Bundle Public Board Meeting 23 July 2026

0 Agenda
Final Agenda Public_Board_Meeting_23 July_2026

1 09:30 - Welcome, introductions and apologies:

2 09:35 - Declarations of interest-Information from Declare
Item 2 Board Declarations July 2026

3 Questions From Members Of The Public

4 Minutes Of Previous Meetings, Action Log And Matters Arising

4.a Minutes of the meetings held on:
Item 4a Draft PUBLIC Board minutes 21 May 2026 - Chair and CEO approved

4.b Action log
Item 4b Public Board Action Log - 23 July 2026 (as at 14-07-26)

4.c 09:40 - Patient Lived Experience: Armley Neighbourhood Team

5 10:00 - Interim Chief Executive's report
Item 5 Chief Executive's Report - July 2026 Board - public

6 10:10 - Quality Strategy
Item 6 Quality Strategy Board paper Final

7 10:20 - People Strategy and Headlines Update
Item 7 People Strategy and Headlines Update for Board - Final July 2026

8 10:30 - a)Quality Committee Chair's Assurance Report: 14 July 2026 b) Incident Management and Investigation Report (Action 2026-27 7 on Board Action Log)
Item 8a Quality Committee- Chairs assurance report - July 2026 v2 HR
Item 8b Incident management update June 2026 (002)

9 10:40 - Business Committee Chair's Assurance Reports: 16 June 2026 and 21 July 2026 (tabled report)
Item 9 Business Committee Chair Assurance Report 16 June 2026 v2LMFinal

10 10:45 - Audit Committee Chair's Assurance Report: 7 July 2026
Item 10 Audit Committee Chair's Assurance Report July 2026 v3-KR

11 10:50 - Charitable Funds Chair's Assurance Report: 7 July 2026
Item 11 Charitable Funds Committee Chair Assurance Report July 2026 v2

12 10:55 - Integrated Performance Report Including •Waiting List Trajectories
Item 12i Cover paper Performance Brief_Board July 2026
Item 12ii IPR_June2026

13 11:10 - National Oversight Framework -Segmentation Update • Sickness Absence update
Item 13 NOF2627 Briefing_Board
Item 13i Sickness Absence - cover report

Item 13ii NOF Sickness Absence update - Board July 2026

14 11:25 - People and Culture Committee Chair's Assurance Report: 10 June 2026
Item 14 PCC Chairs assurance report - PUBLIC_June_26_Final

15 11:35 - Significant Risks And Risk Assurance Report
Item 15 Board Significant Risk Report 230726

16 11:50 - Board Assurance Framework 2026/27 - *for approval*
Item 16 Board Assurance Framework 2026-27
Item 16i Appendix 1 BAF_2026-27_May_2026
Item 16ii Draft Risk_Appetite_Statement_2026_27

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

18 Blue Box: Mortality Report •Q1 Report 2026-27 - presented to Quality Committee 14 July 2026
Item 18 Blue Box Item Mortality Learning from Deaths Q1 2026_2027 report for Board

19 Blue Box: Safeguarding Annual Report 2025/26 -presented to Quality Committee 14 July 2026
Item 19 Safeguarding Annual Report Cover paper - June 2026 (Blue Box)

20 Blue Box: Infection Prevention and Control Annual Report 2025/26 - presented to Quality Committee 14 July 2026
Item 20 IPC Annual Report IPC 25-26 V2 (Blue Box)

21 Blue Box: Guardian for Safe Working Hours Quarter 4 and Annual Report 2025/26 - presented to People and Culture Committee 10 June 2026
Item 21 Blue Box GoSWH Quater 3 and 4 Board Meeting July 2026
Item 21i Blue Box GoSWH Annual report July 2026

22 Blue Box: Sustainability (Green) Plan – presented to Business Committee 19 May 2026 and People and Culture Committee 10 June 2026
Item 22 Annual Sustainability Report (July 2026) Trust Board (Blue Box)

23 Blue Box: Emergency Preparedness, Resilience Annual Report – Presented to the Business Commitee 19 May 2026
Item 23i Covering paper for EPRR Annual Report - July 2026
Item 23ii App 1 - EPRR Annual Report - May 2026
Item 23iii App 2 - LCH Exercise Timetable - 2024-26 v0.3

24 Blue Box: Quality Strategy slides – Presented to the Quality Committee 12 May 2026
Item 24 Quality Strategy Quality Committee Report May 26 Master

25 Blue Box: Glossary
Item 25 - BLUE BOX ITEM - Glossary - v2.2 - April 2026

26 Blue Box: Workplan
Item 26 Trust Board Workplan Public v6 2026-2027 17 06 2026

NHS
Leeds Community Healthcare
NHS Trust

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

Date 23 July 2026
Time 9.30am – 12.00pm
Chair Helen Thomson DL, Acting Trust Chair

AGENDA			Paper
2026-27 1	9.30	**Welcome, Introductions and Apologies** *(Acting Trust Chair)*	**N**
STANDING ITEMS			
2026-27 2	9.35	**Declarations Of Interest** *(Acting Trust Chair)*	**Y**
2026-27 3		**Questions From Members Of The Public**	**N**
2026-27 4		**Minutes Of Previous Meetings, Action Log And Matters Arising** *(Acting Trust Chair)*	
4a		Minutes of the meeting held on: • 21 May 2026	**Y**
4b		Action Log	**Y**
4c	9.40	**Patient Lived Experience:** Armley Neighbourhood Team *(Heather McClelland/Jane Parojcic/Laura Hollins)*	**N**
STRATEGY AND PARTNERSHIPS			
2026-27 5	10.00	**Interim Chief Executive's Report** *(Dr Sara Munro)*	**Y**
2026-27 6	10.10	**Quality Strategy** *(Heather McClelland)*	**Y**
2026-27 7	10.20	**People Strategy and Headlines Update** *(Catherine Hall)*	**Y**
QUALITY AND SAFETY			
2026-27 8	10.30	**a) Quality Committee Chair's Assurance Report:** 14 July 2026 **b) Incident Management and Investigation Report** (Action 2026-27 7 on Board Action Log) *(Professor Ian Lewis)*	**Y**
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2026-27 9	10.40	**Business Committee Chair's Assurance Reports**: 16 June 2026 and 21 July 2026 (tabled report) *(Lynne Mellor)*	**Y**
2026-27 10	10.45	**Audit Committee Chair's Assurance Report**: 7 July 2026 *(Khalil Rehman)*	**Y**
2026-27 11	10.50	**Charitable Funds Chair's Assurance Report:** 7 July 2026 *(Acting Trust Chair)*	**Y**
BREAK – 10 minutes			
2026-27 12	11.05	**Integrated Performance Report** *(All Execs)* Including • Waiting List Trajectories	**Y**
2026-27	11.20	**National Oversight Framework -Segmentation Update**	**Y**

13		• Sickness Absence update *(Dr Sara Munro)*	
WORKFORCE			
2026-27 14	11.35	**People and Culture Committee Chair's Assurance Report: 10 June 2026** *(Rachel Booth)*	**Y**
GOVERNANCE AND WELL LED			
2026-27 15	11.45	**Significant Risks And Risk Assurance Report** *(Dr Sara Munro)*	**Y**
2026-27 16	11.50	**Board Assurance Framework 2026/27 - *for approval*** *(Dr Sara Munro)*	**Y**
CLOSING BUSINESS			
2026-27 17	12.00	**Any Other Business. Questions On Blue Box Items And Close** (Acting Trust Chair) The Board resolves to hold the remainder of the meeting in private due to the confidential or commercially sensitive nature of the business to be transacted.	**N**

All items listed (Blue Box) in blue text, are to be received for information/assurance, having previously been scrutinised by committees. The Acting Chair will invite questions on any of these items under Item 17.

***Blue Box Items – To Note**		
2027-28 18	**Mortality Report** • Q1 Report 2026-27 *(Dr Ruth Burnett)*	**Y**
2027-28 19	**Safeguarding Annual Report 2025/26 -presented to Quality Committee 14 July 2026** *(Heather McClelland)*	**Y**
2026-27 20	**Infection Prevention and Control Annual Report 2025/26 - presented to Quality Committee 14 July 2026** *(Heather McClelland)*	**Y**
2026-27 21	**Guardian for Safe Working Hours Quarter 3 and 4 and Annual Report 2025/26 -presented to People and Culture Committee 10 June 2026** *(Dr Ruth Burnett)*	**Y`**
2026-27 22	**Sustainability (Green) Plan – presented to Business Committee 19 May 2026 and People and Culture Committee 10 June 2026** *(Andrea Osborne)*	**Y**
2026-27 23	**Emergency Preparedness, Resilience Annual Report – Presented to the Business Commitee 19 May 2026** *(Sam Prince)*	**Y**
2026-27 24	**Quality Strategy slides – Presented to the Quality Committee 12 May 2026**	**Y**
2026-27 25	**Glossary**	**Y**
2026-27 26	**Workplan**	**Y**

