and as a GP with an Extended Role (GPER) in musculoskeletal medicine. She continues to see patients in practice.

She became the Medical Director for Buckinghamshire MSK community service in 2011 and then stepped into a national Medical Director role in 2013. Before taking up her current post, she worked for six years as a Medical Director across a mixture of community MSK services, primary care, out of hours and urgent care, new models of care and prison healthcare.

She has a passion for increasing the effectiveness of primary and community services for both patients and staff and the model she created with the Prime Minister's Challenge Fund in 2014, Practice Assist, was shortlisted in the HSJ finals in the category 'Primary Care Innovation'.

Her contribution to medical leadership was recognised in Senior Fellowship of the Faculty of Medical Leadership and Management in 2021.



Andrea Osborne

(Executive Director of Finance and Resources)

Andrea joined LCH in February 2024 as Interim Director of Finance and Resources and was made substantive in July 2024. Based in Tameside she has over twenty years' experience as a qualified accountant, gained mostly within the hospital sector. In 2016 she moved to work within mental health and community services, where she found her passion for this area of healthcare.

With a strong focus on listening to the staff voice to affect change, Andrea is also a keen advocate for health equity, she describes it as a privilege to use her financial experience to support some of the most vulnerable people in our communities, many of whom have long-term or lifelong illnesses.



Lynsey Ure, previously Yeomans

(Executive Director of Nursing and Allied Health Professionals to 28 February 2026)

Lynsey joined LCH in October 2024. She began her nursing career 25 years ago in her home city of Glasgow, where she was a paediatric nurse. Lynsey brings a wealth of experience to Leeds from a wide variety of settings, including children's community nursing and education and training. She has worked in Quality roles in NHS England, as well as

being Chief Nurse for the North West Ambulance Service and Deputy Director of Nursing and AHPs at Pennine Care.

A real advocate for learning from the voice of patients and their loved ones, Lynsey strives to provide the best possible care whilst being mindful of the use of public money.

Directors



Jenny Allen and Laura Smith

(Director of Workforce - job share)

Jenny and Laura job share our Director of Workforce, organisational development and System Development role. Jenny studied law at university before joining the NHS on the National Graduate Management Scheme as a general management trainee in 1998. She has held several senior

HR and Workforce leadership roles across NHS organisations including at Leeds Teaching Hospitals Trust and NHS Digital before commencing with Leeds Community Healthcare NHS Trust (LCH).

Jenny has previously run her own HR consulting business, has held associate lecturer roles at several local universities and is a published academic author in the field of HR and management. She is also an associate editor for an academic journal.

Laura also joined the NHS in 2000 as a General Management trainee, and has held

leadership roles in general management, human resources (HR) and organisational development across acute organisations, primary care trusts and national organisations. She is an accredited coach and mentor as well as a qualified HR professional.

What matters most to both Laura and Jenny in work is people: “the people we work with and the patients and population we work for, both across the City of Leeds and the wider geographic communities served by LCH.”

Changes to the Board

During 2025/26 there were six changes to individual members of the Board, outlined as follows:

- Brodie Clark CBE came to the end of his tenure as Chair on 10 August 2025.
- Helen Thomson was appointed as Acting Chair from 11 August 2025.
- Selina Douglas stood down as Chief Executive from 1 June 2025.
- Dr Sara Munro joined the Trust on secondment from Leeds and York Partnership NHS Foundation Trust as Interim Chief Executive from 1 June 2025.
- Lynsey Yeomans stood down as Executive Director of Nursing and Allied Health Professionals on 28 February 2026.
- Heather McClelland was appointed as Interim Executive Director of Nursing and Allied Health Professionals from 16 March 2026 for a 12-month period.

A ‘fit and proper’ Board

Board members have an annual appraisal, which is a thorough review of the assessment of their performance, reflecting on their contribution to the Trust during the year and setting objectives for the coming year.

The main components of this are:

- The Chair conducts individual performance evaluations of the Non-Executive Directors and the Chief Executive, which involves obtaining feedback from a variety of stakeholders.
- The Senior Independent Director conducts a performance evaluation of the Chair, which involves obtaining feedback from a variety of stakeholders.
- The Chief Executive conducts performance evaluations of the Trust Leadership Team.

The Trust has a programme of workshops to support Board members’ development, and in 2025/26 covered such topics as strategic risks and risk appetite, CQC readiness, the National Oversight Framework, staff survey results, cyber security, integrated performance reporting, health equity, equality and inclusion, the Provider Capability Self Assessment and the well-led developmental review. Both executives and non-executives attend training days and networking events to improve their knowledge base and remain up to date with current NHS matters.

All directors have made a declaration that they comply with the revised ‘fit and proper person framework’ that was introduced from September 2023.

Each director has confirmed in writing that they know of no information that would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and each has taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

All Non-Executive Directors are considered to be independent (demonstrated through annual appraisals, declarations of interest and independence, and Board and Committee minutes).

Director's declarations of interests for disclosure 2025/26

The register of interests for Trust Board members and decision makers is available on the Trust website at the following link:

<https://lch.mydeclarations.co.uk/declarations>

Board meetings and business in 2025/26

As with all NHS Trusts, we are required to hold formal Board meetings in public. The Board has met formally eight times during the year. At these meetings, the Board takes strategic decisions and monitors the operational performance of the Trust. Any member of the public is welcome to attend the formal meetings. The Board has further encouraged the public to attend during the year with some Board meetings being held in community venues across Leeds.

The dates are advertised on the Trust's website, and Board meeting agendas, reports and minutes are published online.

The Board has also met informally on a further five occasions during 2025/26. These events have taken the form of a Board development programme and have on occasions involved a wider group of senior leaders.

Attendance at formal Board meetings is outlined below:

	1 Apr	5 June	25 June (year end sign off)	10 July	4 Sep	6 Nov	5 Feb	27 Mar	
Brodie Clark	✓	✓	X	✓					3/4
Helen Thomson	X	✓	✓	X	✓	✓	✓	✓	6/8
Ian Lewis	✓	✓	✓	X	✓	✓	✓	✓	7/8
Alison Lowe	✓	✓	X	✓	✓	✓	✓	✓	7/8
Rachel Booth	✓	✓	✓	✓	✓	✓	✓	X	7/8
Khalil Rehman	✓	X	✓	✓	✓	✓	✓	✓	7/8
Lynne Mellor	✓	✓	✓	✓	✓	✓	✓	✓	8/8
Selina Douglas	✓								1/1
Sara Munro		✓	✓	✓	✓	✓	✓	✓	7/7
Sam Prince	✓	✓	✓	✓	✓	✓	✓	✓	8/8
Ruth Burnett	✓	✓	✓	✓	✓	✓	✓	✓	8/8
Andrea Osborne	✓	✓	✓	✓	✓	✓	✓	✓	8/8
Lynsey Yeomans (until 28 Feb 2026)	X	✓	✓	✓	✓	✓	X		5/7
Heather McClelland (from 16 March 2026)								✓	1/1
*Jenny Allen/ Laura Smith	✓	✓	✓	✓	✓	✓	✓	✓	8/8

*Director in attendance (job share)

In addition, an Annual General Meeting was held on 16 September 2025. This was held in person at the Vinery Centre, Leeds.

Leeds Community Healthcare NHS Trust has a commitment to providing high quality care and reducing health inequalities within our communities. The Trust aims to innovate, build and standardise in order to deliver high quality, safe and effective care that provides patients, families and carers with the best patient experience. All actions to ensure the Trust meets this commitment are overseen closely by the Board.

The Board receives regular updates on strategic service developments and regular integrated performance reports (the report brings together quality and financial information in one document). Information in the report is aligned to the Care Quality Commission's (CQC) five domains (safe, caring, effective, responsive and well-led). This is the main way the Board assesses that it meets all national and local standards and targets for the services we provide.

The Board's committees (decision making groups)

The Trust has six committees that make sure we carry out our duties effectively, efficiently and economically.

Details of the functions of each committee can be found in our Annual Governance Statement 2025/26 which starts on [page 101](#).

In addition, the Trust has three 'Committees in Common' arrangements involving a number of NHS organisations. A 'Committees in Common' approach allows NHS trusts to establish their own committees, which all meet at the same time and with the same remit and common agenda. The three 'Committees in Common' are:

- West Yorkshire Mental Health Services Learning Disabilities and Autism Collaborative. This comprises of the four mental health and community NHS trusts in West Yorkshire (Bradford District Care NHS Foundation Trust, Leeds and York Partnership NHS Foundation Trust, Leeds Community Healthcare NHS Trust, and South West Yorkshire Partnership NHS Foundation Trust) working together to ensure high quality, sustainable mental health services.
- Leeds Primary Healthcare Collaborative, which is Leeds Community Healthcare NHS Trust and the Leeds GP Confederation whose aim is to jointly deliver city-wide seamless and efficient primary care and community health services for patients.
- West Yorkshire Community Health Services Provider Collaborative. This comprises of eight community providers in West Yorkshire (Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Mid Yorkshire Teaching Hospital NHS Trust, Leeds Community Healthcare NHS Trust, Locala and Yorkshire Ambulance Service NHS Trust) working together to collectively improve outcomes and make the most of resources.

These are reflected in the Trust's current scheme of delegation.

Signed  **Sara Munro**, Interim Chief Executive

Date 24 June 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 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.	Annual Report Quality Account Third Sector Strategy	Annual Governance Statement
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

Provision	Requirement	Evidence	Comply
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.

Provision	Requirement	Evidence	Comply
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. • 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.	Annual Report Nominations and Remuneration Committee Annual Equality, Diversity and Inclusion Report that evidences compliance with the Public Sector Equality Duty (evidenced through Business Committee and Board minutes)	Annual Governance Statement – Nominations and Remuneration Committee summary, and Equality and Diversity section
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. • 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.	Annual Report Process for appointment of auditors	Annual Governance Statement

Provision	Requirement	Evidence	Comply
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, e.g 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 deliver.

Provision	Requirement	Comply
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 People and Culture Committee and the Board of Directors receives annual performance reports which show.
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 Account 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 understanding of the views of the stakeholders including system partners.	Engagement with stakeholders is reported to Public Board via the Chief Executive's report and within the Annual General Meeting.

Provision	Requirement	Comply
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 FTSU 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 adequate time is available for discussion of all agenda items, in particular strategic issues.	Agendas for the Board are prepared by the Chair, CEO and Company Secretary.
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.

Provision	Requirement	Comply
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, should not be the deputy or vice chair or senior independent director.	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. 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.

Provision	Requirement	Comply
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 range of skill sets, backgrounds and lived experience.	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.
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.

Provision	Requirement	Comply
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 non-executive directors without the executive directors present.	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. 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 of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	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.

Provision	Requirement	Comply
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.

Provision	Requirement	Comply
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.

Provision	Requirement	Comply
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.

Provision	Requirement	Comply
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.

Provision	Requirement	Comply
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.

Provision	Requirement	Comply
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 non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment. Committees should be provided with sufficient resources to undertake their duties.	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.

Provision	Requirement	Comply
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.

Provision	Requirement	Comply
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 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.	Comply – evidenced in the Audit Committee annual report to Public Board each year.
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.

Provision	Requirement	Comply
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.

Provision	Requirement	Comply
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 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.	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 and Remuneration Committee.
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.

Provision	Requirement	Comply
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.

Publicly available information

Provision	Requirement	Section in Annual Report
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.

Provision	Requirement	Section in Annual Report
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.

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance.
- Value for money is achieved from the resources available to the Trust.
- The expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them.
- Effective and sound financial management systems are in place, and
- Annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed  **Sara Munro**, Interim Chief Executive

Date 24 June 2026

Statement of Director's responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury.
- Make judgements and estimates which are reasonable and prudent.
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts, and
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

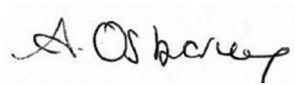
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients regulators and stakeholders to assess the NHS Trust's performance, business model and strategy.

By order of the Board

Signed  **Sara Munro**, Interim Chief Executive

Date 24 June 2026

Signed  **Andrea Osborne**
Executive Director of Finances and Estates

Date 24 June 2026

Corporate Governance Report

Annual Governance Statement 2025/26

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the **NHS Trust Accountable Officer Memorandum**.

Dr Sara Munro

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds Community Healthcare NHS Trust (LCH), to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in LCH for the year ended 31 March 2026 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

The Trust recognises that it is operating in a healthcare environment where patient safety, quality of care and service sustainability is paramount and of mutual benefit to stakeholders and the organisation alike. The Trust manages clinical risks (i.e. risks to individual patients through clinical activity) and financial and business risks (i.e. risks that threaten the achievement of statutory financial duties or the safeguarding of the Trust's assets) in order to deliver its objectives in a controlled way. With controls and assurances in place, and in line with the Trust's statement of how much risk it will accept ('risk appetite'), manageable risks are tolerated - but not where there is a foreseeable risk of harm or adverse outcomes to patients.

Careful risk management is embedded within the culture of the organisation, from risk assessments in clinical practice to considering the risk in each Board decision. Risks are identified and aligned to strategic goals. Risk tolerance, i.e. the level at which risk is escalated, is clearly set out in the Risk Management Policy and Procedure.

The Chief Executive has overall responsibility for the Trust's management of risk and members of the Trust Leadership Team have been given responsibility for managing risk types (see table on next page).

Member of Trust Leadership Team	Risks to
Chief Executive	Staff and stakeholder engagement Integration and system change programmes Compliance with relevant regulations
Executive Director of Finance and Resources	Efficiency Income and expenditure IT infrastructure Data and cyber security Environmental sustainability Contractual governance
Executive Director of Operations	Major change projects Business tenders Contracted activity Performance and service delivery Health and safety of staff
Executive Director of Nursing and Allied Health Professionals and Executive Medical Director	Clinical quality assessment Clinical quality improvement Patient safety and CQC standards Clinical governance The Executive Director of Nursing and Allied Health Professionals held operational responsibility for Risk Management in 2025/26
Director of People	Staff capacity and capability Organisational culture and morale

The role of each director is to ensure that appropriate and robust arrangements are in place to:

- Identify and assess risks.
- Eliminate or reduce risks to an acceptable level, in line with the Trust's approach to risk.
- Comply with policies and procedures, and statutory and external requirements.
- Maintain the Board Assurance Framework.

The Trust employs an experienced Risk Manager who delivers risk management training, coordinates the risk register and provides support and direction in all risk management related matters.

During 2025/26 risk management training has been delivered by the Risk Manager on request and in response to identified needs, this ranged from group briefings to one-to-one coaching sessions. In addition, risk management drop-in sessions were made available to staff. The training offer was refreshed during 2025 and in addition bespoke training, annual risk management training targeted at current and potential risk owners has been added to the training offer. This training is delivered by the Risk Manager through

scheduled guest attendance at team / service development sessions. All training includes awareness of the Trust's approach to risk and how this should be applied in decision-making processes.

There is a dedicated risk management page on the Trust intranet. Staff can access reference material pertaining to effective risk management, such as:

- The role of the Risk Manager and how they can support staff;
- Relevant policies, procedures, and guidance; and
- Signposting to risk management training.

The risk and control framework

The Trust's Risk Management Policy defines the risk management framework and sets out the approach the Trust will take to the management of risk, making sure that sound risk management principles are an integral part of its governance structure and processes. It also sets out the respective responsibilities for corporate and operational risk management throughout the Trust.