Employee	Date Declare	Interest Type	Date Arose	Year	Decision Making Gr	Interest Description (Abbreviated)	Provider
Alison Lowe	16/04/2024	Outside/Secondary Employment	16/04/2024	2024/25,2025/26,2026/27	Board of Directors	Trustee	Together Women
Alison Lowe	16/04/2024	Outside/Secondary Employment	16/04/2024	2024/25,2025/26,2026/27	Board of Directors	Trustee	Citizens Advice - Leeds
Alison Lowe	16/04/2024	Outside/Secondary Employment	16/04/2024	2024/25,2025/26,2026/27	Board of Directors	DMPC in West Yorkshire, employed by the Mayoral Combined Authority. We commission services within the CJS, e.g., the SARC and so on. There is a potential conflict if LCH bids to supply any services.	Deputy mayor Policing and Crime
Alison Lowe	24/09/2025	Outside/Secondary Employment	01/04/2025	2025/26,2026/27	Board of Directors	Director	Association Police and Crime Commissioners
Andrea Osborne	19/06/2026	Nil Declaration	19/06/2026	2026/27	Board of Directors		
Anne Cooper	18/06/2026	Loyalty Interests	01/04/2026	2026/27	Board of Directors	Non-Executive Director	North West Ambulance Service
Anne Cooper	18/06/2026	Shareholdings and other ownership interests	01/04/2026	2026/27	Board of Directors	16% shareholding in business but not a statutory director of the company.	Ethical Healthcare Limited
Heather McClelland	28/06/2026	Nil Declaration	28/06/2026	2026/27	Board of Directors		
Helen Thomson	06/06/2026	Nil Declaration	06/06/2026	2026/27	Board of Directors		
Ian John Lewis	06/06/2026	Nil Declaration	06/06/2026	2026/27	Board of Directors		
Jennifer Allen	09/05/2024	Loyalty Interests	01/04/2024	2024/25,2025/26,2026/27	Board of Directors	Husband is a partner at KPMG	KPMG
Jennifer Allen	09/05/2024	Loyalty Interests	01/04/2024	2024/25,2025/26,2026/27	Board of Directors	I volunteer regularly for Zarach a Leeds based charity.	Zarach
Jennifer Allen	09/05/2024	Outside/Secondary Employment	01/04/2024	2024/25,2025/26,2026/27	Board of Directors	I am also the Director of Workforce for the Leeds GP Confederation	Leeds GP Confederation
Jennifer Allen	18/06/2026	Loyalty Interests	01/06/2026	2026/27	Board of Directors	Husband is a trustee of St Anne's Community Services.	St Anne's Community Services
Khalil ur Rehman	03/10/2024	Outside/Secondary Employment	01/05/2024	2024/25,2025/26,2026/27	Board of Directors	Vice Chair Seacole is the NHS BAME NED network group	Seacole Group
Khalil ur Rehman	03/10/2024	Outside/Secondary Employment	01/10/2024	2024/25,2025/26,2026/27	Board of Directors	NED & Charity Trustee	Association of NHS Charities - NHS Charities Together
Khalil ur Rehman	03/10/2024	Outside/Secondary Employment	04/08/2024	2024/25,2025/26,2026/27	Board of Directors	part time IT & Digital consultant via TSI Caritas Ltd (see shareholding declaration)	Touchstone Leeds Ltd
Khalil ur Rehman	03/10/2024	Shareholdings and other ownership interests	01/04/2024	2024/25,2025/26,2026/27	Board of Directors	100-ordinary	TSI Caritas Ltd
Khalil ur Rehman	03/10/2024	Outside/Secondary Employment	01/04/2024	2024/25,2025/26,2026/27	Board of Directors	Board Member/NED on governing body.	University of Lancashire
Khalil ur Rehman	05/02/2026	Loyalty Interests	01/11/2025	2025/26,2026/27	Board of Directors	Consultant	The Human Digital Collaborative
Laura Smith	23/05/2024	Outside/Secondary Employment	01/04/2024	2024/25,2025/26,2026/27	Board of Directors	I undertake some training & consultancy work on a self employed basis for the above organisation, as an Associate	Prospect Business Consulting and WellNorth Enterprises (also known as 360 Degree Sociey)
Laura Smith	23/05/2024	Outside/Secondary Employment	01/04/2024	2024/25,2025/26,2026/27	Board of Directors	Within my LCH role, I provide DoW support to the Leeds GP Confederation, which could at times represent a conflict of interest, eg if LCH and the Confed bid separately for the same contracts	Leeds GP Confederation
Laura Smith	22/06/2026	Loyalty Interests	11/06/2026	2026/27	Board of Directors	Parent Governor at a High School in Leeds. 4 year term commencing in June 2026.	Roundhay School
Lynne Mellor	04/02/2025	Outside/Secondary Employment	18/09/2024	2024/25,2025/26,2026/27	Board of Directors	Business Consultancy specialising in Cyber and AI	The Human Digital Collaborative Ltd
Lynne Mellor	14/04/2026	Loyalty Interests	01/04/2026	2026/27	Board of Directors	Commenced as a NED, whilst continuing as a ANED for LCH. Will manage any potential conflicts with advice from Company Secretaries but with the Trusts merging in April 27 this is unlikely.	Leeds and York Partnership NHS FT
Rachel Booth	29/10/2025	Outside/Secondary Employment	01/10/2025	2025/26,2026/27	Board of Directors	Job title - General Counsel. Head of legal services for Bupa UK business units: dental practices, care homes, health clinics, hospitals and private medical insurance services.	Bupa
Ruth Burnett	16/04/2024	Outside/Secondary Employment	01/04/2024	2024/25,2025/26,2026/27	Board of Directors	Executive Medical Director and Caldicott Guardian	Leeds GP Confederation
Ruth Burnett	16/04/2024	Outside/Secondary Employment	01/04/2024	2024/25,2025/26,2026/27	Board of Directors	Sessional GP. Not in partnership, not salaried, no enumeration received but regular sessions as CPD at Crossley Street Surgery, Wetherby	Crossley Street Practice
Ruth Burnett	01/05/2024	Loyalty Interests	01/04/2024	2024/25,2025/26,2026/27	Board of Directors	Community and primary care representative on RSET (Rapid Service Evaluation Team)	NIHR
Samantha Prince	15/04/2024	Outside/Secondary Employment	01/04/2024	2024/25,2025/26,2026/27	Board of Directors	Justice of the Peace for England and Wales (West and North Yorkshire)	HM Courts and Tribunals Service
Sara Munro	05/09/2025	Outside/Secondary Employment	01/04/2025	2025/26,2026/27	Board of Directors	substantive CEO of LYPFT NHS Trust	CEO of LYPFT

Minutes: Trust Board Meeting Held in **Public**
Date: 21 May 2026
Location: Boardroom, White Rose Office Park, Millshaw Park Lane, Leeds, LS11 0DL.

Attendance:		
Present:	Helen Thomson DL	Acting Trust Chair
	Dr Sara Munro	Interim Chief Executive
	Rachel Booth (RB)	Non-Executive Director
	Dr Ruth Burnett	Executive Medical Director
	Anne Cooper (AC)	Associate Non-Executive Director
	Professor Ian Lewis (IL)	Non-Executive Director
	Heather McClelland	Interim Executive Director of Nursing and AHPs
	Lynne Mellor (LM)	Associate Non-Executive Director
	Andrea Osborne	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
	Khalil Rehman (KR)	Non-Executive Director *(for items 1-8)*
In attendance:	Helen Robinson	Company Secretary
Minutes:	Sue Grahamslaw	Interim Corporate Governance Officer
Apologies:	Alison Lowe OBE (AL)	Non-Executive Director
	Jenny Allen	Director of People (JA)
One member of staff observed the meeting.		

Item 2026-27 (1): Welcome introduction, apologies, and preliminary business

The Acting Trust Chair opened the Board meeting and welcomed members, attendees, and observers, noting it was the new Associate Non-Executive Director's (AC) first LCH board meeting.

Apologies: Apologies for absence were received from Non-Executive Director (AL) and the Director of People (JA).

Item 2026-27 (2): Declarations of Interest

Prior to the Trust Board meeting, the Acting Trust Chair had considered the Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest before the papers were distributed to Board members. The Trust Chair asked the Board for any additional interests that required declaration.

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

Item 2026-27 (3): Questions from members of the public

There were no questions from members of the public.

Item 2026-27 (4): Minutes of Previous Meetings, Action Log and Matters Arising

a) Minutes of the meeting held on 27 March 2026

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

b) Action log

There were two actions on the log to review:

2025-26 (129) – Freedom to Speak Up – Planning Toolkit: the Interim Chief Executive noted that the LYPFT approach was to link the planning toolkit to the national training module. However, it was not mandated training. She would follow up with the Director of People. **Action Closed.**

2025-26 (149) – 2025 National Staff Survey Results – WRES 8: the Interim Chief Executive advised that a review of previous cases was underway to reflect on how they were handled and the learning to be taken. This had been discussed at a Board workshop as noted in the CEO's report. The findings of the review would feed back into the People and Culture Committee. **Action Closed.**

It was agreed to close the action log items marked as proposed to close.

There were no further actions or matters arising to address.

Item 2026-27 (5): Patient Lived Experience

The Interim Executive Director of Nursing and AHPs noted that unfortunately no-one had been available for the Patient Lived Experience item on this occasion. However, plans were in place to ensure there would be an item for the Board in the future.

Item 2026-27 (6): Interim Chief Executive's Report

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

1. Our services and our people

Staff Survey and Board Intention Planning:
The Acting Chair and Interim Chief Executive had sent out some internal communication regarding the staff survey and intentions which had been well received.

SEND Inspection:
Whilst the full CQC report was still awaited, indications for areas for improvement were as expected and strengthening work was already underway both internally and with LCH partners. The Interim Executive Director of Nursing and AHPs was the Executive responsible for oversight of the outcomes.

Trust Leaders Network:
Ongoing engagement was key and further consideration was being given to maintaining the culture during the integration and in the new Trust.

National Oversight Framework:
It was explained that "business as usual" remained in terms of the King's speech, despite the change in the Health Secretary. However, there were some areas which required the Health Secretary to approve, such as the National Oversight Framework which was now expected to be delayed until the new minister was embedded.

2. Alignment with Leeds and York Partnership NHS Foundation Trust

The National Transaction Team had completed all due diligence with no areas of concern had been flagged at this time. The report from the Regional Support Group was expected on 3 June 2026, following which the Trust would be informed of the assessment of its strategic case. Work continued on Trust Integration Programme workstreams.

3. System Update

Leeds Place Provider Partnership:
The draft Memorandum of Understanding would be received at an Extraordinary Board meeting in June and communications were being prepared to encompass all providers. There was a workstream on ICB functions and the delegated arrangement at Place level.

The Executive Director of Operations requested that Neighbourhood Health was included in communications. It was explained that the full communications included Neighbourhood Health and that there was an engagement event on 3 July which would better explain.

Non-executive Director (IL) questioned where there was oversight now there were no sub-committees in the partnership, what was LCH's role, and how Neighbourhood Health was being kept in the discussions. He was concerned that more discussions could be held at Trust Committee level but may be overlooked in favour of not duplicating work. The discussion noted the lack of Neighbourhood Health discussions at national level compared with discussions at LCH, especially in Business Committee which was working to understand how LCH programmes were fitting with the portfolio of programmes at national level.

Leeds GP Confed CEO Update:
Associate Non-Executive Director (LM) noted the need to ensure Leeds GP Confederation were kept involved in discussions regarding the Trust's ongoing relationship with the Leeds GP Confederation.

4. Reasons to be Proud

Feedback for Armley Neighbourhood Team and Night Service:
It was noted the positive feedback had already been shared with the team. However, it also raised the question of the frequency of patients with learning disabilities having the choice of where they want to die. It was advised that in excess of 90% were able to choose and previous work had looked at common factors affecting those unable to choose, many of which related to safety factors. The Acting Trust Chair remarked that as the Leeds population aged, it would be key to look into factors relating to those who do not get a choice of place of death.

Achieving Excellence in our Website Accessibility:
The excellent website recognition was noted.

Digital Inclusion Work – Excellent Feedback:
The positive work on Digital Inclusion should be celebrated and a suggestion was to include an item in the Annual Report.

Outcome: The Trust Board noted the update on key activities and issues from the Chief Executive.

Item 2026-27 (7): Quality Committee Chair's Assurance Report

Chair of the Committee, Non-Executive Director (IL), presented the report from the meeting on 21 May 2026. The following discussion points were highlighted:

- Alerts to the Board:
  - Medical Device Monitoring – improvements were required and a timescale had been agreed but was not met. The Committee were provided with an update and the challenges were explained but the risk remained of missing medical devices.

The Associate Non-Executive Director (LM) expressed her concern about the medical devices missing from the register and their vulnerability to cyber risks. However, the Board were reminded that some of these devices would be in patients' homes.

- Delays in Incident Management Investigation – improvements not yet seen. The Interim Executive Director of Nursing and AHPs advised a higher-level plan to understand the data would be brought back in July 2026.

The Acting Trust Chair voiced her concern at the continued delays. It was further noted that reporting had improved but had not produced consistent data. Board were given reassurance that the Clinical Leads understood the requirements and the processes in place were appropriate, but their application was inconsistent. The initial need was to understand the challenge of which stages in the process were managed inconsistently. The Acting Trust Chair noted that the report now scheduled to the July committee meeting should also be received at Board. The Committee Chair noted Improvements Groups were established based on similar PSIRF outcomes but there were no outputs seen from these Groups. The Audit Committee Chair, Non-Executive Director (KH) noted that Audit Committee had acknowledged that the PSIRF internal audit recommendations had been closed off in April and would discuss with the Interim Executive Director of Nursing and AHPs after the Board meeting. However, it was noted that different levels of information was required by various levels of seniority in the Trust from the one Datix system and there was a risk to Health and Safety compliance caused by the gaps in information from Datix. The Interim Chief executive noted that at LYPFT, Datix was not just a clinical platform and the LCH redesign work would need the functionality to cater for all levels within the organisation. This was echoed by Associate Non-Executive Director (LM).