The risk management procedure supports staff to identify, assess, manage, and monitor the risks that threaten the organisation's ability to achieve its objectives. The aim of the risk management procedure is to achieve an optimum response to risk, prioritised in accordance with a consistent evaluation of the identified risk.

The Trust has systems in place that contribute to the identification of risk from a number of sources for example:

- Review of performance and working practice.
- Clinical practice.
- Legislation, national policy and guidance.
- Risk assessments.
- Incident reports.
- Complaints.
- Claims for compensation.
- Audit and workplace surveys.
- Patient satisfaction surveys.
- External/internal audits.
- Regulators' inspections and reports.
- External environment within which the Trust operates.

Any of the above can be part of the risk assessment process. Risks are identified in a proactive way, for example: changes or introduction of new processes, new equipment, and different ways of working will initiate a risk assessment.

The Risk Management Policy and procedure is supported by content in a bespoke risk area of the Trust's intranet which is available to all staff.

The Risk Management Policy and Procedure was re-written in 2025 to ensure that it reflected the current working practice. Key changes to the policy included the introduction of the Risk Management Group and the People and Culture Committee in the governance arrangements during 2025, and the Board Assurance Framework quarterly review and reporting process. The procedure has been updated to provide greater guidance on the review and management of risks, and a risk register quality procedure has been included to support the effective operation of risk management. The policy has been scrutinised by the Risk Management Group and the Clinical and Corporate Policy Group and was approved by the Board in November 2025.

The Board Assurance Framework (BAF) enables the Board to be assured that risks to the success of strategic goals and corporate objectives are being managed effectively. The BAF aligns strategic risks to the revised strategic goals and priorities in the Trust's operational plan.

The Risk Register is a record of all the risks that may affect the Trust's ability to achieve its strategic, project or operational objectives. The Trust uses an electronic risk management system to record and monitor risks. The risk register includes: a description of the risk, the risk owner, any controls currently in place, actions to be completed, and the initial, current and target risk scores. Extracts and themes from the risk register are frequently scrutinised by appropriate managers, committees, and the Board. Risk Key Performance Indicators (KPIs) are reported to the Business Units, Trust Leadership Team, and the Board Committees in order to improve the effectiveness of the risk management process. KPIs highlight the number of risks with overdue review and risks with static scores over 12 months.

The integrity and completeness of the risk register has improved during the year due a risk amnesty process requiring all local risk registers to be transferred to the risk management system, ensuring that all risks are recorded and visible in one location.

The Trust Board defines the Trust's **risk appetite** and reviews this on an annual basis. The risk appetite statement is accessed via the risk management page on the Trust intranet. The Trust risk appetite statement was reviewed by the Board in July 2025 and approved by the Board in September 2025. The risk appetite has been aligned to each of the eight strategic risks (formerly aligned to the five strategic objectives) and reflected on the Board Assurance Framework (BAF) and the risk register. The Board also completed an in-year review of the risk appetite statement in January 2026.

In addition to the operation of the risk management strategy, risk management is embedded in the Trust in a number of ways, for example:

- There is a lessons learnt portal on the 'Making Stuff Better' page on the Trust's intranet, where managers can share information about incidents, learning and improvements.
- The risk manager provides guidance, support and training to staff appropriate to their authority and duties.
- Trust employees receive training in equality and diversity, and equity and quality impact assessments are completed for all strategy, policies, and business cases so that the full impact on protected groups is identified and taken into account.
- The Trust has policies in place to encourage employees to highlight risks and report concerns, for example through the whistleblowing policy.

Risk assurance process and scrutiny of risks

The Trust has established a Risk Management Group (RMG). The RMG met quarterly during 2025/26 and is an operational group reporting to the Trust Leadership Team (TLT). It is made up of Senior Management to ensure that assurance on risks can be received by providing challenge on overdue risk reviews and actions, identification of emerging risks and common risk themes across the Trust, and escalation of risks with scores that have been static for more than 12 months. The operation of the RMG is evolving and will continue to develop into 2026/27. The chairing and membership of the group were changed in March 2026 as part of the ongoing improvements. Risks are also reviewed by individual risk owners and by the appropriate directors.

Assurance creates the bedrock of evidence which gives the Trust confidence that risk is being controlled effectively or highlights that certain controls are ineffective or there are gaps that need to be addressed. The Trust's Board Assurance Framework (BAF) records strategic risks including risk descriptions, controls and gaps in controls, sources of assurance and gaps in sources in assurance, actions required to remedy gaps in controls or assurance.

Risks to strategic objectives contained within the Trust's clinical and service strategies and plans are identified and the BAF has been revised during 2025, in line with the Trust's operational plan. The strategic risks changed considerably at the start of 2025/26 following a full review of the BAF, approved by the Board in June 2025. These strategic risks are assigned to a lead executive to manage. Each of the strategic risks are also assigned to one of the Board's committees for oversight and scrutiny. Overall scrutiny of the BAF process is provided by Audit Committee.

Sources of assurance are reviewed and evaluated by the committees to provide an indication to the Board of the current assurance level for each strategic risk. This information is used to populate the BAF. A summary of this information is presented at each Board meeting. The quarterly review process is now well-established, whereby the TLT carries out a full review of all strategic risks and update scores, controls/ sources of assurance and any gaps identified, and any changes to links to the Trust's Corporate Risk Register. Comments from Committee meetings feed into the quarterly review process. The full updated BAF has been presented to the Trust Board in June and November 2025 and in February and March 2026.

The Board receives a significant risks report at each meeting. The report details the Trust's risks scoring 15 or above (extreme), after the application of controls and mitigation measures, as well as information about risks scoring 12 (high). It provides an analysis of all risk movement, identifies themes and links these material risks to the strategic risks on the BAF. The TLT reviews the report in advance of the Board. The Quality Committee reviews high scoring clinical and operational risks, and the Business Committee reviews non-clinical risks, rated as high.

A People and Culture Committee (PCC) has been established in 2025. The PCC receives the details of high scoring workforce-specific risks aligned to strategic risks 3: Failure to comply with legislative and regulatory requirements and 6: Failure to effectively engage staff and leaders to support their health and wellbeing in the current context.

Assurance of risk mitigation is provided to the Board through the Quality, Audit, People

and Culture and Business Committees in relation to clinical and non-clinical risks. The Audit Committee also provides assurance to the Board on the risk management process.

Together, these mechanisms allow for the appropriate identification, monitoring, control and mitigation of risks, which may have an impact on the Trust's objectives.

Data security risks are managed through the Information Governance / Data Protection and Information Technology teams through a series of Trust Policies and technical controls.

Mitigation to Data Security risks are implemented through a series of coordinated activities which include:

- The ongoing and timely release of software patches to ensure our electronic devices remain as resilient as possible to the threat of cyber security risks.
- The pursuit of Cyber Essentials Plus accreditation has led to the introduction of improved threat detection and software patch management.
- Third party penetration tests designed to identify vulnerabilities in the Trust security architecture are conducted regularly and any remedial actions taken.
- The development and testing of service level Business Continuity plans to ensure the Trust can respond to and maintain essential services in the event of an information security incident.
- The importance of maintaining awareness of data security, awareness to phishing emails and other cyber-risks have been highlighted to staff through yearly mandatory training, regular articles in the Trust's staff briefings and simulated Phishing Campaigns.
- The ongoing training and awareness activities for all staff.

All of these activities are designed to help ensure that sensitive information is protected and the risk of unintended loss or disclosure is minimised.

Other significant risk areas that have been reviewed and will continue to be key risk areas for the year ahead are detailed below:

- **Imbalance of Capacity and Demand:** Imbalance of capacity and demand is reflected across the risk register (including but not limited to Neighbourhood Teams and Children and Young Peoples Mental Health Services (MindMate SPA and Neurodiversity assessment and treatment pathways), resulting in unmet need of patients and long waiting lists which could impact on patient outcomes.
- **Staff Wellbeing and sickness:** Workloads resulting from the imbalance of capacity and demand and the impact of change programmes have had an impact on staff wellbeing and sickness levels across business units.

Throughout the year the Trust has focused on the controls and mitigating actions relating to the risks arising from an imbalance of capacity and demand impacting on patients and staff. The Quality and Value programme and improved EQIA processes have provided focus on managing these risks. In addition, staff sickness and engagement projects are well underway and linked by the overall theme of organisational health. An evidentially based approach to undertaking this work has been developed and tested with a specific service

and is now being rolled out to other services based on the data and evidence in terms of sickness, engagement and other well led measures – this enables the Trust to target services as needed.

- **Finance:** The financial savings that LCH needed to achieve in 2024/25, to achieve financial balance, were significant and challenging and required significant transformation work. There was a risk that financial balance might not be achieved, resulting in loss of freedom and autonomy to act in decision making. The risk was effectively managed during 2024/25, with financial balance being achieved. A further risk will be added relating to financial balance in 2025/26.
- **Data quality** and the accuracy of performance reporting, including waiting list information, is reviewed regularly. Validations on waiting list data are collected directly from services on a regular basis and reviews of other Key Performance Indicators (KPIs) happen at performance review meetings across all levels of the Trust. More specific pieces of work to test out and provide assurance around data quality are carried out on a service-by-service basis, which is being supported by the implementation of a Data Quality Framework and dashboard to aid consistency and accuracy of reporting.

The Trust reports monthly on its performance against national KPIs in line with NHS Improvement's Single Oversight Framework and national contract requirements. Specific service indicators in contracts are monitored monthly via internal performance monitoring processes.

Governance structures and accountability

Our Board is made up of six non-executive directors (including the Chair), five executive directors and two non-voting members of the Board - the Director of Workforce (job share role), and an Associate Non-Executive Director. The Board leads the Trust by carrying out three main roles:

- Formulating strategy.
- Holding the organisation to account for the delivery of strategy and seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the wider Trust.

There is a clear division of responsibilities between the Chair and Chief Executive, and both have discharged their leadership functions throughout the whole of 2025/26. The division of responsibilities is set out in the Trust's standing orders and standing financial instructions (scheme of delegation section).

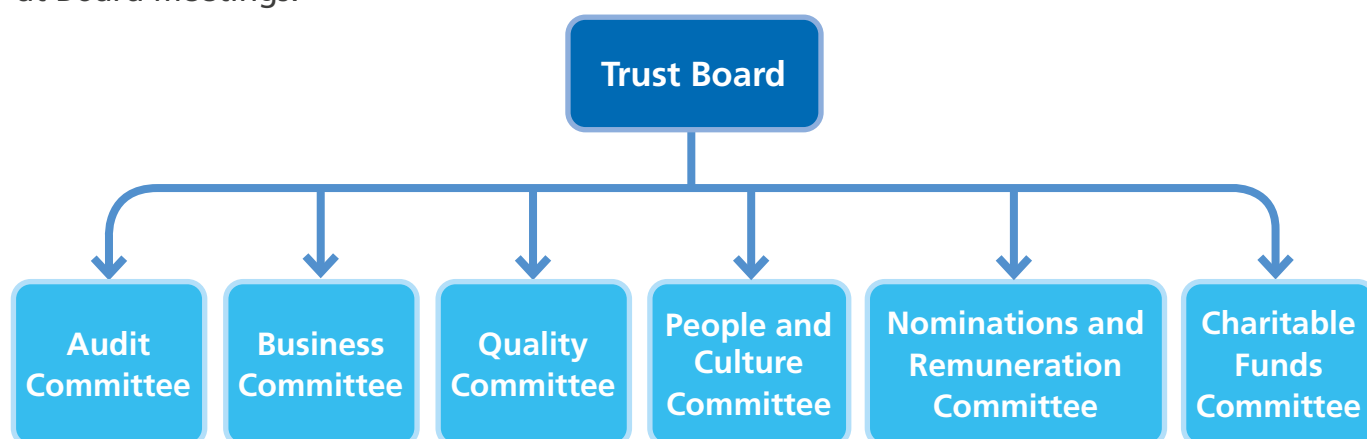
The Board held eight formal meetings in public in 2025/26. The Annual General Meeting was held in person in September 2025. Board member attendance at Board meetings is set out in the Director's report on [page 75](#) and all meetings have been quorate.

The quality of services remains the Trust's first priority, so the Board's agendas feature reports on our quality strategy, patient experience topics and the maintenance of safe staffing levels. Information presented to the Board provides essential assurance and our directors regularly 'visit' frontline services to engage with and support staff and to view the service provided to patients.

The Board has Standing Orders, a Scheme of Reservation and Delegation of powers and Standing Financial Instructions. These are regularly reviewed and provide a governance framework which allows the Trust to show it is well governed and that it meets the requirements of corporate governance codes of practice. It also has an annual work plan, which schedules required and discretionary business.

The Trust has a needs-based Board development programme. In addition to the formal Board meetings, there were five Board workshops during 2025/26. More information on this can be found in the Director's report starting on [page 66](#).

The Board discharges its responsibilities through six Committees (see diagram below). Each committee has Board-approved terms of reference and work plans which have been reviewed during 2025/26. Each committee's minutes and assurance reports are presented at Board meetings.



An integrated performance report and suite of reports which mirror the five Care Quality Commission (CQC) domains is produced for each Board meeting so that our compliance with national and local targets can be assessed. The meetings also receive regular updates on strategic service developments, for example, work to improve how primary and secondary health services and social care work together and the introduction of new ways of working.

Extracts from the Risk Register and the Board Assurance Framework are considered at each meeting so the Board can be assured that risks are being managed in the organisation. The extracts give timely information about existing and potential risks to the Trust.

The Board wants to be sure that it is operating effectively and regularly seeks opportunities to evaluate its effectiveness and strengthen its performance, remaining mindful of the best practice contained within codes of governance.

The Board is required to carry out an independent review of governance against the **well-led framework** every three to five years. In 2024/25 following a tender exercise the Trust commissioned Mersey Internal Audit Agency to undertake a Developmental Well-Led Review to assess the leadership and governance of the Trust, in order to identify developmental actions in order to secure and sustain the Trust's future performance as part of continuous improvement. The review was conducted from October to December 2024 and applied the updated Care Quality Commission (CQC) framework to provide a comprehensive evaluation of the Trust's capabilities, culture, and improvement opportunities.

The detailed outcome of the review was presented to the Board of Directors in January 2025, and the recommendations were assigned priority ratings.

The report identified seven key developmental themes:

1. Overarching Strategy
2. Board development and succession planning
3. Governance
4. Data Quality and Performance Management
5. Quality and Quality Improvement
6. Operational Risk Management
7. Patient Voice

An action plan was developed with an executive lead for each developmental theme, with scheduled 6 monthly updates to the Trust Board. Following feedback from Internal Audit it was agreed that in order to strengthen implementation, additional quarterly updates would be taken to the Trust's Leadership Team, commencing in February 2026. In the February update, significant progress was noted against all themes with the actions within the Overarching Strategy and Operational Risk Management themes completed.

The individual performance of all Board members is reviewed through a formal appraisal process and any individual development needs are identified and supported.

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the '**Managing Conflicts of Interest in the NHS**' guidance.

The Board's six committees are chaired by Non-Executive Directors and are:

Audit Committee

Chair: Khalil Rehman

The Audit Committee comprises of two Non-Executive Directors and the Associate Non-Executive Director. The Audit Committee met formally six times during 2025/26 and is routinely attended by the Executive Director of Finance and Resources, the Company Secretary, Internal Audit and External Audit representatives.

The Committee provides an overarching governance role and reviews the work of the other committees which provides relevant assurance to the Audit Committee's own scope of work. It also has responsibility for overseeing the work of the Information Governance Approval Group and SIRO Data Security Group. The Committee receives minutes from these sub-groups, receives papers on any matters escalated to it and periodically reviews the effectiveness of the sub-groups.

During the year, the Committee has received regular reports from internal audit, external audit, the local counter fraud specialist, the security management service and information governance specialists.

The Committee has considered a range of financial control reports and a number of governance papers and has oversight of risk management processes including the Board Assurance Framework, which it reviewed during the year.

The Chair of each of the Board's committees produces an annual report, which is reviewed by the Audit Committee to provide assurance to the Board that each committee has met its terms of reference during the year. Each committee undertakes a self-assessment exercise which is reported in their annual reports.

Audit Committee attendance

Attendee	15 Apr	23 June	8 July	14 Oct	9 Dec	10 Mar	Total (6)
Khalil Rehman	✓	✓	✓	✓	✓	✓	6/6
Ian Lewis	✓	✓	✓	✓	✓	✓	5/6
Lynne Mellor (Associate Non-Executive Director)	✓	✓	✓	✓	✓	✓	6/6
Andrea Osborne*	✓	✓	✓	✓	✓	✓	6/6

*Executive Director in attendance

Quality Committee

Chair: Helen Thomson (until 10 Aug), then Ian Lewis (11 Aug to present)

The Quality Committee's membership comprises three Non-Executive Directors and three Executive Directors with other senior officers also attending each meeting. The Committee met on six occasions in 2025/26. Two additional informal meetings were held in the form of a joint workshop with members of the Quality Assurance and Improvement Group, which is a sub-group of the Committee.

The Committee provides assurance to the Board that the Trust provides high standards of care and that adequate and appropriate quality governance structures, processes and controls are in place to:

- Promote quality, in particular safety and excellence in patient care.
- Identify, prioritise and manage clinical risk and assure the Board that risks and issues are being managed in a controlled and timely manner.
- Ensure effective evidence-based clinical practice.
- Produce the annual Quality Account and monitor progress.

The committee exercises these functions in the context of the Trust's Quality Strategy 2024/27 which aims to respond to challenges presented with innovation, standardisation, and a focus on improvement.

We continue to work in a challenging landscape, and the Trust ensures we continue to provide services that are clinically effective, safe, well-led, and responsive to patient's needs, offering a positive patient experience. The Committee has received regular updates

on progress with the strategy and has sought assurance about the implementation of specific actions.

The Committee also has responsibility for overseeing the work of three subgroups: the Quality Assurance and Improvement Group, the Infection Prevention and Control Committee; and the Safeguarding Committee.

The Quality Committee and the Board monitor serious incidents, incidents and complaints and the associated action plans. All serious incidents are managed in accordance with the Trust's Incident Management Policy (including Serious Incidents).

Quality Committee attendance

Attendee	27 May	29 July	23 Sep	25 Nov	27 Jan	24 Mar	Total (6)
Ian Lewis	✓	✓	✓	✓	✓	✓	6/6
Helen Thomson	✓	✓			✓		3/6
Alison Lowe	✓	✓	✓	✓	X	✓	5/6
Rachel Booth (from November 2025)				✓	X	✓	2/3
Selina Douglas*	✓						1/1
Ruth Burnett	✓	✓	✓	✓	✓	✓	6/6
Lynsey Yeomans (to February 2026)	✓	✓	✓	✓	X		4/5
Heather McClelland (from 16 March 2026)						✓	1/1
Sam Prince	✓	✓	✓	✓	✓	✓	6/6

*CEO in attendance

Business Committee

Chair: Lynne Mellor

The Business Committee's membership comprises two Non-Executive Directors, the Associate Non-Executive Director, the Chief Executive and two further Executive Directors. Other senior officers attend as required. The Business Committee held 11 meetings in 2025/26.

The Committee provides assurance to the Board on the financial and performance management processes within the organisation, including monitoring the delivery of the Trust's business plan and oversight of significant projects.

The Committee oversees business and commercial developments and makes investment decisions in line with the Scheme of Delegation and the Trust's Investment Policy. It also ensures that the Board has a sufficiently robust understanding of key performance, financial and investment issues to enable sound decision-making.

It also has responsibility for overseeing the work of the Health and Safety Group. This Group provides an overarching view of health and safety and ensures that the Trust complies with its health and safety obligations by monitoring adherence with its policies and procedures. The Committee receives minutes from the Health and Safety Group and papers on any matters escalated to it. It also periodically reviews the effectiveness of the Health and Safety Group in discharging its delegated responsibilities.

The Committee has assumed an extended role in terms of oversight of the Trust's change programmes. The Committee receives in-depth reports from the programme leads and reports from the Quality and Value Board, which provides an overview of inter-connectivity for the main programmes and related projects.

Business Committee attendance

Attendee	30 Apr	28 May	25 Jun	30 Jul	24 Sept	13 Oct (extra ord. meeting)	29 Oct	26 Nov	28 Jan	26 Feb	26 Mar	Total (11)
Helen Thomson	X	✓	X	✓								2/4
Khalil Rehman	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/11
Rachel Booth	X	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	9/11
Lynne Mellor	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	10/11
Selina Douglas	X	X										0/2
Sam Prince	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	10/11
Andrea Osborne	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	10/11
*Laura Smith/ Jenny Allen	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	10/11

*Director in attendance (job share)

People and Culture Committee

Chair: Rachel Booth

The People and Culture Committee was established in Quarter 1 of 2025/26. Its membership comprises two Non-Executive Directors, the Associate Non-Executive Director, the Director of People and the Executive Director of Nursing and AHPs. Other senior officers attend as required. The People and Culture Committee held four meetings in 2025/26.

The Committee discharges a significant role in overseeing the workforce aspects of the Trust's performance. It also provides assurance that the Trust understands its strategic workforce needs, including wellbeing, culture, recruitment, retention, development of people, and organisational design. Equality and inclusion is embedded in all aspects of the Committee's work.

Business Committee attendance

Attendee	21 May	23 Sept	11 Dec	17 Mar	Total (4)
Rachel Booth	✓	✓	✓	✓	4/4
Lynne Mellor	✓	✓	✓	✓	4/4
Ian Lewis	✓	✓	✓	✓	4/4
*Laura Smith/Jenny Allen	✓	✓	✓	✓	4/4
Sam Prince			✓	✓	2/2
Andrea Osborne	✓				1/1
Lynsey Yeomans (to February 26)	✓	X	X		1/3
Heather McClelland (from March 26)				✓	1/1

*Director in attendance (job share)

Nominations and Remuneration Committee

Chair: Brodie Clark CBE (until 10 Aug 2025), then Helen Thomson (11 Aug 2025 - present)

The Nominations and Remuneration Committee's membership comprises the Chair, and two Non-Executive Directors. The Committee is supported by the Director of Workforce and the Company Secretary. The Committee has met four times in 2025/26.

The role of the Nominations and Remuneration Committee is to nominate executive directors, including the Chief Executive, for appointment and advise and make recommendations to the Board about appropriate remuneration and terms of service for the Chief Executive, executive directors, directors and any senior managers not covered by national Agenda for Change terms and conditions of employment.

The Committee also gives full consideration to, and make plans for, succession planning for the Chief Executive and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed.

It monitors and reviews any exceptional and/or significant employee relations cases which are high risk to the Trust, including high-cost employment cases or of reputational significance.

The Committee ratifies and agrees any awards at the discretion of the Trust as the employer.

In 2025/26 the Committee approved the recommendations for the remuneration of the interim Director of Nursing and Allied Health Professionals and continued to support various staff financial incentive schemes which were targeted responses to the challenging workforce situation.

Nominations and Remuneration Committee attendance

Attendee	17 Jun	9 Sept	16 Dec	17 Mar	Total (4)
Brodie Clark	✓				1/1
Helen Thomson		✓	✓	✓	3/3
Alison Lowe	X	✓	✓	✓	3/4
Rachel Booth	✓	✓	✓	X	3/4
*Laura Smith/Jenny Allen	✓	✓	✓	✓	4/4

*Director in attendance (job share)

Charitable Funds Committee

Chair: Alison Lowe OBE

The Charitable Funds Committee's membership is comprised of the Chair and one other Non-Executive Director. The Committee was supported by the Executive Director of Nursing until September 2025, and from that date the Executive Director of Operations provided support. The Committee met four times during 2025/26.

The purpose of the Committee is to give assurance to the Board that the Trust's charitable activities happen within the law and regulations set by the Charity Commissioners for England and Wales. The Committee oversees charitable activities, approves charitable funds expenditure, agrees an investment policy for charitable funds and monitors investments on a regular basis.

Charitable Funds Committee attendance

Attendee	1 July	9 Sept	16 Dec	19 Mar	Total (4)
Brodie Clark	✓				1/1
Helen Thomson		✓	✓	✓	3/3
Alison Lowe	✓	✓	✓	✓	4/4
Lynsey Yeomans (to February 26)			✓	X	1/2
Sam Prince		X	✓	✓	2/3
Andrea Osborne	✓	✓	✓	✓	4/4

Incident reporting and learning from incidents

The Trust confirms that it has fully transitioned to the Patient Safety Incident Response Framework (PSIRF) and has undertaken a further refresh of the Patient Safety Incident Response Plan (PSIRP) to ensure continued alignment with national requirements. Governance arrangements have been strengthened, with the dedicated Trust Improvement Groups now reporting directly into the Quality Assurance and Improvement Group, a formal sub committee of the Quality Committee.

Internal Audit has reviewed the revised arrangements and identified several areas for further improvement. The Trust has accepted these findings, and actions to address them are underway, with progress monitored through established governance structures. The Board is assured that appropriate systems of control are in place and that ongoing improvements will continue to enhance the robustness of the Trust's patient safety governance.

Information Governance

Compliance with Data Protection legislation, data security obligations and transparency requirements are of paramount importance to the Trust. The Trust is committed to ensuring that personal data is protected, and any confidential data is used appropriately and ethically.

The Trust complies with the relevant legislation and national codes of practice and actively supports the transparency of information. The Trust complies with the UK General Data Protection Regulation (UK GDPR) and employs a Data Protection Officer (DPO). The DPO duties include:

- Promoting the organisation's responsibilities, which empowers the organisation to be compliant with the Data Protection legislation.
- Ensuring there is subject matter expert provision for internal and external stakeholders to achieve compliance with privacy and information security in relation to the organisation activities.
- Protecting information, its integrity and availability throughout the lifecycle of the information.

The Senior Information Risk Owner (SIRO) ensures that there is effective information governance in place. The SIRO chairs both the SIRO Group, and the Information Governance Approval Group which reports quarterly to the Audit Committee and in turn to the Board. The Caldicott Guardian is the Deputy Chair of the Information Governance Approval Group, and works closely with the SIRO and the DPO, particularly where there are any identified information risks relating to patient data.

The Trust ensures effective information governance through a number of technical and organisational controls including education, policies and procedures, IT / information security controls, IT vulnerability testing, and by demonstrating annual compliance with the CAF aligned outcomes of the Data Security and Protection Toolkit (DSPT).

The DSPT submission is independently audited.

In recognition of the importance of data security, there is a target of 95% of staff compliance with information governance training. Training compliance is closely monitored, reminder emails are sent and system lockouts are enforced where necessary.



All incidents relating to a potential breach of personal data are reported, investigated and, where appropriate, remedial actions are implemented. The Trust reported four incidents to the Information Commissioner's Office (ICO) during 2025/26.

Details of the incidents are as follows:

Reported	What happened	Reported to
03/12/2025 10:05 by Head of IG / DPO	In error, a link to the subject access data of a service user was released to the incorrect solicitor. The solicitor made us aware of this, and we rescinded the link immediately and the data subject was informed.	Not required to report
23/09/2025 12:16 by Head of IG / DPO	A member of staff has been found to have registered their partner on our system to be able to view their blood results. Upon investigation they also admitted to viewing their grandfather in law's record. HR were involved along with the service lead - however, as this was not a malicious incident the individual was not dismissed.	Not required to report
24/07/2025 11:36 by Head of IG / DPO	Staff member accessed the records of their spouse (also a staff member). A task and finish group including service leads, safeguarding, IG and the medical director was convened to manage this incident as it was part of a potential domestic violence situation which was ongoing. The ICO is satisfied with our response and the actions taken to protect the data subject.	ICO
09/07/2025 14:06 by Head of IG / DPO	Issues with migration to new printing system for clinic and appointment letters 21/01/25 Phase 1 Go live Migration from Synertec to Healthcare Communications (HCC). This issue was reported to the ICO and NHSE. This was closed with no further action required as both ICO and NSHE were satisfied with our response to this incident.	DHSC/NHS England and ICO

NHS pension obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has a legal obligation under the Equality Act 2010 and Public Sector Equality Duty to provide equality in service provision and within employment.

This is how the Trust demonstrates how it meets our statutory duties relating to health equity in its care and pathways:

- **Public Sector Equality Duty** to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out activities. Our Equity and Quality Impact Assessment goes beyond the removal or minimisation of disadvantages on the basis of protected characteristics to align with NHSE Equality and Health Inequality Assessments, including focus on deprivation, health inclusion and other groups at risk of worse health outcomes. These are also included in equity impact assessments in policy development and review.
- **Annual health equity statement**, as a response to the Statement on Information on Health Inequalities, outlines the extent to which we have exercised our functions in line with the 5 domains to: understand health needs; understand healthcare access, experience and outcomes; improve data quality, collection and analysis; using information on health inequalities to develop actionable insights that inform service delivery and; publishing equity information throughout the year in Board reports and our Integrated Performance Report.
- **Accessible Information Standard** to identify, record, flag, share, meet and review the communication needs of people with disabilities and sensory impairments which is being delivered through our 'About Me' project and a range of communication improvements, supporting Leeds-wide commitment to improving the 3Cs – communication, compassion and coordination.
- **Equality Delivery System (EDS22)**, the national framework for assessing equality in the NHS, with Domain 1 focussed on commissioned services and this year included 0-19 service, Long Covid Rehabilitation Services and, Seacroft and Crossgates respiratory pilot, rated as 'Achieving' and with associated improvement plans relating to data availability and analysis, cultural competency and Third Sector engagement.
- **Patient and Carer Race Equality Framework (PCREF)**, the anti-racism framework for mental health services, which in LCH relates directly to Leeds Mental Wellbeing Service and Children and Young People's Mental Health Services, although our own Racial Equity in Care improvement work has been extended across all services, with improvements focussed on lived experience, data and analysis, culturally appropriate service delivery including interpreting and translation.
- **Armed Forces Covenant** to have due regard to the principles of the covenant for currently serving members of the UK Armed Forces (regular and reserve), veterans and family members and ensure they are not disadvantaged as a result of their service. This work is aligned to our VCHA accreditation and associated workplan, focussed on raising awareness of the needs of the Armed Forces community and data quality improvements to enable analysis of key performance metrics.



The Board receives in-depth analysis and updates on a range of proactive work around this wider agenda through the Workforce Strategy. This includes delivery against the Workforce Race Equality Standard (WRES) action plan and the Workforce Disability Equality Standard (WDES) Action Plan. The Equality, Diversity and Inclusion Forum, which is chaired by the Trust's Chair, continues to bring employee perspectives, experiences and ideas in pursuit of our ambition to be much more representative of our communities and to further tackle and reduce outstanding issues of disparity in staff experience. The Trust also has three staff networks: Disability, Neurodiversity and Long-Term Conditions, LGBTQIA+; and the Race Equality Network.



Review of economy, efficiency and effectiveness of the use of resources

The Trust has consistently met the financial targets set by its regulators.