- Service Spotlight – Podiatry team update focussing on waiting list management. However, there was little in terms of quality, safety, effectiveness and patient experience, with it noted that the team had been asked to provide an update on waiting lists reduction being managed equitably and safely, rather than a general update on podiatry. Associate Non-Executive Director (AC) was supportive of the podiatry team noting that areas not covered in their presentation were seen either later in the meeting or in a service visit she attended the following day.
- Positive feedback had been received on Humberside Police Custody Suite.

Action: Incident Management and Investigation Report scheduled for the July Quality committee should also be received at the Board meeting.
Responsible Officer: Corporate Governance Team / Interim Executive Director of Nursing and AHPs

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

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

Agenda items taken out of order

Item 2026-27 (10): Audit Committee Chair's Assurance Report

Chair of the Committee, Non-Executive Director (KR), presented the report from the meeting on 7 April 2026, highlighting the following key areas of discussion:

- Assurances had been received on the progress of EPRR;
- The positive work from Trust management to complete Internal Audit recommendations;
- The prospect of a good Head of Internal Audit report.

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

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

Item 2026-27 (19): Audit Committee Annual Report and Committee Terms of Reference

Chair of the Committee, Non-Executive Director (KR), presented the Audit Committee Annual Report to the Board noting the content had been agreed at the Audit Committee meeting on 7 April 2026. He thanked the Company Secretary for her work in producing the report. He further noted that Internal Audit remained independent whilst managing to be engaged in the work. The risks were noted with the forthcoming year's Internal Audit plan which it was anticipated would be amended slightly.

The Company Secretary was thanked for collating the various minor changes to the Terms of Reference proposed by each Committee into one document.

The amendments were considered and approved.

Outcome: The Trust Board approved:

- the Audit Committee's annual report;
- the changes to the terms of reference of Board sub-committees.

Agenda items returned to order

Item 2026-27 (8): Mortality Reports

The Executive Medical Director presented the two papers – the Q4 Learning from Deaths report and the 2025-26 Learning from Deaths Annual Report outlining the following:

Q4 Learning from Deaths report: This focused on the LYPFT and Internal Audit mortality reviews, and the combined learnings which noted that additional information was provided than that mandated. The resulting Q4 Learning from Deaths report focussed on the nationally mandated reporting as suggested by Internal Audit. However, the Interim Chief Executive noted the need to understand the LMWS deaths and missed level 2 reviews. The Interim Executive Director of Nursing and AHPs advised she would provide feedback to the workshop the following week.

Action: Provide understanding of LMWS deaths and gaps in the data
Responsible Officer: Executive Medical Director

2025-26 Learning from Deaths Annual Report: Part of the ongoing work in Neighbourhood Health was to monitor deaths by cluster and this was shown in SPC charts with data going back to 2018. However, this could be demonstrated more clearly in the annual report.

It was advised that a workshop had been planned for Learning from Deaths with the intention to bring workplans together with the aim of being able to focus on learning and improvement rather than just number reporting.

Associate Non-Executive Director (AC) sought clarity on how the reports aligned with PSIRF reporting and how they could be pulled together to provide themes. The Executive Medical Director suggested connecting with the new Association Non-Executive Director (AC) outside a Board meeting to explain and would arrange for her to attend the (QAIG) meeting which received updates from the Improvement Groups.

Action: Invite Associate Non-Executive Director (AC) to some QAIG meetings.
Responsible Officer: Executive Medical Director

Non-Executive Director (RB) noted an increase in mortality in children and young people in September and questioned the learnings on a city-wide basis and subsequent improvements in the approach to Neighbourhood Health. However, it was explained that the child death review processes were city-wide but that Leeds City Council were slower in their reporting which resulted in a delay in the process. In contrast, it was important for the Trust to do rapid reviews in these circumstances.

Non-Executive Director (KH) noted a gap in the Compliance Summary table in section 4 of the Mortality Review Compliance of the 2025-26 Annual Learning from Deaths Report. The Executive Director would advise if this was missing data or deliberate.

Action: Review Mortality Review Compliance Table included in Annual Learning from Deaths Report for missing data.
Responsible Officer: Executive Medical Director.

The Acting Trust Chair noted that there were control totals in the data which could provide benchmarking against acute Trusts. However, she questioned how LCH would be aware of any potential issues and what questions were being answered by the report, suggesting:

- How would the Trust know if there was a rogue employee?
- How does the Trust learn from the report?
- How does this relate to feedback to patients and families?

Having scrutinised the reports at the Quality Committee, Non-Executive Director (IL) voiced a concern that the attenuated reports resulting from Internal Audit requirements now lacked data which had previously provided the greater understanding and more assurance that the Trust was learning from deaths.

The Interim Chief Executive expressed a concern on the need to understand LMWS deaths, and that the Level 2 reviews were missing from the report. The Interim Executive Director of Nursing and AHPs advised she would provide feedback to the workshop the following week.

Outcome: The Trust Board noted the contents of both the Q4 Learning from Deaths report and the 2025-26 Learning from Deaths Annual Report and received assurance regarding statutory compliance.

Non-Executive Director (KH) left the meeting.

Item 2026-27 (9): Business Committee Chair's Assurance Report

Chair of the Committee, Associate Non-Executive Director (LM), presented the reports from the meetings on 21 April and 19 May 2026.

The following points were highlighted from the meeting on 21 April 2026:

- There were no alerts to the Board.
- Quality and Value Programme – The Grip and Control monitoring, the forecast position for the year, and where benefits were being realised.
- Neighbourhood Health – a helpful report on the ten pillars with milestones and LCH's approach coupled with a discussion around the Neighbourhood maturity index for sharing at the People and Culture Committee.
- Service Spotlight – Paediatric Neuro Development service and waiting list updates, noting the significant work already done and the recruitment needed to address the situation further.

The following points were highlighted from the meeting on 19 May 2026, for which the report was tabled:

- Alerts to the Board:
  - Water sampling at Burmantofts Health Centre – the Water Safety Group were investigating but there was a wider issue to be considered and risks for patients and staff to be mitigated.
  - RIDDOR incidents from the Health and Safety AAA report – two were not submitted in the required timeframe and the ongoing issues with Datix configurations were outlined. The Chairs of the Quality and Audit Committees had been advised.
  - The number of staff assaults.
- Strategic Estates Plan – a two-year transition plan was received which proposed a pause on the work already done to review and form part of the next stages whilst key estates' priorities were addressed.

- Business Cases approved – four from the digital team. Discussions included vendor supplier management as a cyber security concern and ensuring any software chosen should have sufficient enterprise architecture to cover the Trust's transition and should include the ability to review after 12 months.
- Service spotlight – Digital Inclusion, noting the work being done at LCH was to be used as a blue-print for the NHS as a whole. The Committee supported the Associate Chief Clinical Information Officer (ACCIO) / Digital Inclusion Lead to collate data and evidence of the impact of her work and to communicate its successes.

The Acting Trust Chair sought further clarity on actions around the Health and Safety concerns and was advised by the Executive Director of Operations that a short term workaround was being progressed and that a longer-term solution would involve Datix configurations which the Interim Executive Director of Nursing and AHPs would review. The Non-Executive Director (RB) also requested that this should additionally be reported back to the People and Culture Committee.

Action: Advise People & Culture Committee of the outcomes of the Health & Safety AAA Report actions.
Responsible Officer: Corporate Governance Team to add to P&CC agenda; Interim Executive Director of Nursing and AHPs to advise when appropriate to report into Committee.

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

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

Item 2026-27 (11): Charitable Funds Update Report

The Executive Director of Operations presented the Charitable Funds report on activities for the period June 2025 to June 2026, noting that it was a reflection of the team's hard work over the past year. It showed that the Charity was going from strength to strength. Attention was drawn to the case study it contained.

The Charitable Funds Officer was noted to be making a positive difference and it was suggested this should be showcased at the Annual General Meeting.

Outcome: The Trust Board:
- Received the report and noted the extend of fundraising activities;
- Noted and approved the communications plan as outlined in Appendix 2.

Item 2026-27 (12): Integrated Performance Report (IPR)

The Director of Finance and Resources presented the report which provided an overview of performance across the Trust, measured across the six domains that aligned to the NHS Oversight Framework and highlighted that this was the end of year report so slightly shorter.

Non-executive Director (IL) noted that there were no Statistical Process Control (SPC) charts in the annual report but that they would be in the monthly reporting that was usually presented. This had been discussed at the Quality Committee.

Non-executive Director (LM) reported that the Business Committee had recognised the work undertaken to achieve the outcomes in the IPR annual report and drew attention to the National Oversight Framework table which was easy to read and good to see access to services at a glance.

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

Outcome: The Trust Board:
- Sought further assurances as required;
- Received and noted the IPR report.

Item 2026-27 (13): Business Case: Paediatric Neurodevelopmental Assessment Pathway

The Board were advised that the business case had been scrutinised and supported at the Business Committee on 25 March 2026, for onward consideration at Board.

The Executive Director of Operations noted the request was for both recurrent and non-recurrent funding as the Trust already employed locums but they were unable to accept patients with enduring requirements. The recurrent income would provide the ability to manage patients with enduring needs to the age of 19. Additionally, the Executive Director of Finance and Resources reported that the non-recurrent monies would be set aside recurrently depending on productivity improvements.

It was advised that the investment would enable the Trust to reach the 18-week standard target.

The Executive Medical Director highlighted the need to use Artificial Intelligence (AI) to improve paediatricians' productivity which was being brought out in a national project to consider working day community standards for paediatricians.

Associate Non-Executive Director (AC) questioned potential issues with recruitment and national demand. However, the Executive Director of Operations did not foresee a problem as the Trust was already training people in this role who would then qualify and be in search of a position.

The Board were reminded that the figures had been scrutinised at Business Committee. However, Non-Executive Director (IL) questioned if such business cases should also be considered at Quality Committee to review qualities other than waiting list reduction, such as the impact on multi-disciplinary teams. It was agreed that the Head of the ICAN service, Vanessa Hunt, be invited to the Quality Committee as a Spotlight Item to present the changes to assessment pathway that would explain how the business case was considered.

Action: Head of the ICAN Service, Vanessa Hunt, to be invited to present the changes to the PND assessment pathway as a Spotlight Item.
Responsible Officer: Executive Director of Operations

Outcome: The Trust Board supported phase 1 - through a combination of recurrent and non-recurrent investment at an annual cost of £700k pa to increase capacity by delivering 240 additional complex PND assessments in the first year and 288 additional autism assessment appointments annually.

Item 2026-27 (14): Business Case: Early Supported Stroke Discharge

The Executive Director of Operations presented the business case, noting it had been scrutinised and approved at the Business Committee on 15 April 2026. The recommendation to progress recruitment through April and May had been supported, subject to final approval of this business case by LCH Board.

The Board were advised that funding was via the Catalyst Fund which was supported by the Financial aspect of the ten pillars for Neighbourhood Health with the intention of investing in community so patients could be discharged from hospital sooner. It was noted that there was a separate piece of work looking at active recovery which was staffed by Leeds City Council. However, there was a challenge between how the teams would invest the money versus what would be supported by Leeds City Council.

Non-Executive Director (IL) questioned if the business cases should also have been considered at Quality Committee so the outcomes of the new pathway could be better understood and its effectiveness demonstrated. This was agreed by the Executive Medical Director who also noted that it would be a benefit to everyone if it was done correctly.

Associate Non-Executive Director (LM) confirmed the outcomes were considered as part of the scrutiny at Business Committee and it was felt the Business Case had been well written and highlighted the work with Leeds Teaching Hospitals Trust. However, it was unclear how the acute

services would benefit as well as the wider system. The Executive Director of Finance and Resources explained that from a financial angle, as it was a catalyst fund, the intention was to mobilise the service and some of the key performance indicators (KPIs) would be developed as progress was made.

Outcome: The Trust Board approved the business case based on the assumptions outlined in the accompanying papers.

Item 2026-27 (15): People and Culture Committee Chair's Assurance Report

The Deputy Chair of the Committee, Associate Non-Executive Director (LM), presented the assurance report from the meeting on 8 April 2026, highlighting the following key areas of discussion:

- There were no alerts to the Board.
- The Occupational Health Contract – it was noted not all staff needed bereavement support from Occupational Health.
- WRES and WDES – the positive discussions confirmed the clear five-stage process of recording incidents but there had been concern around the wellbeing and psychological safety of staff at each stage of the process and the content and format of the associated correspondence should be reviewed legally.
- Trust Integration Programme – there had been a robust discussion on the importance of culture for both organisations.
- The Staff Story of a neurodiverse employee outlined the Trust's positive cultural changes and noted the support from members of the Executive Team.

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

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

Item 2026-27 (16): Guardian for Safe Working Hours

The Executive Medical Director explained that owing to the changeover of guardians (with the new Guardian not yet in post), the report had been postponed until the following meeting. However, she confirmed verbally that, after consultation with the previous Guardian, the Non-Executive Director (RB) who had responsibility for this area, and the Executive Medical Director there were no issues that needed to be brought to the Board's attention at this point.

The outgoing Guardian for Safe Working Hours was thanked by the Board for her work.

Outcome: The Trust Board noted the verbal update.

Item 2026-27 (17): Code of Governance Compliance

The Interim Chief Executive presented the report which set out the Trust's ongoing compliance against the requirements of the Code of Governance which came into force on 1 April 2023 and reported the Trust's compliance against the standards.

The report highlighted one statement for which an explanation was provided, related to the Trust having a policy on its purchase of non-audit services from its external auditor. While a stand-alone policy was not in place, the process for the appointment of the External Auditor was included in the Trust's Standing Orders and Standing Financial Instructions (SOs/SFIs) and the NHS England guidance in this respect was 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.

Outcome: The Trust Board

- Noted the requirements of the Code of Governance for provider trusts, and the assurance that would be provided in due course by External Audit against the publication within the Annual Report.

- Reflected on the self-assessment of comply or explain against the statements of the Code and approved this as an accurate reflection of the Board and practices at LCH.

Item 2026-27 (18): NHS Provider Licence Compliance

The Company Secretary presented the compliance report to the Board noting the recommendation was to proceed with the compliance wording 'a' : "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

Outcome: The Trust Board agreed that the self-certification against required NHS provider licence condition CoS7 was accurate for 2025/26.

Item 2026-27 (20): Declarations of Interests and Fit & Proper Person Test

The Company Secretary presented the report. It was advised that the list of current declarations could be found in the Annual Report. In addition, the Trust Board were reminded of the need to review the declarations currently held on the register and confirm them again for the forthcoming year.

Furthermore, the Trust Board were additionally advised that the report covered the director's Fit and Proper Persons Testing and the Non-Executive Director's declarations of independence.

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

Item 2026-27 (21): Significant Risks and Risk Assurance Report

The Interim Chief Executive Officer presented the update report and noted that the risks were reviewed regularly at the bi-monthly Risk Management Group and that the next month's deep dive review would focus on the Children's Business Unit (CBU).

Non-Executive Director (LM) drew attention to the number of risks that could be considered to be static to an observer and questioned if the Board could be viewed as complacent. However, the Interim Chief Executive reminded the Trust Board that scrutiny happened at the Risk Management Group and in addition each Committee received reports on significant risks and were invited to review and raise any issues.

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

Item 2026-27 (22): Use of the Trust Seal

The Company Secretary provided an update on the use of the Trust corporate seal. The Board noted the number of times and the reasons for which the seal was used.

Outcome: The Trust Board noted the use of the Corporate Seal.

Item 2026-27 (23): Board Assurance Framework (BAF) Update on Review Process for 2026-27

The Interim Chief Executive presented the update report on the BAF review process, noting that a refresh of the BAF was in the process of being completed. This would be considered at each Committee Meeting in June prior to being submitted to Board in July for approval.

Outcome: The Trust Board
- Noted the process for review of the strategic risks, gaps in controls and sources of assurance for 2026/27.

- Discussed the Strategic Risks for 2026/27 for further amends.

Item 2026-27 (153): Any Other Business, Questions On Blue Box Items, And Close

No matters of any other business were raised.

The Interim Chief Executive was grateful for the inclusion of the glossary in the Blue Box Items and it was noted that this could be added to and updated if needed.

Items in the Blue Box were noted.

No questions were raised.

The Acting Trust Chair closed the meeting at 11.45am**.**

Date and time of next meeting

Thursday 23 July 2026 9.30am
Boardroom, Building 3, White Rose Office Park,
Millshaw Park Lane, Leeds, LS11 0DL.

AGENDA ITEM 2026-27 (4b)

Leeds Community Healthcare NHS Trust
Trust Board Meeting (held in public) Action Log: 23 July 2026

Key		Key colour code
Total actions on action log	6	
Actions on log **completed** since last Board meeting on 21 May 2026 with a **proposal to close**	0	
Actions due for completion by 23 July 2026 – for update at the meeting	6	
Actions not due for completion before 23 July 2026		
Actions outstanding at 23 July 2026**: not having met agreed timescales and/or requirements**		

21 May 2026				
Agenda Item Number	**Action Agreed**	**Lead**	**Timescale/ Deadline**	**Status**
2026-27 (7)	**Quality Committee Chair's Assurance Report**: Incident Management and Investigation Report scheduled for the July Quality committee should also be received at the Board meeting.	Corporate Governance Team / Interim Executive Director of Nursing and AHPs	23 July 2026	**Agenda 23 July 2026**
2026-27 (8) a	**Mortality Reports:** Provide Understanding of LMWS deaths and gaps in data	Executive Medical Director	23 July 2026	**Update on 23 July 2026**
2026-27 (8) b	**Mortality Reports:** Invite Associate Non-Executive Director (AC) to some QAIG Meetings	Executive Medical Director	23 July 2026	**Update on 23 July 2026**
2026-27 (8) c	**Mortality Reports**: Review Mortality Review Compliance Table included in Annual Learning from Deaths Report for missing data.	Executive Medical Director	23 July 2026	**Update on 23 July 2026**
2026-27 (9)	**Business Committee Chair's Assurance Report**: Advise People & Culture Committee of the outcomes of the Health & Safety AAA Report actions.	**Corporate Governance Team** *to add to P&CC agenda*; **Interim Executive Director of Nursing and AHPs** *to advise when appropriate to report into Committee*	TBC	**Update on 23 July 2026**
2026-27 (13)	**Business Case: PND Assessment Pathway**: Head of the ICAN Service, Vanessa Hunt, to be invited to present the changes to the PND assessment pathway as a Spotlight Item.	Executive Director of Operations	TBC	**Update on 23 July 2026**

ACTIONS CLOSED AT MEETING ON 21 MAY 2026				
5 February 2025				
Item 2025-26 (118)	**Youth Board:** A list of Youth Board meeting dates to be circulated.	Participation Lead, Child Health Management	By email following meeting	List of Youth Board dates circulated to Board members 7 April 2026. **Action Closed**
Item 2025-26 (129)	**Freedom to Speak Up – Planning Toolkit:** The options for mandating training for new starters to be considered by the People and Culture Committee and a proposal to be presented to the Board for approval.	Freedom to Speak Up Guardian	May 26	May 2026: LYPFT link was to national training module. Training not mandated. **Action Closed**
27 March 2026				
Item 2025-26 (149)	**2025 National Staff Survey Results:** WRES 8 – Discrimination from Manager or Team data to be analysed further and reflections provided.	Director of People	May 2026	May 2026: Review of previous cases underway to reflect on learnings; discussed at Board workshop as noted in CEO's May 2026 report. **Action Closed**
Item 2025-26 (151)	**Significant Risks and Risk Assurance Report:** Risk trend report with original formatting to clarify trends to be circulated.	Company Secretary	By email following meeting	Circulated 14 April 2026 **Closed: Action Complete**

Agenda item:	2026-27 (5)
Title of report:	Interim Chief Executive's Report
Meeting:	Trust Board
Date:	23 July 2026

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

Purpose of the report:		
The purpose of this report is to update and inform the Board of key activities and issues from the Chief Executive.	Approval	x
	Discussion	
	Assurance	x

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

Summary of Key Issues:
Updates are provided on activities relating to: • Our services and our people • Alignment with Leeds and York Partnership NHS Foundation Trust (LYPFT) • System updates

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

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

	Yes		What does it tell us?	

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

Recommendation(s)	The Board is recommended to: • note the update on key activities and issues from the Chief Executive. • Approve the definition of anti-Muslim hostility set out following the Lord Mann Review

List of Appendices:	No appendices

Interim Chief Executive's Report

1 Executive Summary

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

2 Our people and our services

Service Visits

It was a pleasure to visit the Recovery Hub at Wharfdale on 1 July 2026– although it wasn't intentional to be there on the go live of the new service model for the community beds. However, it was good to see that the changes had been very well planned for and there are ongoing arrangements in place to work through any issues that surface as we work differently with Adult Social Care. Whilst the ward environment is very clinical, the team there do identify benefits of being co- located with Leeds Teaching Hospital NHS Trust services and have made a number of adaptations to better use the environment for rehabilitation.

The ward sister shared with me the ongoing work around staff engagement, inclusion and support which is being supported by the People Directorate and the Freedom to Speak Up Guardian. I received a follow up request from the ward sister to make wider connections across the future trust services to enable staff at Wharfdale to be better skilled and equipped to support patients with complex needs - which is an excellent example of how we can deliver enhanced care as a result of the merger of our organisation.

Alongside other Board colleagues it was a pleasure to attend the AGM for the Race Equality Network. Having been established nine years ago there is a great history of change and impact the network should be proud of, and a great opportunity to carry that learning forward so we can have a greater impact in future years. This was followed by the Equality Diversity and Inclusion Forum at which the Director of People led a session sharing the outputs from our Board workshop last month and asked for constructive feedback on how we can strengthen our approaches in the Trust. A specific example which we are actioning through the senior leadership team is improving the consistency of our

approach to dealing with discriminatory behaviour in the community – for our staff providing care and treatment in people's own homes.

- **Celebrations in our Children's Business Unit**
  - Children and Young People's Mental Health Services (CYPMHS) - the Eating Disorders Team no longer has any long waiters and Neurodevelopmental (ND) assessment waiting times continue to reduce, with 455 people waiting over 18 weeks compared to 1,600 people 18 months ago.
  - Speech and Language Therapy (SLT) – only 21 patients are now waiting over 18 weeks compared to 149 in November 2025 with only five patients breaching 40 weeks.
  - Hannah House - charitable funds received to update the lounge to a cinema room (Jane Tomlinson charity).
  - New referral form for pre-school autism launched which will be completed by the 0-19 teams. This will result in better referrals, quicker triage time and reduction in the amount of time families must wait for a decision.

- **Nursing Workforce Reform – Band 5 Review**

  The Government and NHS England have launched a national Band 5 Nursing Job Evaluation Review to ensure that nurses are being paid appropriately for the work they undertake, and that job descriptions accurately reflect contemporary nursing responsibilities. All NHS trusts are required to develop and submit plans by 31 July 2026 to review Band 5 nursing roles by October 2027, with the work undertaken through established Agenda for Change job evaluation processes and in partnership with staff representatives.