The Board sets an annual budget to meet the Trust's financial obligations. For 2025/26 revenue and capital resources were agreed between the Trust and West Yorkshire ICS. The revenue plan approved was to deliver a balanced (breakeven) position, however a revised surplus of £0.9m (favourable to plan) was subsequently agreed as part of the Trust's contribution to the WY system's stretch target for 2025/26.

Achieving a balanced plan has depended on delivery of the £14m efficiency programme, which represents a 6% reduction in costs. The schemes identified to deliver the efficiencies were managed within the Quality and Value Programme, focussing on service transformation as well as a series of grip and control measures around workforce and discretionary spend.

An internal audit review of financial sustainability concluded an opinion of significant assurance, and the Trust is forecast to end the year in an underlying break-even position as we enter 2026/27.

The Trust has worked closely with all partners within Leeds Place and across the WY ICS to ensure achievement of value for money. At the end of February, the Trust is forecasting to deliver its agreed surplus.

The Trust maintained its financial governance arrangements throughout 2025/26 with the Business Committee and Board continuing to receive financial reports at each of their meetings, and the Audit Committee receiving assurances on financial governance from management, internal and external auditors.

The effectiveness of the Trust's services is regularly assessed by the Trust's Quality Committee and by the Board.

Sustainability

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Quality Account

The Trust has complied with the statutory duty to produce an annual Quality Account, as required for all NHS providers under the Health Act 2009 and subsequent regulations. The Quality Account has been prepared in accordance with the mandated national guidance issued by NHS England, including the prescribed content, reporting requirements, and assurance processes.



In producing the Quality Account, the organisation has continued to detail the successes, opportunities and challenges of improving quality over the year across the Trust and has included engagement with commissioners, local Healthwatch, and overview and scrutiny committees. The Board has reviewed the Quality Account and is satisfied that it provides a fair, balanced, and accurate representation of the quality of services delivered during the reporting year.

Review of effectiveness

The Chief Executive has responsibility for reviewing the effectiveness of the system of internal control. The review of the effectiveness of the system of internal control is informed by the work of internal auditors, the comments made by external auditors in the ISA260 report, the continuing engagement of the Audit Committee, managers and clinical leads who have responsibility for the development and maintenance of the internal control framework. The Audit Committee undertakes a role in terms of providing assurance to the Chief Executive.

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Dr Sara Munro

Internal audit

Audit Yorkshire has been the provider of the Trust's internal audit services since 1 April 2022. The Head of Internal Audit has provided an opinion which concludes that for the areas reviewed during the year, Leeds Community Healthcare NHS Trust has reasonable and effective risk management, control and governance processes in place.

This opinion is based solely on the matters that came to the attention of Audit Yorkshire during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or the ability to meet financial obligations which must be obtained by Leeds Community Healthcare NHS Trust from its various sources of assurance.

In areas where the effectiveness of internal control arrangements provided less than 'substantial' assurance, internal audit recommendations were made to further strengthen the control environment. The resulting management actions, which are monitored by the Audit Committee, have been completed or are being progressed in a satisfactory manner.

External audit

Forvis Mazars LLP were re-appointed as the Trust's external auditors in 2024/25 following a formal tender process carried out by the Auditor Appointment Panel and approved by Trust Board. The agreed contract period was three + one + one years.

Clinical audit

The Trust submitted data for three out of five of these audits and are working with auditors to ensure data is able to be provided for all five in 2025/26. More information about these can be found in the Quality Account (separate document - please follow link below).

Clinical audit is a dynamic process which allows quality improvement to take place and improve outcomes for patients through systematic review of care against explicit criteria. Clinical audit can be used to identify areas for improvement and learning. When findings from clinical audit are implemented, further monitoring is used to ensure continued delivery of quality, safe, and effective care.

Clinical audit is managed at service level with the support of the clinical governance team. The Quality Committee approves an annual programme of clinical audit and has oversight of progress during the year.

During 2025/26 eight national clinical audits covered the NHS services that the Trust provides, and the Trust registered for all eight. The Trust submitted complete datasets for five, partial data for two and were unable to submit data for one of the audits. The partial and no data submission were due to changes in requirements and the need for auditors to provide functionality for community datasets upload. The Trust is working with auditors to ensure full data is able to be provided for all eight audits in 2026/27. More information about these can be found in the Quality Account (separate document) by visiting www.leedscommunityhealthcare.nhs.uk

Working in collaboration

Partnership working is one of LCH's strategic goals: Collaborating with partners to enable people to live better lives, and most services deliver some part of their service in partnership – from informal arrangements to more formal partnership agreements.

We recognise the importance of collaborative working and the benefits that integration can bring for our service users, patient and carers. The Trust is a member of a number of collaboratives on a West Yorkshire footprint including the Mental Health, Learning Disability and Autism Collaboration, and the Community Health Services Provider Collaborative. We have an established alliance with Leeds City Council which has delivered a number of key initiatives such as Homefirst. Partnership working with the Voluntary and Community Sector (VCS) is described and delivered through our third sector strategy.

In addition to this, during 2025 the Value Circle was commissioned to undertake an external, evidence-based strategic review of the provider partnership across the Leeds health and care system. A recommendation was made to formalise the joint governance arrangements in the city, including with Leeds City Council, and this is now a system priority for 2026/27, working with the Integrated Care Board to establish a Place provider partnership.

Working at System level: West Yorkshire Health and Care Partnership (WYH&CP), an integrated care system



Over the last 12 months the Trust has continued to be actively involved in the development of the WYH&CP.

The Partnership is made up of the NHS, councils, hospices, Healthwatch, the voluntary community social enterprise sector. The Partnership supports 2.4 million people, living in urban and rural areas.

The WYH&CP takes a place-based approach across Bradford District and Craven; Calderdale, Kirklees, Leeds, and Wakefield that highlights the strengths, capacity, and knowledge of all those involved. This way of working is supported by West Yorkshire wide priority programmes, such as cancer, maternity, mental health, urgent care, tackling health inequalities, children and young people. The Partnership provides greater opportunities to deliver the Five-Year Plan ambitions, ensuring that all people are given the best start in life, are able to remain healthy and age well.

Leeds Health and Care Partnership (LHCP)



"We know that people's lives are better when those who deliver health and care work together."

The Leeds Health and Care Partnership (LHCP) includes health and care organisations from across Leeds who are working together to improve the health of people in Leeds. The LHCP understands that by listening to people, and by sharing knowledge and resources, it can make a bigger difference to people's lives.

Represented through the LCH Chief Executive, The Leeds Committee of the West Yorkshire Integrated Care Board makes decisions about the best way to allocate resources across the City that will have the biggest impact on improving health outcomes, people's experiences and reducing health inequalities.

Medium Term Plan

In February 2026 we submitted our first medium-term plan which was a new requirement for all NHS and Foundation Trusts. In it we set out our strategic goals, financial, operational and workforce trajectories including planned capital investment for five years. Our plan has been confirmed as compliant by NHSE.

A key change in our longer-term planning is to merge with LYPFT via a legal acquisition, a decision that was approved in our Board meeting on 6 November 2025 following the system review conducted by The Value Circle in 2025. We submitted a strategic outline case to NHSE on 12 February 2026 to seek their approval and support and this will be a priority piece of work in 2026/27 and beyond. The Boards of both organisations have established a Transition Committee which will oversee the transaction of acquisition reporting into boards. Our Boards have also scheduled joint sessions for the next 12 months.

NHS Provider Licence

The Trust has put in place measures to ensure the Board is able to confirm compliance with the NHS provider licence section 4 (governance) i.e. that we apply systems and standards of good corporate governance expected of a supplier of health services.

Our arrangements include a governance structure with four locally determined Board committees, over and above those required in statute (the Quality Committee, the Business Committee, the People and Culture Committee and the Charitable Funds Committee). This ensures that members of the Board (particularly Non-Executive Directors) are assured of the governance of the organisation and are assured on the quality of services (clinical and non-clinical). There is also a comprehensive governance and management structure beneath the Trust Leadership Team to support Executive Directors in delivering their individual portfolios and support the Chief Executive in carrying out their duties as Accounting Officer.

The Board of Directors and its committees have agreed terms of reference setting out the accountabilities and the delegated authority they have been given by the Board to carry out work on its behalf. The Trust has in place all the necessary statutory documentation including standing orders, standing financial instructions a scheme of delegation and matters reserved to the Board. All members of the Board have role descriptions, clearly setting out their duties and areas of accountability and there is a division of duties between the Chair and Chief Executive. All Board members have been deemed to be Fit and Proper in accordance with the CQC standard.

In accordance with its cycle of business, the Board receives reports from Executive Directors that detail compliance with, and achievement of, regulatory, contractual and local targets. The Board and its committees receive timely and accurate information at each of their meetings, and in accordance with their scheduled cycles of business. Performance data relating to their areas of responsibility will be scrutinised.

CQC compliance

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

NHS England oversight

NHS England has assigned the Trust a segment rating of '2' which indicates standard oversight whereby the provider may be offered targeted support in one or more areas.

The Trust works with a range of regulators including the CQC, HM Inspectorate of Prisons, and Ofsted.

The Trust's National Oversight Framework segmentation improved to segment 3 in Quarter 3 due to the ongoing improvements in reducing waits.

The Trust also submitted the Provider Board Capability self-assessment in October 2025 and has been rated Amber-Green by NHS England.

Conclusion

The Trust is a well-established health care provider that has built a system of internal control on sound foundations. The Trust has a strong safety culture and sees quality of care as its primary objective. Ongoing scrutiny enhances learning and strengthens governance.

The annual governance statement demonstrates that the Trust has the necessary control arrangements in place to manage risks and takes action when incidents occur.

Strong financial control and the achievement of statutory financial duties support the view that, clinically and financially, the Trust has effective and improving systems in place.

During 2025/26, no significant control issues have been identified by the Trust's systems of internal control.

Signed  **Sara Munro**, Interim Chief Executive

Date **24 June 2026**

Remuneration and Staff Report

Total remuneration includes salary, non-consolidated performance related pay, clinical excellence awards and on-call payments and benefits-in-kind. It does not include severance payments, employer pension contributions or cash equivalent transfer value of pensions.

The Trust appointed an interim Chief Executive on 1 June 2025. The appointee is currently the substantive Chief Executive of Leeds and York Partnership NHS Foundation Trust. The figures presented in this report represent the costs in respect of the Trust's share of salary and remuneration; for completeness the total salary for the shared role is also disclosed.

Two of the senior manager roles for the Trust are joint appointments with the Leeds GP Confederation; half a day per week of the remuneration of the Medical Director one day a week of the Director of People are recharged to the Leeds GP Confederation. Additionally, until the end of August 2024 the Executive Director of Nursing and Allied Health Professionals was a joint appointment with the GP Confederation.

See tables on the following pages.

Senior managers' remuneration - single total figure (subject to audit)

Board Member	2025 / 2026						2024 / 2025					
	Salary (bands of £5,000)	Expense payments (Rounded to the nearest hundred)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (Rounded to the nearest hundred)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£'000s	£'s	£'000s	£'000s	£'000s	£'000s	£'000s	£'s	£'000s	£'000s	£'000s	£'000s
Jennifer Allen – Director of People	70 - 75	-	-	-	52.5 - 55	125 - 135	55 - 60	-	-	-	-	55 - 60
Rachel Booth – Associate Non- Executive Director to 30/09/2024, Non- Executive Director from 01/10/2024	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Ruth Burnett – Executive Medical Director*	135 - 140	800	-	-	27.5 - 30	165 - 170	120 - 125	300	-	-	15 - 17.5	135 - 140
Brodie Clark CBE – Chair (to 10/08/2025)	10 - 15	200	-	-	-	10 - 15	35 - 40	400	-	-	-	40 - 45
Selina Douglas – Chief Executive from 15/04/2024 to 01/06/2025*	35 - 40	-	-	-	902.5 - 905	940 - 945	160 - 165	900	-	-	-	165 - 170
Richard Gladman – Non-Executive Director to 30/06/2024	-	-	-	-	-	-	0 - 5	-	-	-	-	0 - 5
Stephanie Lawrence MBE – Executive Director of Nursing and Allied Health Professionals to 31/08/2024	-	-	-	-	-	-	35 - 40	100	-	-	-	35 - 40
Ian Lewis – Non- Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15

	2025 / 2026						2024 / 2025					
Board Member	Salary (bands of £5,000)	Expense payments (Rounded to the nearest hundred)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (Rounded to the nearest hundred)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£'000s	£'s	£'000s	£'000s	£'000s	£'000s	£'000s	£'s	£'000s	£'000s	£'000s	£'000s
Alison Lowe OBE – Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Heather McClelland – Executive Director of Nursing and Allied Health Professionals from 16/03/2026	0 - 5	-	-	-	42.5 - 45	45 - 50	-	-	-	-	-	-
Lynne Mellor – Associate Non- Executive Director from 01/11/2024**	10 - 15	-	-	-	-	10 - 15	5 - 10	-	-	-	0 - 2.5	5 - 10
Sara Munro – Interim Chief Executive from 01/06/2025	110 - 115	-	-	-	22.5 - 25	130 - 135	-	-	-	-	-	-
Andrea North – Interim Director of Operations from 01/09/2023 to 14/04/2024	-	-	-	-	-	-	0 - 5	-	-	-	-	0 - 5
Andrea Osborne – Interim Executive Director of Finance and Resources from 05/02/2024 to 30/06/2024, Executive Director of Finance and Resources from 01/07/2024	140 - 145	-	-	-	90 - 92.5	235 - 240	130 - 135	-	-	-	277.5 - 280	410 - 415

	2025 / 2026						2024 / 2025					
Board Member	Salary (bands of £5,000)	Expense payments (Rounded to the nearest hundred)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (Rounded to the nearest hundred)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£'000s	£'s	£'000s	£'000s	£'000s	£'000s	£'000s	£'s	£'000s	£'000s	£'000s	£'000s
Samantha Prince – Interim Chief Executive from 01/09/23 - 14/04/24, Executive Director of Operations from 15/04/2024	140 - 145	-	-	-	-	140 - 145	140 - 145	100	-	-	-	140 - 145
Khalil Rehman – Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Laura Smith – Director of People	65 - 70	-	-	-	57.5 - 60	125 - 130	55 - 60	-	-	-	-	55 - 60
Sheila Sorby – Interim Director of Nursing and Allied Health Professionals from 16/08/2024 to 30/09/2024	-	-	-	-	-	-	10 - 15	-	-	-	85 - 87.5	95 - 100
Helen Thomson – Non-Executive Director	35 - 40	-	-	-	-	35 - 40	10 - 15	-	-	-	-	10 - 15
Lynsey Ure (formerly Yeomans) – Executive Director of Nursing and Allied Health Professionals from 01/10/2024* **	185 - 190	1,500	-	-	30 - 32.5	215 - 220	55 - 60	500	-	-	32.5 - 35	90 - 95

*For comparability, the 2024/25 bandings have been restated for these individuals to reflect a change in reporting of salary sacrifice adjustments in 2025/26. The bandings reported here are gross, before any salary sacrifice.

**Lynne Mellor was reported as having received a pension benefit in 2024/25; however, this transaction was an error and subsequently reversed. The 2024/25 reported figures have been corrected to remove the error.

**Lynsey Ure received a contractual payment in lieu of notice during 2025/26 at a cost of £74k, this included £10k of employers' national insurance contributions. In line with guidance, the salary cost shown in the table above includes the net figure of £64k.