  The Trust has already commenced preparatory work alongside LYPFT colleagues and in line with the national requirements and will develop a comprehensive Band 5 Nursing Job Evaluation Delivery Plan, supported by appropriate Board oversight, staff-side partnership working and workforce engagement arrangements. This will include reviewing existing Band 5 nursing job descriptions against the updated national profiles, assessing local job evaluation capacity and governance processes, identifying any workforce and financial implications, establishing a phased implementation timetable, and monitoring progress through regular reporting as appropriate.

- **NHS Staff Standards**

  The newly published NHS Staff Standards introduce a nationally mandated set of minimum employment standards for NHS trusts, covering six key areas that staff have identified as most important: line management, health and wellbeing, violence prevention and reduction, sexual safety, tackling racism, and flexible working. The standards are intended to improve consistency in staff experience across the NHS, reduce unwarranted variation, strengthen retention and attendance, and ultimately support better patient care and organisational performance. Importantly, delivery will be monitored through the NHS Oversight Framework through a collection of linked Staff Survey questions, signalling a greater focus on staff experience as a core measure of organisational success alongside operational and financial performance which is welcome.

  In support of the standard relating to line management NHS England have also published the **NHS Leadership and Management Framework** – which is for all leaders and managers - and launched the **NHS College of Leadership and Management** as the national home for NHS leadership, management and talent development. This includes a code of practice and leadership and management standards for all NHS leaders and managers, and the college will be providing a range of development and training courses in due course. It is intended to support stronger management capability, competent, compassionate and inclusive leaders, better staff experiences and, ultimately, improved care for patients.

  We are undertaking a baseline assessment against the new NHS Staff Standards and will align any next steps with the existing people strategy and work across the Trust. A further update will be provided to the People and Culture Committee ahead of a future Board meeting in terms of further progress, and once national assurance and oversight arrangements are established.

- ***Lord Mann Review***

  The Lord Mann Review into anti-Semitism published in June 2026 concluded that a stronger, more consistent anti-racist culture is required across the NHS and makes recommendations to strengthen leadership, accountability, training, data transparency and staff support. The findings are important for all Trust Boards because they place greater responsibility on leaders to actively

demonstrate inclusive leadership, address racism in all its forms, and provide assurance that staff and patients are protected from discrimination. NHS England has accepted the recommendations and has confirmed expectations that NHS Boards and system leaders undertake regular anti-racism training, strengthen accountability for racial inclusion, and embed anti-racist principles within governance and performance arrangements.

Additionally, every NHS organisation is expected to adopt the below government definition of anti-Muslim hostility, and the Board is therefore asked to approve Leeds Community Healthcare's sign up to this definition:

Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.
It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life.
Source - *A Definition of Anti-Muslim Hostility - GOV.UK*

Building on the Trust's existing inclusion agenda, we are now undertaking a targeted review of alignment with the Lord Mann Review recommendations, and incorporating any identified enhancements to Board development, overall Trust inclusion objectives, policy frameworks, workforce metrics and assurance arrangements. We will again report into the People and Culture Committee in October 2026 when the Trust's annual inclusion report will be considered which both reviews progress over the last year and commits to plans and work for the coming year. The recommendations from the Lord Mann Review will be incorporated into this planning process, with delivery on imminent actions

commencing straight away. The Board will also continue to be appraised of progress on this critical agenda.

➢ 3 Alignment with Leeds and York Partnership NHS Foundation Trust

Significant work and progress continue to be made in the transition workstreams to ensure a safe day one for our new organisation, post transaction implementation planning, completion of our full business case and looking ahead to our 5-year ambitions.

At the Transition Committee in July, the outcomes from the engagement to determine the name for our new organisation were considered. A structured engagement process was delivered, centred on a two-week online vote supported by a comprehensive communications campaign. A total of **2,132 responses** were received, alongside extensive qualitative feedback from a broad range of stakeholders. This process has been undertaken in line with NHS England naming principles.

It focused on selecting from a shortlist of four compliant options, and while respondents have been given the opportunity to suggest alternatives, this hasn't been an open creative exercise. The approved shortlisted options put to vote were:

- Leeds Healthcare NHS Foundation Trust (LHFT)
- Leeds NHS Foundation Trust (LFT)
- Leeds Partnership NHS Foundation Trust (LPFT)
- Leeds Mental Health and Community NHS Foundation Trust (LMHCFT)

Two names received most of the votes, with only a very small difference in overall voting numbers between Leeds NHS Foundation Trust and Leeds Partnership NHS Foundation Trust. The committee discussed the two names and the pros and cons of each. The final recommendation approved by the committee is to adopt the name:

Leeds Partnership NHS Foundation Trust (LPFT)

This was selected as the word **partnership** was considered important for several reasons

- It reflects the wider partnership model and service delivery that exist into our regional and specialist services so signals we are not solely Leeds based.

- It represents the way we work now and the way we want to continue to develop in the future, as working in partnership with others is critical for the services we provide.
- This approach is being raised in the best of both culture engagement work and in the workshop on future strategy as to what we want to be known for, and the culture within the organisation.
- It is an important marker to distinguish us from acute trusts.

As the list for consultation was agreed in advance with NHS England (NHSE)/Department for Health and Social Care we do not require any further approvals at this stage but have sought endorsement from the NHSE Regional Director. We are now socialising the new name internally and externally, including formally updating local MPs.

Key Dates ahead are*:*

- Joint Board meeting on 30 July 2026 to review due diligence (legal and internal)
- Best of Both culture diagnostic work will continue into August 2026.
- Submission of checkpoint report to NHSE on 4 September 2026.
- Draft full business case (FBC) to be reviewed by both Trust Boards at the end of September 2026 and formal support for submission sought.
- FBC submission to NHSE national transaction team and regional team October 2026.
- Process for the appointment of a new Trust Board to commence in August and conclude by end of October 2026 that will come into effect from 1 April 2027.

Throughout and beyond this time work will continue through the workstreams, including the development of a new draft trust strategy that will be approved by the new Trust Board prior to the launch of the Leeds Partnership NHS Foundation Trust (LPFT).

➢ 4 Next steps

➢ Leeds Place Provider Partnership

On 3 July approximately 100 leaders from across Leeds health and care organisations came together to explore system dynamics that enable or hinder

effective partnership working. The event formed part of the ongoing development of the Leeds Provider Partnership (LPP) and focused on understanding why barriers to collaboration persist, despite widespread commitment to integrated working. The event was designed to support a system-wide conversation about how Leeds can strengthen collaboration in the context of:

- Team Leeds and Leeds Ambitions
- Neighbourhood health and community-based models.
- A greater emphasis on prevention and reducing health inequalities.
- Increased integration across health, care, local government and voluntary sector.
- The development of the Leeds Provider Partnership.

Participants explored five key dimensions of system dynamics:

1. Moving from organisational thinking to system thinking.
2. Making collaboration real at all levels.
3. Creating safe spaces for honesty and challenge.
4. Understanding power dynamics.
5. Bridging different organisation and sector cultures.

Key Messages from participants:

Feedback from all discussion groups pointed to four interconnected themes:

- ***Trust and Relationships*:** Collaboration depends on trust, relationships and psychological safety. Participants felt these should be recognised as core components of system productivity rather than additional activity.
- ***Shared Purpose and Collective Accountability*:** Participants called for a stronger focus on population outcomes, shared success measures and collective decision-making rather than organisational priorities.
- ***Leadership and Culture*:** Leaders have a critical role in modelling collaborative behaviours, supporting innovation and creating environments where staff feel empowered to work across boundaries.
- ***Conditions for Collaboration*:** Participants highlighted the need to remove barriers, clarify risk and accountability, and create the practical conditions that enable collaborative working at scale.

What this means for the partnership

The table discussions and panel questions were broadly aligned. Delegates were less concerned with whether collaboration is desirable and more concerned with how leaders will make it happen in practice. Several consistent themes emerged:

- How Team Leeds ambitions can be translated into meaningful change for frontline teams.
- How capacity and headspace can be created for collaboration and innovation.
- How leaders will model collaborative behaviours and hold themselves accountable.
- How progress will be measured.
- How challenge, transparency and community influence can be strengthened.

The event demonstrated strong alignment around the direction of travel for Leeds. Participants consistently highlighted that the future success of the Leeds Provider Partnership will depend not only on governance and structures, but on trust, relationships, leadership behaviours and shared purpose. The challenge for the partnership is no longer defining what good collaboration looks like, it is creating the conditions that allow it to happen consistently, at every level of the system. The outputs have been shared and discussed by the partnership leadership team.

In addition, a smaller group of accountable officers with Manraj Khela and Tim Ryley, in his new role as our Director of Partnership development in Leeds, are working together to establish a much clearer vision and ambition for what we want to achieve over the next five years, that aligns our statutory organisations and gives the purpose for the Joint Committee and the benefits of us holding a delegated budget and functions from the West Yorkshire Integrated Care Board (ICB) by 2028.

- **West Yorkshire Integrated Care Board**

  Interviews have taken place for the appointment of a substantive CEO for the ICB. At the time of writing the successful candidate has not been announced. The management of change process is continuing with place-based integrator roles to be appointed to in early August 2026.

- **Regional Updates**

  Sam Allen has been appointed as the Regional Director for NHSE in the North East Yorkshire and Humber region following the departure of Fiona Edwards earlier this month. Sam is a very experienced provider and ICB CEO and will continue to be the CEO for the North East North Cumbria ICB. Sam has already put in place direct engagement opportunities with CEOs to agree ways of working and opportunities for closer working going forward. Chairs and CEOs have been invited to a regional event with Sam and Bill McCarthy, the Regional Chair, on the 17 July and outputs from this will be shared at the Board meeting.

- **Quality strategy for NHS-funded care in England**

  A long awaited new national quality strategy for NHS funded care was published by the National Quality Board on the 14 July 2026. The strategy defines quality through 3 core domains which all must improve together:

  - **safety** – reducing the risk of unintended or unexpected harm to patients arising from the provision of healthcare
  - **effectiveness** – providing evidence-based care that improves outcomes for people
  - **experience** – delivering co-ordinated, compassionate and responsive care that meets people's needs

  The strategy focuses on:

  - improving health outcomes and healthy life expectancy
  - reducing healthcare inequalities
  - improving satisfaction with NHS services

  Why this matters now

  High-quality care is delivered across the NHS every day, but recent reviews and data still show a mixed picture of care quality. Some encouraging gains have emerged – for example, continued improvement in early lung cancer diagnosis and a partial recovery in the timeliness of cancer treatment. Yet, outcomes and experiences remain uneven, and healthy life expectancy at birth in the UK has fallen to its lowest level since 2011. To address these challenges, this strategy aligns with:

- the 10 Year Health Plan, which sets a system-wide commitment to **high-quality care and transparency**, based on a new operating model and moving care from hospital to community, analogue to digital and sickness to prevention
- the Dash Review, which calls for a more **co-ordinated, value-based approach** to quality to make the best use of NHS resources by focusing on interventions that deliver the greatest overall health benefit and improved productivity
- a strengthened role for the National Quality Board (NQB) in **overseeing progress and improving accountability**

Priorities for this strategy

This strategy does not introduce new requirements. It focuses on applying proven approaches more consistently, where this will deliver the greatest improvements in outcomes, equity and value. Initial priorities focus on:

- improving outcomes and reducing unwarranted variation across major conditions and priority groups through implementation of the National Cancer Plan and modern service frameworks
- making sustained improvements in maternity and neonatal services
- strengthening patient safety across all settings
- improving experience of care and restoring trust in NHS services
- reducing inequalities across safety, effectiveness and experience
- monitoring clinical and population health outcomes

These priorities will evolve over time, reflecting progress, emerging risks and changing population need.

The strategy sets out 10 enablers to create the conditions for improvement across the system. Each enabler links to further detail on how it will be delivered:

- clarifying who is responsible and accountable for quality at every level of the healthcare system
- setting clear priorities to improve the quality of care while adopting a transparent, co-ordinated and value-based approach
- strengthening leadership and management capability to create the right culture and conditions for improvement
- listening to and working with people and communities on what matters to them

- using data to manage quality, inform decisions and support accountability at all levels
- increasing transparency**,** making the NHS the world's leading healthcare system for public access to information on care quality
- developing and embedding technology to underpin quality management and improvement
- aligning incentives and rewards with accessible, high-quality and productive care
- promoting research and innovation to support continuous improvement in clinical care and how the NHS operates
- creating a more co-ordinated and improvement-focused approach to regulation

Building on the 10 enablers, the strategy also outlines how quality management systems provide local organisations with a structured way to plan, deliver, monitor and improve quality.

A shared responsibility

This strategy asks every member of staff, both clinical and non-clinical, to see quality improvement as their responsibility, not someone else's. It also asks the system to be honest about where care is falling short and what it will take to put things right. The prize is significant: fewer avoidable deaths, longer healthier lives and care that people can trust. Working together, we can create a system that delivers high-quality care everywhere and for everyone.

It is recommended that the Quality Committee undertake an initial review ahead of a session at a joint Board with LYPFT later in the year so we can plan ahead for the quality strategy for the new organisation.

➢ **5 Recommendations**

The Board is recommended to:

- note the update on key activities and issues from the Chief Executive
- approve the definition of anti-Muslim hostility set out following he Lord Mann Review

Dr Sara Munro
Interim Chief Executive
14 July 2026

Agenda item:	2026-27 (6)
Title of report:	Quality Strategy
Meeting:	Trust Board Meeting
Date:	23rd July, 2026

Presented by:	Heather McClelland – Interim Director of Nursing, AHPs & Quality
Prepared by:	As above

Purpose of the report:		
This report provides: An overview of the progress to date of the Trust's Quality Strategy 2024-27, including achievements and risks to delivery.	Approval	
	Discussion	
	Assurance	x

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

Summary of Key Issues:

- Trust currently in Year 2 of the Strategic plan with good progress made against the five priority areas.
- Some areas of delay in delivery of the plan due to business unit and corporate capacity.
- Work already commenced in planning for the Trust integration and delivery of a combined quality function, with learning from the national NHSE Quality Strategy, published last week.

Previously considered by:	Quality Committee – May 2026
Outcome of previous discussion/s:	

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

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

Recommendation(s)	• Consider progress of the Quality Strategy • Identify any further assurance required.

List of Appendices:	

Quality Strategy 2024-27

1 Executive Summary

The paper presents the six-monthly update on delivery of the Trust's Quality Strategy at the end of Year 1. Delivery of the Quality Strategy is focussed on the three key tenets of quality – safety, effectiveness and experience and five priorities agreed for the Trust. Key achievements against these five priorities are outlined, alongside the work continuing into 2026/27. Some progress has been delayed due to capacity issues and changes across the Business Units and Corporate team. A focus on visibility of the strategy and on associated metrics for assurance and improvement will be prioritised, whilst the Trust transitions into the new organisation and integrated changes outlined in the recently published national Quality Strategy.

2 Main body of the report

The Quality Strategy was approved by Quality Committee in December 2024, and the operational plan initiated early 2025.

The Strategy sets out the Trust priorities against the three key tenets of quality – Safety, Effectiveness and Experience, aiming to deliver a culture of continuous improvement and learning, as set out in the national Patient Safety Strategy.

Five key workstreams were generated to deliver on these priorities, with several actions within each priority area, planned across the three-year strategy

Safety: Ensuring patient safety is our top priority

1. We will regularly ask if people felt safe in our care and we will use that insight to improve our care for everyone through the implementation of the Patient Safety Incident Response Framework.

Effectiveness: Providing care that achieves the best care and outcomes for people

2. Our processes will fully comply with Care Quality Commission (CQC) standards.
3. Feedback will inform and improve safety and quality of care

Experience: Creating a positive experience to improve how satisfied people are when engaging with our services

4. We will implement PHSO standards to ensure effective feedback
5. We will consider quality & equity in our quality and safety improvements

3 Impact

The six-monthly update was presented to QC May 2026, reporting on the first full year of activity (included in the Blue Box). Implementation of the Patient Safety Incident Response Framework continues to mature and will involve annual review to ensure it is built around the Trust's key areas of harm.

Key achievements in the last year include

- Safe – PSIRF policy and plan in place and plan undated annually, training completed for patient safety specialists and Learning Response Leads; use of LCH Learns and Safety Summits to share learning from Investigations and Rapid Reviews.
- Effectiveness – the Trust's Quality Challenge + standards have been reviewed in line with CQC single assessment framework; patient feedback reports now routinely shared at QAIG and QC; Clinical audit plan revised to reflect business unit and Trust priorities; increased research activity
- Experience – new Parliamentary Health Services Ombudsman (PHSO) standards have been piloted across a cohort of services; EQIA processes in place for all service developments.

Some key areas of further work that is ongoing and to be developed further this year including

- Development of safety metrics – Progress has been made in strengthening safety oversight through the introduction of dashboards for Improvement Groups. Further work is required to enhance the reporting framework from ward to Board, ensuring clear lines of sight on safety performance and risks. This will include the integration of safety metrics into the Integrated Performance Report to support more effective organisational oversight and assurance.

- Digital solutions – Opportunities have been identified to improve the efficiency, consistency and timeliness of key safety processes through greater digitisation. The continued development and implementation of digital solutions will support more streamlined data collection, analysis, reporting and governance arrangements.

- Learning – Further work is required to strengthen the organisation's approach to learning by bringing together intelligence from multiple sources, including incidents, complaints, claims, audits and engagement activities. This will support a more comprehensive understanding of underlying themes and priorities, ensuring improvement activity is targeted effectively and that learning is translated into clear, meaningful messages for clinical teams and services.

4 Quality

Quality Committee received the report and identified that some of the 'complete' actions were ongoing – this will be updated in future reports. Concerns were raised about the consistency and visibility of effective metrics, and a lack of clarity on the

impact of the changes made. They emphasised the need for clearer, more accessible reporting, including a simplified format to support oversight.

5 Resources

Some significant gaps in staffing and increasing demand on the Clinical Governance team has limited the pace of progress, especially in the refinement of the EQIA processes and full roll out of the PSHO standards.

- **Risk and assurance**

There is a risk to delivery of the priorities without effective engagement across clinical and operational leadership, and visibility of progress. This is reflected in both feedback on the strategy but also in visibility of assurance and improvement metrics. There is also a risk that the work required to deliver the Trust Integration programme will impact on the delivery of the priority areas – this will be monitored and adjusted as required to avoid duplication of effort and workforce well-being.

4 Next steps

The actions within the strategy will continue to be developed over the next year as we move through Trust transition. Work is already underway to understand differences and similarities in quality management and improvement across the two Trusts and an external consultancy company have been commissioned to support this work.

The national Quality Strategy has now been published (14 July 2026) so this will be reviewed to identify any shift in priorities and how, as a Trust, we can integrate national guidance into our strategic plan.

5 Recommendations

The Board is recommended to:

- Consider progress of the Quality Strategy
- Identify any further assurance required.

Heather McClelland
Executive Director of Nursing, AHPs and Quality
15/07/2026

Agenda item:	2026-27 (7)
Title of report:	People Strategy and Headlines Update
Meeting:	Board meeting
Date:	23 July 2026

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

Purpose of the report:		
This report provides: The Board with an update on progress against the approved LCH Strategic People Framework, as well as sighting the Board on key aspects of the national NHS people agenda.	Approval	
	Discussion	X
	Assurance	X

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

Summary of Key Issues:
- Note the update against the internal LCH Strategic People Framework. - The significant growth in national expectations in terms of the people agenda. - Performance expectations nationally in respect of the national people agenda. - The need to balance BAU with internal development work alongside the national expectations and the Trust's Integration Programme with LYPFT.

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

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

Embed equity in all that we do	

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes	X	What does it tell us?	Workforce data relating to protected characteristics informs our targeted support to teams as needed.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	It is recommended that the Board notes the people headlines presented in this report including the national NHS people headlines and reflects on the interplay of our organisational people priorities with the national people agenda.

List of Appendices:	

People Strategy Update & Headlines

1. Introduction:

This report is presented to each meeting of the LCH People & Culture Committee as a current snapshot of People & Culture headlines, priorities, and progress. Additionally on a bi-annual basis the report is presented to the Trust Board. This report focuses on updating the Board on progress against the LCH Strategic People Framework which was approved by People and Culture committee members at the March 2026 meeting as well as setting out key areas in terms of the national NHS people agenda.

It is important to note the alignment between the two with the national policy direction and expectations shaping our LCH people priorities.

2. Progress Against the LCH Strategic People Framework:

This framework was approved by the P&C Committee at its March meeting. It covers four key areas of people activity as follows:

- Leadership and Management;
- Transforming our People Services;

- Staff Experience;
- Transforming our Organisation.

In terms of specific headlines and updates, each of these areas is considered in turn below:

2.1 Leadership and Management:

Within this domain and in the first three months of the framework's operation, a number of things are of note:

- Health and well-being training for managers has now been designed and delivery is embedded – this was considered a priority area considering the Trust's sickness absence rates and linked NOF performance and segmentation.
- The training has been well evaluated and is also now being nuanced and extended further into areas including softer skills for managers and reasonable adjustments.
- In line with our aim to provide more targeted support for teams in more challenged circumstances, our organisational health approach continues to evolve and be used in areas including Police Custody, Wetherby YOI and Dental services.
- Additionally, targeted interventions are also taking place in particular services including Wharfedale, Community Care Beds and Nights which were identified following consideration of the Trust's Staff Survey results and further analysis of our WRES results.
- We ensure all leadership development offers are promoted through our staff networks and to all network members. We also have a coaching network that is diverse and available to all staff including those with protected characteristics.
- To note our leadership and management framework and support is now being reviewed to ensure that the expectations of the new National Leadership and Management Framework are being met (please see below).

2.2 Transforming our People Services:

Our aim is to continue to transform and improve our LCH people services offer to staff and managers and aligned with the national transforming people services direction of travel. Key headlines include:

- We are midst implementation of a single front door access to people services within LCH – the technology being used is Halo, which the Trust is already licenced to use. It is anticipated that this digital front door will transform our service offer ensuring that routine queries are dealt with more efficiently coupled with additional manager support and self-service for staff and managers.
- Our People Partnering project continues with a key focus on case work deep dives and ensuring that we are partnering with key parts of the business on for

example the targeted intervention work mentioned above. The role of People Partners in this work and as a key part of business unit teams is critical.

- We are in the first wave of Trusts collaborating with the national team on the New Workforce Solution (NWS) which is effectively the replacement of ESR. With LYPFT we are hoping to be able to move in wave one and are aiming to align this work as closely as possible with the move to one organisation with LYPFT.
- In terms of the resourcing agenda there is continued focus on understanding both Bank and Agency usage across the Trust with a view to continuing to drive down this usage and cost.
- Additionally, the new establishment control and redeployment processes again aligned with LYPFT and in advance of the coming together of the two organisations have been implemented.
- Our roll out of people dashboards to enable managers to understand and make decisions based on their people data in real time continues with several additional dashboards now in development.