Total remuneration for senior managers with shared responsibilities

	2025 / 2026						2024 / 2025					
Board Member	Salary (bands of £5,000)	Expense payments (Rounded to the nearest hundred)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (Rounded to the nearest hundred)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£'000s	£'s	£'000s	£'000s	£'000s	£'000s	£'000s	£'s	£'000s	£'000s	£'000s	£'000s
Ruth Burnett* – Executive Medical Director, employed by LCH role shared with Leeds GP Confederation	150 - 155	900	-	-	30 - 32.5	185 - 190	150 - 155	400	-	-	20 - 22.5	170 -175
Stephanie Lawrence MBE – Executive Director of Nursing and Allied Health Professionals to 31/08/2024, employed by LCH role shared with Leeds GP Confederation	-	-	-	-	-	-	45 - 50	100	-	-	-	45 - 50
Jennifer Allen – Director of People, employed by LCH role shared with Leeds GP Confederation	80 - 85	-	-	-	62.5 - 65	145 - 150	70 - 75	-	-	-	-	70 - 75
Laura Smith – Director of People, employed by LCH role shared with Leeds GP Confederation	80 - 85	-	-	-	70 - 72.5	150 - 155	70 - 75	-	-	-	-	70 - 75
Sara Munro – Interim Chief Executive from 01/06/2025, substantively employed by Leeds and York Partnership NHS FT	275 - 280	1,900	-	-	75 - 77.5	355 - 360	-	-	-	-	-	-

*For comparability, the 2024/25 bandings have been restated for this individual to reflect a change in reporting of salary sacrifice adjustments in 2025/26. The bandings reported here are gross, before any salary sacrifice.

Senior managers' remuneration – pension benefits (subject to audit) 2025/26

Board Member	Real increase in pension at pensionable age (bands of £2,500) £'000	Real increase in pension lump sum at pensionable age (bands of £2,500) £'000	Total accrued pension at pensionable age at 31 March 2023 (bands of £5,000) £'000	Lump sum at pensionable age related to accrued pension at 31 March 2023 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2023 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2023 £'000	Employer's contribution to stakeholder pension £'000
Jennifer Allen – Director of People	2.5 - 5	5 - 7.5	30 - 35	75 - 80	597	64	682	0
Ruth Burnett – Executive Medical Director	2.5 - 5	0	25 - 30	50 - 55	465	20	517	0
Selina Douglas – Chief Executive Officer (to 01/06/2025)	7.5 - 10	0	50 - 55	0	129	119	862	0
Heather McClelland – Executive Director of Nursing and Allied Health Professionals (from 16/03/2026)	0 - 2.5	0	10	0	76	1	113	0
Sara Munro – Interim Chief Executive (from 01/06/2025)	5 - 7.5	2.5 - 5	70 - 75	170 - 175	1,364	71	1,485	0
Andrea Osbourne – Executive Director of Finance and Resources	5 - 7.5	5 - 7.5	55 - 60	135 - 140	1,150	101	1,289	0
Laura Smith – Director of People	2.5 - 5	5 - 7.5	35 - 40	90 - 95	674	70	766	0
Lynsey Ure (formerly Yeomans) – Executive Director of Nursing and Allied Health Professionals (to 28/02/2026)	0 - 2.5	0	15 - 20	5 - 10	189	14	222	0

Information presented here is supplied by the NHS Pensions Agency.

No other senior managers are members of the pensions scheme.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with Statutory Instrument 2008 number 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2026.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Payments to past directors

There have been no payments made to past directors.

Fair pay disclosures

Reporting bodies are required to disclose the relationship between the remuneration and salary of the highest paid director in their organisation and the median and 25th and 75th percentiles remuneration and salary of the organisation's workforce.

Total remuneration used here includes gross pay plus all direct payments (taxable or not) this includes salary, non-consolidated performance related pay, clinical excellence awards, on-call payments, benefits-in-kind and all re-imbursed expenses. It does not include severance payments, employer pension contributions or cash equivalent transfer value of pensions.

Range of remuneration

During 2025/26 the Trust's staff were paid annualised salaries ranging from £24,465 to £264,479. The Trust's highest paid director was the Interim Chief Executive whose annualised salary was £264,479. This is a joint role which means the individual is Chief Executive for both the Trust and Leeds and York Partnership NHS Foundation Trust. The annualised salary reflects the combined responsibilities of the accountable officer for both organisations with a grouped turnover in excess of £0.5 billion. No members of staff received a performance bonus in 2024/25 or in 2025/26.

The percentage changes in pay of the highest paid director, the Chief Executive and other employees were as tabled below:

Percentage changes	2025/2026		2024/2025	
	Salary and allowances	Performance related pay and bonus	Salary and allowances	Performance related pay and bonus
Highest paid Director	66.67%	0%	10.53%	-100%
Other employees	3.55%	0%	2.69%	-100%

Performance related bonus was paid to six directors in 2023/24 hence the 100% reduction reported for 2024/25.

The total annualised remuneration and salaries for the Trust's staff including agency was as tabled below.

2025/2026	25th percentile	Median	75th percentile
Total Remuneration (£)	30,228	40,486	50,273
Salary component of total remuneration (£)	30,228	40,486	50,273
Pay ratio information remuneration	8.7:1	6.5:1	5.2:1
Pay ratio information salary	8.7:1	6.5:1	5.2:1

2024/2025	25th percentile	Median	75th percentile
Total Remuneration (£)	29,114	39,151	46,389
Salary component of total remuneration (£)	29,114	39,151	46,389
Pay ratio information remuneration	5.4:1	4.0:1	3.2:1
Pay ratio information salary	5.6:1	4.2:1	3.3:1

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is broken down further to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and the 75th percentile of salary components of the organisation's workforce.

The banded salary of the highest paid director / member in Leeds Community Healthcare NHS Trust in the financial year 2025/26 was £260k - £265k (2024/25, £155k - £160k). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

Year	25th percentile pay ratio		Median pay ratio		75th percentile pay ratio	
	Total remuneration	Salary	Total remuneration	Salary	Total remuneration	Salary
2025/26	8.7:1	8.7:1	6.5:1	6.5:1	5.2:1	5.2:1
2024/25	5.4:1	5.6:1	4.0:1	4.2:1	3.2:1	3.3:1

The salary and total remuneration of the Interim Chief Executive was 8.7 times more than the employee who was paid the 25th percentile point in 2025/26; the median ratio is 6.5 times more than the employee in this position and 5.2 times more than the 75th percentile employee. The total remuneration includes all payments such as travel expenses not just salary. The ratios between the highest paid director and other staff have increased for all categories between 2024/25 and 2025/26 due to the appointment of the interim Chief Executive. The majority of staff in the Trust received a pay increase in 2025/26.

Staff Report

Staff costs and numbers including senior officers (subject to audit)

Staff costs	2025/26			2024/25		
	Permanent £k	Other £k	Total £k	Permanent £k	Other £k	Total £k
Salaries and wages	120,538	7,912	128,450	117,909	7,706	125,615
Social security costs	15,540	570	16,110	12,006	448	12,454
Apprenticeship levy	586	22	608	576	22	598
Employer's contributions to NHS pensions	25,856	950	26,806	25,522	953	26,475
Pension cost - other	15	1	16	21	1	22
Other post employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	3,257	0	3,257	1,460	0	1,460
Temporary staff	0	2,833	2,833	0	2,408	2,408
Total gross staff costs (including seconded out)	165,792	12,288	178,080	157,494	11,538	169,032
Of which: Costs capitalised as part of assets	0	486	486	292	24	316

Average staff numbers in post by occupation groupings (subject to audit)

Average number of employees (WTE basis)	2025/26			2024/25		
	Permanent Number	Other Number	Total Number	Permanent Number	Other Number	Total Number
Medical and dental	49	24	72	52	25	77
Administration and estates	813	36	849	836	38	874
Healthcare assistants and other support staff	537	40	577	560	34	594
Nursing, midwifery and health visiting staff	875	49	924	884	49	933
Nursing, midwifery and health visiting learners	0	0	0	0	0	0
Scientific, therapeutic and technical staff	566	13	579	584	10	594
Healthcare science staff	0	0	0	0	0	0
Other	49	0	49	51	0	51
Total average numbers	2,888	162	3,050	2,967	156	3,123
Of which: Number of employees (WTE) engaged on capital projects	0	4	4	5	1	6

Expenditure on consultancy

The Trust had no expenditure on consultancy services during 2025/26 or 2024/25.

Off-payroll engagements

The Trust had the following off-payroll engagements as of 31 March 2026, that were for more than £245 per day and where engagement was for six months or more. The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Length of all highly paid off-payroll engagements

Number of existing engagements as of 31 March 2026	18
Of which, the number that have existed:	
For less than one year at the time of reporting	2
For between one and two years at the time of reporting	10
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	6

Six of the off-payroll appointments relate to forensic medical examiners and sixteen are individuals who provide clinical supervision to some of our senior clinical staff. Given the nature of the individual's work the off-payroll arrangements give the Trust the best value for money.

Off-payroll workers engaged at any point during the financial year

The Trust must also disclose how many off-payroll contractors who worked for the Trust at any time during 2025/26 where the earnings were £245 or more per day, this picks up all agency staff who are employed by and on the payroll of an umbrella company.

For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day:

Number of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	124
Of which:	
Number not subject to off-payroll legislation*	106
Number subject to off-payroll legislation and determined as in-scope of IR35*	0
Number subject to off-payroll legislation and determined as out of scope of IR35*	18
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which, number of engagements that saw a change to IR35 status following review	0

*A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

The Trust is required to disclose how many members of the Board or those with significant financial responsibility have been subject to off-payroll arrangements during the financial year 2025/26.

Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year.	0
Total number of individuals on payroll and off-payroll that have been deemed 'Board members, and/or, senior officials with significant financial responsibility' during the financial year. This figure must include both on payroll and off-payroll engagements.	16

Gender composition

*Directors here are either NEDs or individuals who have (either substantively or on an interim bases) sat on the Board of Directors at any time between April 2025 – March 2026. There are no Very Senior Managers (VSMs) below Board level.

Role	Gender	Headcount	%	FTE
Directors	Female	11	0.3%	10.25
	Male	2	0.0%	2.00
Employees	Female	2882	84.8%	2410.60
	Male	506	14.9%	470.44
	Grand total	3401	100%	2893.29

Staff turnover

	2025									2026		
Month	04	05	06	07	08	09	10	11	12	01	02	03
Headcount	3,357	3,346	3,358	3,354	3,352	3,376	3,377	3,380	3,383	3,358	3,382	3,399
Leavers Headcount	20	23	20	28	22	23	23	16	18	63	25	45
Starters Headcount	34	15	30	29	28	41	28	25	29	39	51	48
Turnover Rate (Headcount)	11.1%	11.1%	10.8%	10.5%	10.2%	10.0%	9.8%	9.6%	9.6%	10.4%	10.5%	9.6%
Turnover Rate (12m)	10.6%	10.6%	10.3%	10.0%	9.7%	9.6%	9.4%	9.2%	9.3%	10.0%	10.1%	9.1%

Exit packages (subject to audit)

The figures reported here are in respect of exit packages agreed in year. The actual date of departure may be in a subsequent period, and the expense in relation to departure costs may have been accrued in a previous period. The data here therefore is presented on a different basis to other staff cost expenditure presented in the accounts.

During 2025/26 the Trust ran a Mutually Agreed Resignation Scheme which are classified as other departures.

2025/2026

Exit package cost band (including any special payment element)	Total number of compulsory redundancies Number	Cost of compulsory redundancies £k	Number of other departures agreed Number	Cost of other departures £k	Total number of exit packages Number	Total cost of exit packages £k
<£10,000			14	79	14	79
£10,000 - £25,000			16	277	16	277
£25,001 - £50,000	1	50	7	235	8	285
£50,001 - £100,000	1	63	5	330	6	393
Total number	2		42	-	44	-
Total cost (£)	-	113	0	921	-	1,034

The remuneration report includes disclosure of exit packages payable to individuals named in that report.

	2025/26		2024/25	
Exit packages: other (non-compulsory) departure payments	Payments agreed Number	Total value of agreements £k	Payments agreed Number	Total value of agreements £k
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	41	847	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	1	74	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT / DHSC approval	0	0	0	0
Total	0	0	0	0
Of which:	42	921	0	0
Non-contractual payments requiring HMT / DHSC approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

2024/2025

Exit package cost band (including any special payment element)	Total number of compulsory redundancies Number	Cost of compulsory redundancies £k	Number of other departures agreed Number	Cost of other departures £k	Total number of exit packages Number	Total cost of exit packages £k
<£10,000	1	5			1	5
£10,000 - £25,000	1	22			1	22
£25,001 - £50,000	1	33			1	33
£50,001 - £100,000	2	129			2	129
Total number	5	-	0	-	5	-
Total cost (£)	-	189	0	0	-	189

Staff sickness

The table below illustrates a total number of days lost through sickness absence across the calendar year. These figures are supplied to the Trust by the Department of Health and Social Care. This ensures a standard approach is taken so that figures can be compared across NHS organisations.

Staff sickness	2025	2024
Total days lost (WTE)	68,739	66,231
Total days available (WTE)	1,054,005	1,095,104
Sickness rate	6.52%	6.32%

Source: NHS England/Digital – Sickness Absence and Workforce Publications, based on data from the ESR Data Warehouse. Periods covered: January to December 2025 and January to December 2024

Staff policies applied during the financial year

LCH's employment policies are available online at LCH Policies and Guidelines (leedscommunityhealthcare.nhs.uk). The suite of policies includes due regard to the important equality, diversity and inclusion considerations intrinsic to LCH's work and strategic goals.

Further information about LCH's Equality, Diversity and Inclusion actions and ambitions including its Public Sector Equality Duty publications and declarations are available at: www.leedscommunityhealthcare.nhs.uk/about-us-new/equality-and-diversity/

Signed  **Sara Munro**, Interim Chief Executive

Date **24 June 2026**

Parliamentary Accountability and Audit Report

We disclose the mandated content (fees and charges, remote contingent liabilities, losses and special payments and gifts) in the accounts.

Independent auditor's report to the Directors of Leeds Community Healthcare NHS Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Leeds Community Healthcare NHS Trust ('the Trust') for the year ended 31 March 2026, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026, the Statement of Cash Flows, and notes to the financial statements, including material accounting policy information.

The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2025/26 as contained in the Department of Health and Social Care Group Accounting Manual 2025/26, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of the Directors and the Accountable Officer for the financial statements

As explained more fully in the Statement of Directors' Responsibilities in respect of the accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2025/26 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

Based on our understanding of the Trust, we did not identify any laws and regulations that have an indirect effect on the preparation of the financial statements, where non-compliance might have a material effect on the financial statements.

To help us identify instances of non-compliance with laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- gaining an understanding of the legal and regulatory framework applicable to the Trust, the environment in which it operates, and the structure of the Trust, and considering the risk of acts by the Trust which were contrary to the applicable laws and regulations, including fraud;
- inquiring with management and the Audit Committee, as to whether the Trust is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- inspecting correspondence, if any, with relevant licensing or regulatory authorities;
- reviewing minutes of relevant meetings in the year; communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

In addition, we evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, in particular in relation to year end accruals, the risk of fraud in revenue recognition (which we pinpointed to the cut off, existence and valuation assertions), the risk of fraud in expenditure recognition (which we pinpointed to the cut off, completeness and valuation assertions) and significant one-off or unusual transactions.