2.3 Staff Experience:

Our work overall on staff engagement and experience continues with our staff engagement project closely aligned with our focus on staff absence and organisational health as reflected in the Board IPR report.

Additionally, the people and culture transform elements of the Trust Integration Programme continues at pace and that work will impact on the experience of every member of staff in LCH. A current key focus is the 'Best of Both' programme which is being rolled out within LCH as well as LYPFT.

In terms of inclusion and following good and constructive discussions with both the People and Culture Committee as well as the Board at a recent Board workshop, several actions are underway:

- The Board Intention Plan has been formulated with a clear commitment to zero tolerance in terms of discrimination against protected characteristics including race and disability and on behalf of the Board, our CEO and Chair have communicated this clearly to staff.
- Further work has been undertaken on the WRES and WDES Staff Survey data with specific interventions in areas where WRES scores are of concern (and as set out above) as well as progress made on projects including in terms of inclusive recruitment.
- We continue to collaborate with colleagues in other organisations to understand what more we could implement in terms of anti-racist practise, and we are building on our 'cultural conversations' work to improve both the awareness and competence of our leaders and managers.

- Aligned with the Lord Mann review (please see below), and our continued focus on inclusion, we are identifying a provider of Board and Senior Manager anti-racism training for LCH in conjunction with LYPFT colleagues.
- The Trust's annual inclusion plan is due at Board in the autumn, and we are aiming to clearly specify the programme of work and interventions needed to continue work to eliminate the disparity of experience in our workplace between those staff without and those with protected characteristics.
- This plan and its implementation will include further recommendations from the Lord Mann review as well as a focus on the newly published NHS Staff Standards.

2.4 Transforming our Organisation:

Under this heading and amongst other areas of focus there is the People and Culture workstream for the Trust Integration Programme (TIP).

Additionally, people teams within the directorate continue to support the Admin Review as well as the Leadership and Management restructure and several tender processes linked to specific business areas. The work includes advising on the implications of organisational change, consultation, and the management of the implications of organisational change and updating all workforce systems because of change as well as selection process design informed and shaped by the EQIA process.

In addition, it is worth noting that work on linking with LYPFT colleagues in respect of the provision of people services at scale and for the future is well underway with a number of teams connecting on specific matters, mapping existing and shaping future service provision, as well as sharing best practice and resources as appropriate.

2.5 Ongoing Service Provision:

Alongside change and integration programmes as well as the development work set out above, the People Directorate continues to deliver the day-to-day services that make up a large proportion of its work.

Much of this is invisible by design: employee relations casework continues at pace; early intervention conversations occur every day; colleagues are paid correctly; rosters and leave are managed; expenses and benefits are administered; and the ordinary changes of employment are processed without friction. The success of this work is measured by an absence of problems rather than by visible output, but its value to every colleague across the Trust is important.

A responsive, efficient service in the current context remains a further key priority for the Directorate.

3. National NHS People Agenda:

3.1 Strategic Context:

The national NHS people agenda has developed significantly in recent months with several key policy updates and focusses on inclusion, engagement and staff experience published with a clear expectation of delivery across various areas.

3.2 Key National Policy and Programme Updates:

Nursing Workforce Reform – Band 5 Review:

The Government and NHS England have launched a national Band 5 Nursing Job Evaluation Review to ensure that nurses are being paid appropriately for the work they undertake and that job descriptions accurately reflect contemporary nursing responsibilities. All NHS trusts are required to develop and submit plans by 31st July to review Band 5 nursing roles by October 2027, with the work undertaken through established Agenda for Change job evaluation processes and in partnership with staff representatives.

The Trust has already commenced preparatory work alongside LYPFT colleagues and in line with the national requirements and will develop a comprehensive Band 5 Nursing Job Evaluation Delivery Plan, supported by appropriate Board oversight, staff-side partnership working and workforce engagement arrangements. This will include reviewing existing Band 5 nursing job descriptions against the updated national profiles, assessing local job evaluation capacity and governance processes, identifying any workforce and financial implications, establishing a phased implementation timetable, and monitoring progress through regular reporting as appropriate.

Transforming People Services (TPS):

- This programme aims to standardise and automate HR processes shifting People Services across the NHS from transactional to more strategic workforce support whilst improving manager and staff experience alongside reducing costs and duplication;
- The national rollout will include tools, blueprints, and readiness assessments, with some regions acting as early adopters with the programme spanning more than 5 years of implementation;
- The Trust is in an advantageous position to adopt elements of this change programme and given our continued commitment to transforming our People Services here in LCH and as we work with LYPFT to integrate our combined offer in the new organisation.

Freedom to Speak Up (FTSU) Changes:

- The National Guardian's Office closed in June 2026 and from July 2026 greater accountability sits with providers for embedding effective speaking-up cultures;
- The FTSU Guardian role will remain mandatory, reinforcing the importance of local culture and governance;

- At LCH we have a strong speaking up culture and practices and our Guardian's initial assessment of the changes is that we will be able to implement them and retain our strong practice in this area.

3.3 Culture, Inclusion and Staff Experience:

Lord Mann Review:

The Lord Mann Review into antisemitism published in June concluded that a stronger, more consistent anti-racist culture is required across the NHS and makes recommendations to strengthen leadership, accountability, training, data transparency, and staff support. The findings are important for all Trust Boards because they place greater responsibility on leaders to actively demonstrate inclusive leadership, address racism in all its forms, and provide assurance that staff and patients are protected from discrimination. NHS England has accepted the recommendations and has confirmed expectations that NHS Boards and system leaders undertake regular anti-racism training, strengthen accountability for racial inclusion, and embed anti-racist principles within governance and performance arrangements. Additionally, every NHS organisation is expected to adopt the government's definition of Anti-Muslim hostility immediately and as set out in the CEO report to this Board.

Building on the Trust's existing inclusion agenda, we are now undertaking a targeted review of alignment with the Lord Mann Review recommendations, and incorporating any identified enhancements to Board development, overall Trust inclusion objectives, policy frameworks, workforce metrics and assurance arrangements. We will bring this back to the People and Culture Committee in October when the Trust's annual inclusion report will be considered which both reviews progress over the last year and commits to plans and work for the coming year. The recommendations from the Lord Mann review will be incorporated into this planning process with delivery on imminent actions commencing straight away. The Board will also continue to be appraised of progress on this critical agenda.

NHS Staff Standards:

As set out in the CEO report, the newly published NHS Staff Standards introduce a nationally mandated set of minimum employment standards for NHS Trusts, covering six key areas that staff have identified as most important:

- line management;
- health and wellbeing;
- violence prevention and reduction;
- sexual safety;
- tackling racism and;
- flexible working.

The standards are intended to improve consistency in staff experience across the NHS, reduce unwarranted variation, strengthen retention and attendance, and ultimately support better patient care and organisational performance. Importantly, delivery will be monitored through the NHS Oversight Framework through a collection of linked Staff Survey questions, signalling a greater focus on staff experience as a core measure of organisational success alongside operational and financial performance which is welcome.

We are currently undertaking a baseline assessment against the new NHS Staff Standards and will align any next steps with the existing people strategy and work across the Trust. Further updates will be provided to both the People and Culture Committee as well as the Board in terms of further progress and once national assurance and oversight arrangements are established.

NHS Leadership and Management Framework:

Underpinning the NHS Staff Standards, a new Leadership and Management Framework has also been published, alongside the establishment of the NHS College of Leadership and Management, creating for the first time a single national framework that defines the behaviours, standards, competencies and expectations expected of all NHS leaders and managers, across both clinical and non-clinical roles.

The framework responds to the Messenger and Kark reviews and is intended to strengthen the quality and consistency of leadership, management capability, talent development, and organisational culture across the NHS. It is particularly important because effective leadership is recognised as a key enabler of staff experience, productivity, service improvement, and patient outcomes.

For Trusts, the framework will increasingly inform leadership development, appraisal, recruitment, succession planning, and organisational assurance arrangements. The Trust is well placed to respond through its existing leadership and inclusion programmes and will use the framework to further strengthen leadership capability, promote inclusive leadership behaviours, and support the development of current and future leaders.

3.4 Additional Operational Updates:

Mileage reimbursement reforms have been recently introduced with changes to the mileage rate as well as the threshold mileage for claiming of rates increased. Additionally, it has been confirmed that rates will be reviewed annually for the NHS. We have collaborated with staff side colleagues to ensure this is communicated across the workforce with ongoing routes to escalate any concerns.

3.5 National NHS People Agenda - Implications for LCH:

The national direction for people issues is moving towards a more standardised, accountable, and strategic people function, with increasing emphasis on:

- Workforce sustainability and supply;
- Culture, inclusion, and staff experience;
- Efficiency and productivity through transformation.

There are significant workload implications for the Trust's people function as well as operational colleagues and LCH will need to balance delivery of immediate workforce pressures with readiness for significant structural and cultural reforms over the coming period alongside continued delivery of the People and Culture workstream of the Trust Integration Programme (TIP).

As we move towards the creation of a new organisation it will be important that the foundational work in both LCH and LYPFT is used to create the right working conditions, environment, and staff experience in a merged Trust.

4. Conclusion

This paper seeks to show, progress against the LCH Strategic People Framework as well as to sight the Board on significant development within the national NHS people agenda. The two are of course interrelated and connected and delivery across both will be important.

5. Recommendations:

It is recommended that the Board notes the people headlines presented in this report including the national NHS people headlines and reflects on the interplay of our organisational people priorities with the national people agenda.

Jenny Allen

Director of People

14th July 2026

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	**Report to:**	Trust Board 23 July 2026
Date of Meeting:	14 July 2026	**Date of next meeting:**	8 Sep 2026

Introduction

The meeting was quorate. The agenda was particularly full; however, all items were discussed within the allocated timeframe, with constructive and healthy discussion throughout. Service Spotlight from Sexual Health Service team who presented an innovative outreach project targeting sexual health outcomes among street-based sex workers, detailing the use of d-PEP, partnership working, and challenges in data collection and outcome measurement, with committee members exploring opportunities for broader support and research.

Alert

None

Advise

- Safeguarding Strategy Update – Most actions have been completed. Ongoing work on self-neglect and changes in responsibilities for looked after children. Discussed the need for clearer outcome measurement in future updates.
- ABU beds Mobilisation CQC Registration - Received an update on the mobilisation of new recovery hubs and Wharfedale beds, focusing on partnership arrangements with the city council, CQC registration processes. Emphasised the importance of clear governance and escalation pathways to avoid gaps in responsibility, especially given the joint management structure. A paper outlining this would be provided for the next meeting in September.
- Leeds SEND Inspection Report 2026 - Discussed the outcomes of the recent SEND inspection, which identified systemic failures in supporting families, leadership challenges. An action plan is being developed to address inspection findings which will be presented to the next meeting in September.
- Incident Management & Investigation oversight update – Partial assurance - Weekly oversight meetings and action plans have been implemented to address delays in incident investigations. Committee raised concerns that incident reviews were too focused on process rather than extracting meaningful learning and emphasised the need for a cultural shift towards proactive organisational learning. An update will be brought to a future committee.
- Safe Staffing Report - Received the six-monthly safe staffing update, focusing on inpatient areas, plans to expand reporting to community services, and the development of methodologies for measuring missed care. In process of testing methodologies for reporting safe staffing in community settings, with plans developing to bring a paper to the committee to discuss findings and next steps.
- Business Case – Active Recovery Catalyst Investment 2026/27 - Considered the proposal for a £1 million investment, noting that final approval would be required from the Board. Committee endorsed the proposal and supported its progression to the Board for approval.

Committee Escalation and Assurance Report

Assurance

- Quality Live Issues – EDoN outlined the national review of Band 5 nursing roles, highlighting the provisional agreement between the government and the RCN, the need to review all Band 5 role profiles, and the challenges of financial affordability and workforce structure, with the trust's workforce plan due for submission by the end of July. To be monitored through the People & Culture Committee.
- NOF Briefing on new framework – Segment 5 is being removed from the segmentation and intervention levels will now be based on segmentation and capability scores, with LCH currently in segment 3 and scores revised quarterly. Organisations will no longer be benchmarked against each other for segmentation, and 13 new measures will be introduced. The BI team is currently assessing the new measures, integrating them into the integrated performance report, and taking short-term actions to improve data quality and DQMI scores.
- NoF waiting List update - Provided an update on waiting list reductions. highlighted improvements in paediatric neuro-disability services due to permanent recruitment. Committee discussed equity concerns for children from disadvantaged backgrounds and described ongoing initiatives to monitor and address inequities.
- Spotlight – Sexual Health Service - Described the identification of a syphilis outbreak among street-based sex workers, with 18 confirmed cases. The team developed a flexible, outreach-based model for delivering treatment. Difficulties in tracking outcomes noted due to the transient nature of the population. Plans outlined for ongoing monitoring, surveillance, and potential research collaborations to assess the project's impact.
- LMWS talking therapies - Confirmation that the bid had been submitted and no outcome had yet been received.
- Integrated Performance Report - noted positive performance improvements, particularly in relation to sickness absence. Further work was required to develop quality indicators, as the report remained largely focused on operational performance measures.
- Quality and Value Report – Noted the Q&V report and the internal audit report. The Q&V report had clear focus on quality improvement alongside efficiency and value.
- Clinical Audit - The audit schedule has been refreshed to align with trust priorities and risks, with efforts to increase audit activity in underrepresented areas such as the Adult Business Unit.
- Mortality Report – Noted the Q 1 Learning from Deaths report. Assurance was provided that all mandated mortality reviews were being completed and that additional reviews were undertaken where potential learning was identified.
- Mental Capacity Act – Internal Audit report – Committee noted the report. It was reported that an EQIA had recently been finalised and would be presented in a future meeting.
- Patient Experience Report - Noted an increase in complaint numbers following implementation of the new Ombudsman framework. A reduction in FFT satisfaction scores was noted. Some planned FFT improvement work had been delayed due to resource pressures associated with managing complaints activity.

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- Introduction to other quality, data, information and knowledge improvements - Introduction of an ambient voice technology pilot within Neuro-disability services. EPR re-procurement programme underway, with workshops planned to gather clinical and operational requirements ahead of the expiry of the current SystmOne contract in July 2028. Successful completion of the Patient Information Hub project, which had met its objectives. ICE pathology and radiology requesting project, with progress continuing despite complexities associated with partnership working and system integration.
- QAIG AAA - Progress noted in the development of a Pressure Ulcer Business Intelligence dashboard. Committee welcomed the dashboard as a positive example of using data to support quality improvement and organisational learning.
- Safeguarding AAA - Noted an alert relating to rising waiting times for Child Health Needs Assessments due to increasing demand and limited paediatrician capacity – an update would be brought to the September meeting. Committee noted positive progress in relation to Oliver McGowan Training. An update was provided on work to strengthen sexual safety across the organisation.
- Safeguarding Annual Report – Approved. Good assurance regarding safeguarding activity and performance. Positive feedback on Children's safeguarding section. Adult safeguarding section more narrative and suggested future reports could include additional detail and supporting information.
- IPC Annual Report – Approved. Good assurance regarding IPC arrangements and performance. Acknowledged the significant contribution of IPC team in supporting infection prevention initiatives across partner organisations. Further clarification would be sought regarding ongoing hand hygiene improvement work.

Risks Discussed and New Risks Identified

- The Risk Register report was presented, showing movement in clinical and operational risks scoring 8 and above. One risk scores 15 and 60 risks score 8-12 (high). Patient harm is the most common risk theme. Reporting threshold had recently been considered by the Risk Management Group, and it had been agreed to retain the current threshold pending the development of a new risk management framework for the new organisation.

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	**Risk score (current)**	**Overall level of assurance provided that the strategic risk is being managed (or not)**	**Additional comments** **See above comments in report**
Risk 1 Failure to deliver high-quality, equitable care and continuous improvement: If the Trust fails to identify, deliver, and sustain high-quality care, promote learning, and drive continuous improvement in an equitable manner, there is an increased risk of unsafe or ineffective services. This may lead	16 (extreme)	Reasonable	• Incident Management and investigation oversight –It was noted that assurance remained limited because there was not yet

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to preventable harm, poor patient outcomes, and a diminished patient experience.			enough evidence to show that the recent improvements would continue over time. • Service Spotlight – Innovative work undertaken within sexual health services to address health inequalities and engage with vulnerable and hard-to-reach groups. Reasonable assurance overall, highlighted positive assurance from recent work relating to~~,~~ quality and value initiatives, and mortality review processes.
Risk 2 Failure to respond to increasing demand for services: If the Trust fails to respond to population growth and presentation, and the consequent increase in demand, then the impact will be potential harm to patients, inability to strengthen equity of access, additional pressure on staff, financial consequences and reputational damage.	12 (high)	Reasonable	
Risk 7 Failure to reduce inequalities experienced by the population we serve. If the Trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently delivering unfair access or care and exacerbating inequalities in health outcomes within some cohorts of the population.	12 (high)	Reasonable	

Author:	Rakhi Palliyath/Alison Lowe
Role:	Corporate Governance Officer/Committee Chair
Date:	14/07/2026

Agenda item:	2026-27 (8b)
Title of report:	Incident Management & Investigation Oversight update
Meeting:	Trust Board
Date:	23 July 2026

Presented by:	Prof Ian Lewis/ Heather McClelland, Director of Nursing and AHPs
Prepared by:	Sheila Sorby, Deputy Director of Nursing and Quality

Purpose of the report:		
This report provides an update on the previously identified incident management delays and investigation backlogs. Its purpose is to reaffirm the Trust's position of assurance, assess progress to date, and outline the ongoing and revised strategic requirements needed to address these systemic issues and achieve sustainable improvement.	Approval	
	Discussion	X
	Assurance	X

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

Summary of Key Issues:

- Performance has improved over the past four weeks, demonstrating early positive impact from interventions implemented since the previous report.
- Systemic causes of delay are now better understood, enabling a more targeted and informed approach to improvement.
- Targeted interventions are beginning to deliver measurable benefits, supporting more timely management of patient safety learning.
- Greater emphasis on process controls, structural reform and oversight is strengthening governance and reducing reliance on training and bespoke support alone.
- Sustained leadership focus is required to maintain momentum, embed changes, and ensure learning is translated into timely patient safety improvements.
- Continued monitoring and assurance activity will be essential to secure further gains and move the Trust towards a position of reasonable assurance.

Previously considered by:	QAIG Quality Committee May 2026

	Trust Board May 2026
Outcome of previous discussion/s:	Updates to be provided to July 2026 Committee and Trust Board

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

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

Recommendation(s)	Board is recommended to: • Note the findings of the report • Confirm the level of assurance (i.e. Limited Assurance) based on the current update and reliance on operational capacity within services • Note any implications for the Board Assurance Framework (BAF)

List of Appendices:	

Executive Summary:

The Trust vision is to maintain a systematic approach to incident reporting and management, ensuring that those affected are supported in a timely and effective manner, while enabling thorough investigation to understand what occurred, why it occurred, and what actions are required to prevent recurrence.

Having identified backlogs across the journey of incident management in the previous paper/s to QAIG, Quality Committee and Board, the implementation of targeted interventions have taken place.

This update provides an overview of progress made in addressing delays and reducing investigation backlogs. It sets out current performance, highlights areas of improvement, and identifies any ongoing challenges.

This paper offers assurance to the Quality Committee on the effectiveness of actions taken to date, and outlines the further measures required to sustain improvements and ensure a consistently timely and robust incident management process.

Current Risk Position:

A review of current performance data demonstrates an improving position, with compliance against Trust timeframes showing measurable progress. The Trust position at the time of this report is:

Initial Review**:** There has been a modest improvement in compliance with the requirement to complete initial reviews within three working days. Compliance has increased from 10% reported previously to 20% at the time of reporting, demonstrating early progress against improvement actions.

Analysis indicates that a significant proportion of reviews completed outside the required timeframe relate to non-clinical incidents. Work is therefore underway to better understand the factors contributing to delays within this category and to identify opportunities to streamline processes, improve timeliness and ensure resources are focused proportionately on incidents presenting the greatest risk.

Whilst compliance remains below the expected standard, the improving trajectory provides assurance that the actions implemented are beginning to have a positive impact, and performance will continue to be closely monitored through established governance and escalation arrangements.

Rapid review timeframes: The rapid review backlog has reduced significantly from 78 reviews at the previous reporting period to 37 reviews currently. All outstanding rapid review incidents relate to events occurring from April 2026 onwards, indicating that older historical cases have now been addressed.

To support backlog reduction, a tabletop review exercise has been undertaken for pressure ulcer incidents. This resulted in 15 of 27 incidents being cleared, with no new themes or organisational learning identified. A similar exercise is being conducted for falls incidents this week, with 14 rapid reviews currently under review.

Of the remaining 11 rapid reviews, it is anticipated that several will be re-categorised following review and therefore may not require completion of a rapid review process.

In addition to reducing the backlog, the tabletop exercise has provided an opportunity to test a more streamlined and concise rapid review template. Initial feedback has been positive, and the revised template will continue to be tested through the falls review exercise before being considered for wider implementation across services.

Good progress is being made in reducing the rapid review backlog, with a clear trajectory towards resolution of outstanding cases. No new learning

themes have been identified through the reviews completed to date, and improvements to the review process are being tested to support greater efficiency and sustainability going forward.

Investigation Timelines**:** Three further PSIIs have been concluded in May and June. The current position is 16 open PSIIs, 5 of which are IPC reviews into MRSA blood stream infections on behalf of the Leeds system and in line with the co-operation agreement. Two of the remaining 11 are being externally / independently led, one by the ICB, one by LYPFT and the final 9 are being managed within LCH.

Investigator Capacity & PSIRF Compliance:

The current position is that:

- Investigator training compliance remains high, with 17 of 19 investigators having completed the required HSSIB Systems Approach training. The remaining two investigators are currently unable to access the programme due to the absence of available national training dates since the last Committee report. To mitigate this risk and maintain compliance, the Trust is working collaboratively with colleagues at LYPFT to secure an alternative externally commissioned training package that will meet the required standards and address the outstanding training needs.

- A training gap remains in relation to "Involving Those Affected" training, with 11 investigation leads yet to complete the programme. National HSSIB course capacity continues to be limited, constraining access to training opportunities. To provide assurance that capability requirements are met in a timely manner, the Trust is progressing plans to commission a bespoke training solution. This approach has been developed in partnership with LYPFT and includes consideration of three potential training providers, with the aim of accelerating compliance and strengthening investigator competence in line with PSIRF expectations.

Progress Against Recovery Plan

The previous report outlined a recovery plan centred on ensuring the right person, at the right time, with the right ownership. An update on progress against this plan is provided in Table 1.

Table 1:

Theme and objective	Action item	Responsible owner	Target date	Action progress	Assurance metrics	Risk and mitigation
Right person