Our audit procedures in relation to fraud included, but were not limited to:

- making enquiries of management, Head of Internal Audit and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing, testing of accounting estimates, and consideration of any significant transaction outside the normal course of business;

- testing income and expenditure transactions around the year end;
- testing year end expenditure accruals and receivables; and
- reviewing intra-NHS reconciliations provided by the Department of Health and Social Care.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with both management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, (Revised 2024) and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in November 2024.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at

www.frc.org.uk/auditorsresponsibilities

This description forms part of our auditor's report.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under section 21 of the Local Audit and Accountability Act 2014 (as amended) to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Board of Directors of Leeds Community Healthcare NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the NAO that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.



Alastair Newall, Key Audit Partner
For and on behalf of Forvis Mazars LLP (Local Auditor)

One St Peter's Square
Manchester, M2 3DE

24 June 2026

Leeds Community Healthcare NHS Trust

Annual accounts for the year ended

31 March 2026

Statement of Comprehensive Income

		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	230,048	223,542
Other operating income	4	15,798	14,706
Operating expenses	7,9	(247,325)	(237,919)
Operating surplus / (deficit) from continuing operations		(1,479)	329
Finance income	11	2,317	2,690
Finance expenses	12	(631)	(669)
PDC dividends payable		(232)	(239)
Net finance costs		1,454	1,782
Other gains / (losses)	13	(112)	(180)
Surplus / (deficit) for the year from continuing operations		(137)	1,931
Surplus / (deficit) for the year		(137)	1,931
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(1,068)	-
Revaluations	17	984	-
Total other comprehensive income for the period		(84)	-
Total comprehensive income / (expense) for the period		(221)	1,931

Statement of Financial Position

		31 March 2026 £000	31 March 2025 £000
	Note		
Non-current assets			
Intangible assets	14	504	894
Property, plant and equipment	15	38,380	35,888
Right of use assets	18	51,199	56,422
Receivables	19	15	15
Total non-current assets		90,098	93,219
Current assets			
Receivables	19	10,039	9,733
Non-current assets for sale and assets in disposal groups	20	999	-
Cash and cash equivalents	21	49,922	50,910
Total current assets		60,960	60,643
Current liabilities			
Trade and other payables	22	(25,466)	(27,910)
Borrowings	24	(7,748)	(7,736)
Provisions	25	(6,183)	(2,857)
Other liabilities	23	(2,066)	(1,014)
Total current liabilities		(41,463)	(39,517)
Total assets less current liabilities		109,595	114,345
Non-current liabilities			
Borrowings	24	(44,311)	(49,056)
Provisions	25	(349)	(349)
Total non-current liabilities		(44,660)	(49,405)
Total assets employed		64,935	64,940
Financed by			
Public dividend capital		4,258	4,042
Revaluation reserve		13,823	14,200
Income and expenditure reserve		46,854	46,698
Total taxpayers' equity		64,935	64,940

The notes on pages 150 to 198 form part of these accounts.

Sara Munro

Name Sara Munro
Position Interim Chief Executive
Date 24th June 2026

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	4,042	14,200	46,698	64,940
(Deficit) for the year	-	-	(137)	(137)
Other transfers between reserves	-	(293)	293	-
Impairments	-	(1,068)	-	(1,068)
Revaluations	-	984	-	984
Public dividend capital received	216	-	-	216
Taxpayers' equity at 31 March 2026	4,258	13,823	46,854	64,935

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2024 - brought forward	2,526	14,504	44,463	61,493
Surplus for the year	-	-	1,931	1,931
Other transfers between reserves	-	(304)	304	-
Impairments	-	-	-	-
Revaluations	-	-	-	-
Public dividend capital received	1,516	-	-	1,516
Taxpayers' equity at 31 March 2025	4,042	14,200	46,698	64,940

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves

Leeds Community Healthcare NHS Trust does not hold a financial assets (available for sale) reserve, a merger reserve or any other reserves not specifically included in the taxpayers' equity.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

		2025/26 £000	2024/25 £000
	Note		
Cash flows from operating activities			
Operating surplus / (deficit)		(1,479)	329
Non-cash income and expense:			
Depreciation and amortisation	7.1	11,178	10,293
Net impairments	8	1,076	-
(Increase) / decrease in receivables and other assets		(528)	163
Increase / (decrease) in payables and other liabilities		(3,400)	3,852
Increase / (decrease) in provisions		3,326	2,217
Net cash flows from / (used in) operating activities		10,173	16,854
Cash flows from investing activities			
Interest received		2,317	2,690
Purchase of intangible assets		(25)	(799)
Purchase of PPE and investment property		(5,210)	(3,872)
Initial direct costs or up front payments in respect of new right of use assets		(189)	(171)
Net cash flows from / (used in) investing activities		(3,107)	(2,152)
Cash flows from financing activities			
Public dividend capital received		216	1,516
Capital element of lease rental payments		(7,634)	(7,599)
Other interest		-	(2)
Interest paid on lease liability repayments		(626)	(664)
PDC dividend (paid) / refunded		(10)	(579)
Net cash flows from / (used in) financing activities		(8,054)	(7,328)
Increase / (decrease) in cash and cash equivalents		(988)	7,374
Cash and cash equivalents at 1 April - brought forward		50,910	43,536
Cash and cash equivalents at 31 March	21	49,922	50,910

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Interests in other entities

Joint operations

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. Leeds Community Healthcare NHS Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

Leeds Community Healthcare NHS Trust provides the following services as lead provider. The contract income flows to the Trust and the relevant partner recharges expenditure associated with the provision of the service. Where agreed, Leeds Community Healthcare NHS Trust distributes a share of any profit or loss to the relevant partner.

Sexual Health Services - Partner: Leeds Teaching Hospitals NHS Trust.

Leeds Mental Wellbeing Service - Partners: Leeds and York Partnership NHS Foundation Trust, Northpoint, Touchstone, Community Links, Leeds GP Confederation, Women's Counselling Service and Homestart Leeds.

Weight Management Services - Partners: Leeds Teaching Hospitals NHS Trust and Leeds and York Partnership NHS Foundation Trust.

The Trust works in partnership with other West Yorkshire Mental Health Providers and collectively this partnership is known as the West Yorkshire Mental Health, Learning Disabilities and Autism Collaborative. Leeds Community Healthcare NHS Trust is part of a Committee in Common which oversees the system-wide programme to deliver a collaborative model of care. The Trust is commissioned to provide a Children and Young People's mental health crisis service and the income and costs for this service are included in the Trust's financial position. As a Collaborative partner, Leeds Community Healthcare NHS Trust has a share of any assets or liabilities of the CYPMH services provider collaborative.

Leeds Community Healthcare NHS Trust provides a Community Care Beds service under a joint operation with Leeds City Council. The Trust is the lead provider and contract income flows to the Trust. Leeds City Council recharges expenditure associated with the service. The total cost of this service is recognised by Leeds Community Healthcare NHS Trust.

Leeds Community Healthcare NHS Trust provides a 10 bed dementia / general rehab service under a joint operation with Leeds City Council. Leeds City Council is the lead provider and contract income flows to them. Leeds Community Healthcare NHS Trust recharges expenditure associated with the service to Leeds City Council.

NHS Charitable Fund

Leeds Community Healthcare NHS Trust is the Corporate Trustee with the Leeds Community Healthcare Charitable Trust. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund. It also has the ability to affect those returns and other benefits through its power over the fund.

Leeds Community Healthcare NHS Trust has decided not to consolidate the charitable funds into these accounts as the transactions and balances are not material.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods / services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods / services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor, other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts (API) form the main payment mechanism under the NHSPS. API contracts contain both a fixed and a variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts, with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Revenue from non-NHS contracts

Revenue is recognised by Leeds Community Healthcare NHS Trust from non-NHS commissioners for health care services under IFRS 15. The revenue is recognised as and when performance obligations are satisfied.

The performance obligation relating to the delivery of health care is satisfied over the time the healthcare is received and consumed simultaneously by the customer, as the Trust performs it. At the year end, the Trust accrues income relating to activity delivered in that year. Income relating to future periods is deferred.

Where Leeds Community Healthcare NHS Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services, or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has a cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits, or service potential deriving from the cost incurred to replace a component of such item, will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie, operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation / grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation / grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	5	80
Plant & machinery	5	10
Information technology	2	5
Furniture & fittings	10	10

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg, an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg, application software, is capitalised as an intangible asset where it meets the recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, Leeds Community Healthcare NHS Trusts intangible assets were held at cost less amortisation

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	3	5

Note 1.10 Inventories

Leeds Community Healthcare NHS Trust does not hold inventories and the cost of inventory items are expensed through the income and expenditure account.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial assets and financial liabilities**Recognition**

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash, or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through profit and loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

For financial liabilities, the carrying value of short term trade and other payables is a reasonable approximation to fair value, all trade payables are considered to be short term. The nature of obligations relating to lease and other borrowings are that they are arms length transactions with values determined by contract. There is no significant difference between the carrying value and the fair value of these liabilities.

For financial assets, the carrying value of short term trade and other receivables is a reasonable approximation of fair value.

Financial assets so classified are subsequently measured at amortised cost.

Financial liabilities so classified are subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and is recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss', require an allowance for an expected credit loss. Lifetime credit losses are recognised if there is objective evidence of impairment as a result of one or more events that occurred after initial recognition of the asset and that have an impact on the estimated future cash flows of the asset. However NHS bodies are not allowed to recognise any impairments against intra-DHSC balances as it is expected that they will be recoverable, therefore no lifetime credit losses are made against NHS bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13 Leases

A lease is a contract, or part of a contract, that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meets the definition of a lease. As per mandatory GAM adaptations, the Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes an estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate, and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% was applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less, or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications, or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates, effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 25.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise, or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2025/26:

IFRS 14 Regulatory Deferral Accounts - The Standard is not UK-endorsed and applies to first time adopters of IFRS after 1 January 2016, therefore it is not applicable to DHSC group bodies.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE currently subject to revaluation has a total book value of £28.7m as at 31 March 2026.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to its requirements for valuation frequency, valuation methodology and classification of non-investment property assets. The changes are effective in the public sector from 1 April 2025 with a 5 year transition period, however NHS bodies are adopting these changes to an alternative timeline.

Note 1.21 Critical judgements in applying accounting policies

In the application of Leeds Community Healthcare NHS Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions, are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates, and underlying assumptions, are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

As part of the adoption of IFRS 16, Leeds Community Healthcare NHS Trust reviewed all leases to determine whether a revaluation model or cost model would be used as a basis for valuing property leases. On review, it was determined that the property leases are subject to regular rent reviews throughout the lease term, based on the Retail Prices Index (RPI) and market conditions. As the rental values are regularly updated to account for market conditions, the Trust has applied the cost model when accounting for the property leases under IFRS16.

IFRS 16 has been applied to all leases held by the Trust with a length of over 12 months and a value over £5k.

Note 1.22 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property Valuation and Asset Lives

Valuations have been undertaken by Leeds Community Healthcare NHS Trust's expert independent valuer, the District Valuer, part of the Valuation Office Agency, as at 31 March 2026. All operational assets have been valued on a current value in existing use basis. The land and building valuations are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury and the Department of Health and Social Care. These valuations will therefore be subject to changes in market conditions and market values. As part of this valuation the asset lives are also estimated by the District Valuer and are subject to professional judgement.

Two properties, Otley Clinic and Horsforth Clinic, have been designated by the Trust as surplus assets, with no plan to bring them back into use and have been reclassified as assets held for sale. The value of these assets is held at the net book value at transfer to Assets Held for Sale and have not been included in the revaluation.

The Valuation Office Agency has valued the estate as at 31 March 2026 as £28,732k, with land being £7,988k and buildings, excluding dwellings, being £20,744k.

Provisions

Estimates for restructuring, redundancy and legal costs has been made and included in the Trust's expenditure for 2025/26 as required under IAS 37. The estimated value of these are £2,038k restructuring, £3,075k redundancy and £1,069k legal costs. Details of provisions are in Note 25.

Note 2 Operating Segments

All activity at Leeds Community Healthcare NHS Trust is healthcare related and the majority of the Trust's revenue is received from within UK government departments.

The main proportion of operating expenses are payroll related and are for the staff directly involved in the provision of healthcare, and the indirect and overhead costs associated with that provision. It is deemed that the business activities that earn revenues for the Trust, and in turn incur the expenses, are therefore one broad provision on which it is deemed appropriate to identify as only one segment, namely healthcare.

Monthly operating results are published for assessment and review by the Trust's Chief Operating Decision Maker, which is the overall Trust Board that includes Executive and Non-Executive Directors. The financial position of the Trust to date, the Trust's Statement of Financial Position and Cash Flow and projections of future performance are assessed as a whole Trust rather than individual component parts that make up the sum total. In addition, all reporting of the position of the Trust is presented on a whole Trust basis that again implies a single operating segment under IFRS 8. As all decisions affecting the Trust's future direction and viability are made based on the overall total presented to Board, the Trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Note 3.1 Income from patient care activities (by nature)	2025/26	2024/25
	£000	£000
Mental health services		
Income from commissioners under API contracts*	36,467	34,174
Services delivered under a mental health collaborative	210	194
Community services		
Income from commissioners under API contracts*	147,157	145,565
Income from other sources (eg, local authorities)****	35,637	33,099
All services		
National pay award central funding**	-	29
Additional pension contribution central funding***	10,577	10,481
Total income from activities	230,048	223,542

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

***Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	2025/26	2024/25
Income from patient care activities received from:	£000	£000
NHS England	12,968	17,988
Integrated Care Boards	181,233	172,259
Other NHS providers	3,924	194
Local authorities	29,910	30,970
Non NHS: other	2,013	2,131
Total income from activities	230,048	223,542
Of which:		
Related to continuing operations	230,048	223,542

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

Leeds Community Healthcare NHS Trust has made no charges relating to patients who are overseas visitors.

Note 4 Other operating income

	2025/26			2024/25		
	Contract	Non-contract	Total	Contract	Non-contract	Total
	income	income		income	income	
	£000	£000	£000	£000	£000	£000
Research and development	673	-	673	365	-	365
Education and training	4,352	484	4,836	4,192	487	4,679
Non-patient care services to other bodies	116	-	116	61	-	61
Income in respect of employee benefits accounted on a gross basis	2,935	-	2,935	3,837	-	3,837
Revenue from operating leases	-	493	493	-	582	582
Other income*	6,745	-	6,745	5,182	-	5,182
Total other operating income	14,821	977	15,798	13,637	1,069	14,706
Of which:						
Related to continuing operations			15,798			14,706

*Other income totalled £6,745k: this includes £945k rental income, £1,416k contribution to the Integrated Mental Wellbeing service for Leeds, £359k lease car income, £741k MSK services, £1,873k Leeds Equipment service, £418k Fair Share Allocation, £118k Sexual Health service, £66k Weight Management service, £90k Leeds GP Confederation, £386k Leeds City Council (One Adoption West Yorkshire service and Therapeutic Social Work Team) and £333k various other income.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	683	1,206

Note 6 Operating leases - Leeds Community Healthcare NHS Trust as lessor

This note discloses income generated in operating lease agreements where Leeds Community Healthcare NHS Trust is the lessor.

Leasing arrangements where the Trust is a lessor relate to the sub-letting of office accommodation, health centres and clinics, where the lessee is a GP practice or other healthcare organisation.

Leasing arrangements are generally managed through a formal leasing process, with an ongoing review process. For some GP practices, where this is not in place, there are regular reviews of the GP commissioning arrangements with the Integrated Care Board (ICB).

Any vacant space is reviewed, to ensure there is no long term void space and short term arrangements may be made with third parties.

Note 6.1 Operating lease income

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	493	582
Total in-year operating lease income	493	582

Note 6.2 Future lease receipts

	31 March	31 March
	2026	2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year;	494	511
- later than one year and not later than two years;	481	498
- later than two years and not later than three years;	468	485
- later than three years and not later than four years;	420	483
- later than four years and not later than five years;	309	372
- later than five years.	365	484
Total	2,537	2,833

Note 7.1 Operating expenses

	2025/26	2024/25
	£000	£000
Staff and executive directors costs	174,337	167,256
Remuneration of non-executive directors	128	124
Supplies and services - clinical (excluding drugs costs)	27,623	30,128
Supplies and services - general	8,781	6,350
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,047	979
Establishment	3,037	3,686
Premises	7,962	8,274
Transport (including patient travel)	1,741	1,816
Depreciation on property, plant and equipment	10,823	10,198
Amortisation on intangible assets	355	95
Net impairments	1,076	-
Movement in credit loss allowance: contract receivables / contract assets	84	164
Fees payable to the external auditor		
audit services - statutory audit	126	108
Internal audit costs	105	100
Clinical negligence	807	735
Legal fees	176	367
Insurance (as a policy holder)	100	119
Research and development	115	116
Education and training	1,333	760
Expenditure on short term leases	105	581
Expenditure on low value leases	95	95
Redundancy	3,257	1,460
Car parking & security	449	424
Hospitality	1	1
Losses, ex gratia & special payments	14	5
Other services, eg, external payroll	1,774	1,339
Other*	1,874	2,639
Total**	247,325	237,919
Of which:		
Related to continuing operations	247,325	237,919

*Other expenditure includes £487k for External Recharges including £265k in respect of Leeds Sexual Health Service recharges from Leeds Teaching Hospital NHS Trust, £1,323k for Trust integration programme costs, £31k for car parking permits and £39k for the staff assistance programme.

**All expenditure includes VAT where not recoverable.

Note 7.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2025/26 or 2024/25.

Note 8 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	1,076	-
Total net impairments charged to operating surplus / deficit	1,076	-
Impairments charged to the revaluation reserve	1,068	-
Total net impairments	2,144	-

The impairment of assets is due to the full revaluation of Leeds Community Healthcare NHS Trust's estate undertaken by the District Valuer. A net impairment loss of £1,076k has been included in operating expenses during the year and the £1,068k impairment has been included in the revaluation reserve. The net impact on the value of assets was an overall reduction of £2,144k and was due to changes in market prices. Further details can be found in Note 17.

Note 9 Employee benefits

	2025/26	2024/25
	£000	£000
Salaries and wages	128,450	125,615
Social security costs	16,110	12,454
Apprenticeship levy	608	598
Employer's contributions to NHS pensions	26,806	26,475
Pension cost - other	16	22
Termination benefits	3,257	1,460
Temporary staff (including agency)	2,833	2,408
Total gross staff costs	178,080	169,032
Of which		
Costs capitalised as part of assets	486	316

Note 9.1 Retirements due to ill-health

During 2025/26 there were 3 early retirements from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £161k (£222k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

For 2026/27 the Trust's expected pension costs are £27,690k.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Other pension costs

NEST (National Employment Savings Trust) is an alternative pension scheme set up to comply with new legislation which provides that employees fulfilling certain criteria must auto-enrol into a pension scheme. When they do not qualify for or wish not to join the NHS Pension Scheme, this is Leeds Community Healthcare NHS Trust's mandatory alternative scheme. NEST Corporation is the Trustee body that has overall responsibility for running NEST. It is a non-departmental public body that operates at arm's length from government and is accountable to Parliament through the Department of Work and Pensions (DWP).

Leeds Community Healthcare NHS Trust has incurred expenditure of £16k during the year in respect of contributions for employees under the NEST scheme.

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	2,317	2,690
Total finance income	2,317	2,690

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on lease obligations	626	664
Interest on late payment of commercial debt	-	3
Total interest expense	626	667
Unwinding of discount on provisions	5	2
Total finance costs	631	669

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	3

Note 13 Other gains / (losses)

	2025/26	2024/25
	£000	£000
Losses on disposal of assets	(112)	(180)
Total gains / (losses) on disposal of assets	(112)	(180)
Total other gains / (losses)	(112)	(180)

Loss on disposal of assets relates to the disposal of lease cars held by the Trust under IFRS 16 of £28k and the disposal of Clinical and IT Equipment of £84k, following an asset verification exercise.

Note 14 Intangible assets - 2025/26

	Software licences	Total
	£000	£000
Cost at 1 April 2025 - brought forward*	1,234	1,234
Additions	25	25
Disposals / de-recognition	(141)	(141)
Cost at 31 March 2026	1,118	1,118
Amortisation at 1 April 2025 - brought forward	340	340
Provided during the year	355	355
Disposals / de-recognition	(81)	(81)
Amortisation at 31 March 2026	614	614
Net book value at 31 March 2026	504	504
Net book value at 1 April 2025	894	894

*From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 14.1 Intangible assets - 2024/25

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	435	435
Additions	799	799
Valuation / gross cost at 31 March 2025	1,234	1,234
Amortisation at 1 April 2024 - brought forward	245	245
Provided during the year	95	95
Amortisation at 31 March 2025	340	340
Net book value at 31 March 2025	894	894
Net book value at 1 April 2024	190	190

Note 15.1 Property, plant and equipment - 2025/26

	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2025 - brought forward	8,730	25,050	2,633	9,686	88	46,187
Additions	-	2,337	3,264	1,341	276	7,218
Impairments	-	(1,175)	-	-	-	(1,175)
Reversals of impairments	-	107	-	-	-	107
Revaluations	-	(1,386)	-	-	-	(1,386)
Reclassifications	-	-	-	-	-	-
Transfers to / from assets held for sale*	(742)	(274)	-	-	-	(1,016)
Disposals / de-recognition	-	(2,121)	(314)	(3,777)	(53)	(6,265)
Valuation / gross cost at 31 March 2026	7,988	22,538	5,583	7,250	311	43,670
Accumulated depreciation at 1 April 2025 - brought forward	-	3,124	1,513	5,607	55	10,299
Provided during the year	-	828	282	1,429	4	2,543
Impairments	-	1,413	-	-	-	1,413
Reversals of impairments	-	(337)	-	-	-	(337)
Revaluations	-	(2,370)	-	-	-	(2,370)
Reclassifications	-	-	-	-	-	-
Transfers to / from assets held for sale*	-	(17)	-	-	-	(17)
Disposals / de-recognition	-	(2,121)	(303)	(3,764)	(53)	(6,241)
Accumulated depreciation at 31 March 2026	-	520	1,492	3,272	6	5,290
Net book value at 31 March 2026	7,988	22,018	4,091	3,978	305	38,380
Net book value at 1 April 2025	8,730	21,926	1,120	4,079	33	35,888

* The assets held for sale relate to two properties at Otley and Horsforth which are currently in sale negotiations. Further details are in Note 20

Leeds Community Healthcare NHS Trust has a number of assets fully written down to a nil value within the asset register which are still in operational use. The gross value of these assets is £1,664k this consists of £131k for buildings, £782k for plant and machinery, £485k for information technology and £266k for intangible assets.

Note 15.2 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	8,730	22,194	2,635	11,379	1,524	46,462
Additions	-	1,521	372	1,132	35	3,060
Impairments	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Reclassifications	-	1,335	-	-	(1,335)	-
Transfers to / from assets held for sale	-	-	-	-	-	-
Disposals / de-recognition	-	-	(374)	(2,825)	(136)	(3,335)
Valuation / gross cost at 31 March 2025	8,730	25,050	2,633	9,686	88	46,187
Accumulated depreciation at 1 April 2024 - brought forward	-	2,329	1,586	7,150	224	11,289
Provided during the year	-	759	226	1,218	2	2,205
Impairments	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-
Reclassifications	-	36	-	-	(36)	-
Transfers to / from assets held for sale	-	-	-	-	-	-
Disposals / de-recognition	-	-	(299)	(2,761)	(135)	(3,195)
Accumulated depreciation at 31 March 2025	-	3,124	1,513	5,607	55	10,299
Net book value at 31 March 2025	8,730	21,926	1,120	4,079	33	35,888
Net book value at 1 April 2024	8,730	19,865	1,049	4,229	1,300	35,173

Note 15.3 Property, plant and equipment financing - 31 March 2026

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Owned - purchased	7,988	21,436	4,091	3,978	305	37,798
Owned - donated / granted	-	582	-	-	-	582
Total net book value at 31 March 2026	7,988	22,018	4,091	3,978	305	38,380

Note 15.4 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Owned - purchased	8,730	21,384	1,120	4,079	33	35,346
Owned - donated / granted	-	542	-	-	-	542
Total net book value at 31 March 2025	8,730	21,926	1,120	4,079	33	35,888

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	16,197	-	-	-	16,197
Not subject to an operating lease	7,988	5,821	4,091	3,978	305	22,183
Total net book value at 31 March 2026	7,988	22,018	4,091	3,978	305	38,380

Note 15.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	14,943	-	-	-	14,943
Not subject to an operating lease	8,730	6,983	1,120	4,079	33	20,945
Total net book value at 31 March 2025	8,730	21,926	1,120	4,079	33	35,888

Note 16 Donations of property, plant and equipment

Leeds Community Healthcare NHS Trust has not received any donations from the Leeds Community Healthcare Charitable Trust and related Charities in 2025/26 (2024/25 - £Nil).

Note 17 Revaluations of property, plant and equipment

During 2025/26 a desktop valuation was undertaken by the District Valuer, part of the Valuation Office Agency, an independent RICS valuer, in accordance with RICS guidance.

The valuation took into account improvements undertaken during the year on buildings as well as their current condition. The valuation methodology assumes that our buildings will be maintained to their current condition over their remaining lives. The valuation was undertaken on a current value in existing use basis, as defined in the DHSC GAM and reflecting the adaptation approved by Financial Reporting Advisory Board to IAS16.

The impact of the valuation on land and property in full use is a net reduction in value of £1,160k. A reduction of £84k was charged to the revaluation reserve and an impairment loss of £1,076k was charged to operating expenditure. The revaluation reserve movement consisted of a positive £983k revaluation and an impairment reduction of £1,068k.

The useful lives applied to property, plant and equipment assets are shown in note 1.8.

The properties at Otley and Horsforth have been identified by Leeds Community Healthcare NHS Trust as surplus to requirements with no plan to bring them back into use and have been reclassified as assets held for sale. The District Valuer has valued them and there is a net gain when compared to the net book value, but the value is unchanged and held at the lower figure of net book value. The related land and buildings have a net book value of £742k and £257k, respectively.

Note 18.1 Right of use assets - 2025/26

	Property (land and buildings)	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	76,698	861	77,559	71,707
Additions	579	339	918	-
Remeasurements of the right of use asset	2,188	-	2,188	1,797
Movements in provisions for restoration / removal costs	(5)	-	(5)	-
Disposals / de-recognition	(897)	(308)	(1,205)	(897)
Valuation / gross cost at 31 March 2026	78,563	892	79,455	72,607
Accumulated depreciation at 1 April 2025 - brought forward	20,779	358	21,137	19,730
Provided during the year	7,940	340	8,280	7,343
Disposals / de-recognition	(897)	(264)	(1,161)	(897)
Accumulated depreciation at 31 March 2026	27,822	434	28,256	26,176
Net book value at 31 March 2026	50,741	458	51,199	46,431
Net book value at 1 April 2025	55,919	503	56,422	51,977
Net book value of right of use assets leased from other NHS providers				-
Net book value of right of use assets leased from other DHSC group bodies				46,431

Note 18.2 Right of use assets - 2024/25

	Property (land and buildings)	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	73,426	825	74,251	68,897
Additions	437	369	806	-
Remeasurements of the right of use asset	3,172	10	3,182	2,810
Movements in provisions for restoration / removal costs	(3)	-	(3)	-
Disposals / de-recognition	(334)	(343)	(677)	-
Valuation / gross cost at 31 March 2025	76,698	861	77,559	71,707
Accumulated depreciation at 1 April 2024 - brought forward	13,431	311	13,742	12,636
Provided during the year	7,682	311	7,993	7,094
Disposals / de-recognition	(334)	(264)	(598)	-
Accumulated depreciation at 31 March 2025	20,779	358	21,137	19,730
Net book value at 31 March 2025	55,919	503	56,422	51,977
Net book value at 1 April 2024	59,995	514	60,509	56,261
Net book value of right of use assets leased from other NHS providers				-
Net book value of right of use assets leased from other DHSC group bodies				51,977

Note 18.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the Statement of Financial Position. A breakdown of borrowings is disclosed in note 24.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	56,792	60,613
Lease additions	729	635
Lease liability remeasurements	2,188	3,182
Interest charge arising in year	626	664
Early terminations	(16)	(39)
Lease payments (cash outflows)	(8,260)	(8,263)
Carrying value at 31 March	52,059	56,792

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Income generated from subleasing right of use assets is £118k and is included within revenue from operating leases in note 4.

Note 18.4 Maturity analysis of future lease payments

	Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:	
	Total		Total	
	31 March	31 March	31 March	31 March
	2026	2026	2025	2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	8,330	7,435	8,325	7,423
- later than one year and not later than five years;	31,552	28,753	31,038	28,761
- later than five years.	14,583	12,541	19,951	18,362
Total gross future lease payments	54,465	48,729	59,314	54,546
Finance charges allocated to future periods	(2,406)	(1,564)	(2,522)	(1,974)
Net lease liabilities at 31 March 2026	52,059	47,165	56,792	52,572
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		47,165		52,572

Note 19.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	8,441	6,280
Allowance for impaired contract receivables / assets	(277)	(296)
Prepayments (non-PFI)	1,244	1,982
PDC dividend receivable	236	458
VAT receivable	210	915
Other receivables	185	394
Total current receivables	10,039	9,733
Non-current		
Other receivables	15	15
Total non-current receivables	15	15
Of which receivable from NHS and DHSC group bodies:		
Current	1,083	1,318
Non-current	15	15

Note 19.2 Allowances for credit losses

	2025/26		2024/25	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	296	-	132	-
New allowances arising	277	-	296	-
Reversals of allowances	(193)	-	(132)	-
Utilisation of allowances (write offs)	(103)	-	-	-
Allowances as at 31 March 2026	277	-	296	-

Note 19.3 Exposure to credit risk

NHS debt is resolved through the agreement of balances process and, as such, is not considered to be a credit risk. In line with IFRS 9 Leeds Community Healthcare NHS Trust uses a provision matrix to categorise the debts and reviews historical losses over a two year period. The historical debt rates of non-NHS debt were determined by calculating invoices written off as a percentage of total non-NHS debt. Forward looking macro-economic factors were considered and the final credit loss rates were calculated.

Leeds Community Healthcare NHS Trust has a credit risk from ex-employee debt and the credit loss rate to be applied to this type of debt was calculated as 26.75%. For the majority of other outstanding debt over 6 months a credit risk of 100% has been applied. This is lowered to 50% for between 3 and 6 months and 25% for over 3 months. Where discussions are taking place with specific debtors the rating has been adjusted to reflect the likelihood of resolution. Overall a £277k credit loss allowance has been recognised for non-NHS receivables in 2025/26.

Note 20 Non-current assets held for sale and assets in disposal groups

	2025/26	2024/25
	£000	£000
NBV of non-current assets held for sale and assets in disposal groups at 1 April	-	-
Assets classified as available for sale in the year	999	-
NBV of non-current assets held for sale and assets in disposal groups at 31 March	999	-

The properties at Otley and Horsforth have been identified by Leeds Community Healthcare NHS Trust as surplus to requirements with no plan to bring them back into use and have been reclassified as assets held for sale. Both properties have been advertised for sale and offers have been received.

Negotiations are currently underway to complete the sales and these are expected to be completed in 2026/27.

The related land and buildings have a net book value of £742k and £257k, respectively.

Note 21 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2025/26	2024/25
	£000	£000
At 1 April	50,910	43,536
Net change in year	(988)	7,374
At 31 March	49,922	50,910
Broken down into:		
Cash at commercial banks and in hand	2	2
Cash with the Government Banking Service	49,920	50,908
Total cash and cash equivalents as in SoFP	49,922	50,910
Total cash and cash equivalents as in SoCF	49,922	50,910

Note 22 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	6,534	9,003
Capital payables	2,634	626
Accruals	10,908	13,305
Social security costs	1,747	1,436
Other taxes payable	1,437	1,345
Pension contributions payable	2,198	2,137
Other payables	8	58
Total current trade and other payables	25,466	27,910
Non-current		
Total non-current trade and other payables	-	-
Of which payables from NHS and DHSC group bodies:		
Current	5,117	6,489
Non-current	-	-

Note 23 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	2,066	1,014
Total other current liabilities	2,066	1,014
Non-current		
Total other non-current liabilities	-	-

Note 24 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Lease liabilities	7,748	7,736
Total current borrowings	7,748	7,736
Non-current		
Lease liabilities	44,311	49,056
Total non-current borrowings	44,311	49,056

Note 24.1 Reconciliation of liabilities arising from financing activities

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2025	56,792	56,792
Cash movements:		
Financing cash flows - payments and receipts of principal	(7,634)	(7,634)
Financing cash flows - payments of interest	(626)	(626)
Non-cash movements:		
Additions	729	729
Lease liability remeasurements	2,188	2,188
Application of effective interest rate	626	626
Early terminations	(16)	(16)
Carrying value at 31 March 2026	52,059	52,059

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2024	60,613	60,613
Cash movements:		
Financing cash flows - payments and receipts of principal	(7,599)	(7,599)
Financing cash flows - payments of interest	(664)	(664)
Non-cash movements:		
Additions	635	635
Lease liability remeasurements	3,182	3,182
Application of effective interest rate	664	664
Early terminations	(39)	(39)
Carrying value at 31 March 2025	56,792	56,792

Note 25 Provisions for liabilities and charges analysis

	Legal claims	Restructuring	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	1,069	-	1,787	350	3,206
Change in the discount rate	-	-	-	(5)	(5)
Arising during the year	185	2,038	2,134	-	4,357
Utilised during the year	(85)	-	(696)	-	(781)
Reversed unused	(100)	-	(150)	-	(250)
Unwinding of discount	-	-	-	5	5
At 31 March 2026	1,069	2,038	3,075	350	6,532
Expected timing of cash flows:					
- not later than one year;	1,069	2,038	3,075	1	6,183
- later than one year and not later than five years;	-	-	-	3	3
- later than five years.	-	-	-	346	346
Total	1,069	2,038	3,075	350	6,532

In respect of legal claims, the uncertainty as to amounts and timings relates to the time taken to determine whether or not Leeds Community Healthcare NHS Trust is liable and if so, what the value of that liability will be. The provision includes an amount for employment tribunals, a claim for a clinicians working hours dispute and a Guardians of Safe Working Hours (GoSWH) fine relating to the same incident.

In respect of redundancy, the uncertainty as to amounts and timings relates to the time that will need to be taken to complete the formal redundancy processes.

The restructuring provision relates to commitments arising from the merger of Leeds Community Healthcare NHS Trust with Leeds and York Partnership NHS Foundation Trust.

Other provisions include a dilapidation provision for the offices at White Rose for £334k.

Note 25.1 Clinical negligence liabilities

At 31 March 2026, £652k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Leeds Community Healthcare NHS Trust (31 March 2025 - £269k).

Note 26 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	(19)	(5)
Redundancy	(1,246)	(1,642)
Gross value of contingent liabilities	(1,265)	(1,647)
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	(1,265)	(1,647)
Net value of contingent assets	-	-

Leeds Community Healthcare NHS Trust has a possible obligation arising from its employ and deploy model of staffing. The redundancy liability would arise should a decision be made by the third parties to terminate the deployment contracts.

Leeds Community Healthcare NHS Trust has no contingent assets in 2025/26 (2024/25 - £Nil)

Note 27 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements), analysed by the period during which the payment is made:

	31 March 2026 £000	31 March 2025 £000
- not later than one year;	8,472	15,316
- after one year and not later than five years;	5,444	9,084
- after more than five years.	16	-
Total	13,932	24,400

Note 28 Financial instruments

Note 28.1 Financial risk management

In accordance with IFRS 7, Trusts should disclose information that enables users of the accounts to evaluate the nature and extent of risks arising from financial instruments to which the Trust is exposed at the end of the reporting period. Because of the continuing service provider relationship that Leeds Community Healthcare NHS Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. In addition financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

Leeds Community Healthcare NHS Trust has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities, rather than being held to change the risks facing the Trust in undertaking its activities.

Leeds Community Healthcare NHS Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Trust Board. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

Leeds Community Healthcare NHS Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations.

Leeds Community Healthcare NHS Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

Leeds Community Healthcare NHS Trust has no borrowing in 2025/26.

The Trust may borrow from government for capital expenditure, subject to affordability, as confirmed by NHS England. The borrowings would be for 1 - 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan.

The Trust may also borrow from government for revenue financing subject to approval by NHS England. Interest rates are confirmed by the Department of Health and Social Care, the lender, at the point borrowing is undertaken.

Leeds Community Healthcare NHS Trust therefore has low exposure to interest rate fluctuations.

Credit risk

The majority of Leeds Community Healthcare NHS Trust's revenue comes from contracts with other public sector bodies, therefore, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from customers, as disclosed in note 19.2.

Liquidity risk

The majority of Leeds Community Healthcare NHS Trust's operating costs are incurred under contracts with Integrated Care Boards, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from depreciation and Public Dividend Capital allocated by the Department of Health and Social Care.

Leeds Community Healthcare NHS Trust is not therefore exposed to significant liquidity risks.

Note 28.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026

Trade and other receivables excluding non financial assets
Cash and cash equivalents
Total at 31 March 2026

Held at amortised cost £000	Held at fair value through P&L £000	Held at fair value through OCI £000	Total book value £000
8,364	-	-	8,364
49,922	-	-	49,922
58,286	-	-	58,286

Carrying values of financial assets as at 31 March 2025

Trade and other receivables excluding non financial assets
Cash and cash equivalents
Total at 31 March 2025

Held at amortised cost £000	Held at fair value through P&L £000	Held at fair value through OCI £000	Total book value £000
6,392	-	-	6,392
50,910	-	-	50,910
57,302	-	-	57,302

Note 28.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026

Obligations under leases
Trade and other payables excluding non financial liabilities
Total at 31 March 2026

Held at amortised cost £000	Held at fair value through P&L £000	Total book value £000
52,059	-	52,059
19,672	-	19,672
71,731	-	71,731

Carrying values of financial liabilities as at 31 March 2025

Obligations under leases
Trade and other payables excluding non financial liabilities
Total at 31 March 2025

Held at amortised cost £000	Held at fair value through P&L £000	Total book value £000
56,792	-	56,792
22,615	-	22,615
79,407	-	79,407

Note 28.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position which are discounted to present value.

	31 March 2026 £000	31 March 2025 £000
- In one year or less;	28,002	30,940
- In more than one year but not more than five years;	31,552	31,038
- In more than five years.	14,583	19,951
Total	74,137	81,929

Note 29 Losses and special payments

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	1	1	-	-
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	10	3	-	-
Stores losses and damage to property	-	-	-	-
Total losses	11	4	-	-
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	5	95	2	5
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	5	95	2	5
Total losses and special payments	16	99	2	5
Compensation payments received				

Note 30 Related parties

Organisation and related party	Revenue from Related Party £000	Expenditure with Related Party £000	Amounts due from Related Party £000	Amounts owed to Related Party £000
Crossley Street Surgery, Wetherby Dr Ruth Burnett (Executive Medical Director) <i>Performs unpaid GP work as part of CPD and maintaining registration</i>		185		15
Leeds and York Partnership NHS Foundation Trust Sara Munro (Interim Chief Executive) <i>Chief Executive</i>	451	4,393	35	2,234
West Yorkshire Combined Authority (Policing and Crime) Alison Lowe (Non-Executive Director) <i>Deputy Mayor Policing and Crime</i>	7,953			72
Leeds GP Confederation Jenny Allen (Director of People, OD and System Development) <i>Director of Workforce, Leeds GP Confederation</i> Dr Ruth Burnett (Executive Medical Director) <i>Medical Director, Leeds GP Confederation</i> Laura Smith (Director of People, OD and System Development) <i>Director of Workforce, Leeds GP Confederation</i>	247		42	42
NHS Charities Together Khalil ur Rehman (Non-Executive Director) <i>Non-Executive Director and Trustee</i>				1
Touchstone Leeds Ltd Khalil ur Rehman (Non-Executive Director) <i>Part time IT and digital consultant</i>	58	2,438		194

The Department of Health and Social Care is regarded as a related party as well as other entities for which the Department is regarded as the parent Department. During the year 2025/26 Leeds Community Healthcare NHS Trust had transactions with the following public sector bodies as listed below:

Alder Hey Children's NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Calderdale & Huddersfield NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
East London NHS Foundation Trust
Devon Partnership NHS Trust
East of England Ambulance Service NHS Trust
Harrogate and District NHS Foundation Trust
Hertfordshire Community NHS Trust
Imperial College Healthcare NHS Trust
Leeds and York Partnership NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Leicestershire Partnership NHS Trust
Liverpool University Hospitals NHS Foundation Trust
Manchester University NHS Foundation Trust
Mersey and West Lancashire Teaching Hospitals NHS Trust
Midlands Partnership University NHS Foundation Trust
North Cumbria Integrated Care NHS Foundation Trust
Pennine Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Tavistock and Portman NHS Foundation Trust
The Rotherham NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust

University College London Hospitals NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation Trust
University Hospitals Coventry and Warwickshire NHS Trust
University Hospitals Sussex NHS Foundation Trust
Warrington and Halton Teaching Hospitals NHS Foundation Trust
York and Scarborough Teaching Hospitals NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust
NHS Black Country ICB
NHS Greater Manchester ICB
NHS Hertfordshire and West Essex ICB
NHS Humber and North Yorkshire ICB
NHS Kent and Medway ICB
NHS Lancashire and South Cumbria ICB
NHS Norfolk and Waveney ICB
NHS North Central London ICB
NHS North East and North Cumbria ICB
NHS Nottingham and Nottinghamshire ICB
NHS South Yorkshire ICB
NHS West Yorkshire ICB
NHS England
NHS North of England Commissioning Support Unit
North East and Yorkshire Regional Office
UK Health Security Agency
NHS Resolution
Care Quality Commission
Department of Health and Social Care

Listed below are the other government departments and other central and local government bodies that the Trust has had dealings with:

Community Health Partnerships Ltd
HM Revenue and Customs
Bradford City Council
Leeds City Council

National Employment Savings Trust (NEST)
NHS Business Services Authority
NHS Property Services
West Yorkshire Combined Authority (Policing and Crime)

Wakefield City Council

West Yorkshire Police and Crime Commissioner and Chief Constable

Leeds Community Healthcare NHS Trust has also had transactions with Lancaster University and NHS Confederation which the Department of Health and Social Care has deemed to be related parties of entities within the Departmental Group.

The Trust Board is a Corporate Trustee of Leeds Community Healthcare Charitable Trust. A debtor of £17k is held by the Trust in relation to the Charity for transactions made by the Trust on behalf of the charity.

Note 31 Events after the reporting date

A Strategic Outline Business case has been submitted to NHS England for the acquisition of Leeds Community Hospitals NHS Trust by Leeds and York Partnership NHS Foundation Trust . Approval is expected in June 2026. The two Trust s are currently working on a Full Business case (FBC) to be submitted in October for approval by NHS England. Once the FBC is approved Leeds Community Healthcare will be acquired by Leeds and York Partnership and will cease to exist. The process is expected to be completed by 31st March 2027.

The financial statements were authorised for issue on 24th June 2026 by Sara Munro, the Interim Chief Executive.

Note 32 Better Payment Practice code

	2025/26 Number	2025/26 £000	2024/25 Number	2024/25 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	11,167	55,909	12,761	51,327
Total non-NHS trade invoices paid within target	10,882	54,391	12,131	49,634
Percentage of non-NHS trade invoices paid within target	97.4%	97.3%	95.1%	96.7%
NHS Payables				
Total NHS trade invoices paid in the year	323	24,065	492	25,963
Total NHS trade invoices paid within target	318	23,791	481	25,160
Percentage of NHS trade invoices paid within target	98.5%	98.9%	97.8%	96.9%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Note 33 Capital Resource Limit

	2025/26 £000	2024/25 £000
Gross capital expenditure	10,349	7,847
Less: Disposals	(128)	(219)
Charge against Capital Resource Limit	10,221	7,628
Capital Resource Limit	10,221	7,628
Under / (over) spend against CRL	-	-

Note 34 Adjusted financial performance

	2025/26 £000	2024/25 £000
Surplus / (deficit) for the period per SOCI	(137)	1,931
Remove net impairments not scoring to the departmental expenditure limit	1,076	-
Remove I&E impact of capital grants and donations	12	12
Adjusted financial performance surplus / (deficit)	951	1,943

Note 35 Breakeven duty financial performance

	2025/26 £000	2024/25 £000
Adjusted financial performance surplus / (deficit) (control total basis)	951	1,943
Breakeven duty financial performance surplus / (deficit)	951	1,943

Note 36 Breakeven duty rolling assessment

	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance	2,577	1,809	1,425	2,007	2,985	3,350	4,655
Breakeven duty cumulative position	2,577	4,386	5,811	7,818	10,803	14,153	18,808
Operating income	134,978	139,906	142,863	146,668	156,367	148,654	149,526
Cumulative breakeven position as a percentage of operating income	1.9%	3.1%	4.1%	5.3%	6.9%	9.5%	12.6%

	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	2024/25 £000	2025/26 £000
Breakeven duty in-year financial performance	5,661	2,045	1,557	507	1,042	267	1,943	951
Breakeven duty cumulative position	24,469	26,514	28,071	28,578	29,620	29,887	31,830	32,781
Operating income	155,640	171,312	187,920	195,550	218,532	227,088	238,248	245,846
Cumulative breakeven position as a percentage of operating income	15.7%	15.5%	14.9%	14.6%	13.6%	13.2%	13.4%	13.3%

Thank you for taking the time to read our Annual Report and Accounts for 2025-2026. You can also view this document on our website at www.leedscommunityhealthcare.nhs.uk where you can also find the full accounts.

If you would like hard copies of this report or an accessible version of the financial statements and notes on pages 144-198, please email lch.comms@nhs.net



Our Quality Account is also available on our website at www.leedscommunityhealthcare.nhs.uk

If you would like any of our reports in an alternative format or large print please email lcht.lch.pet@nhs.net or call 0113 220 8585.

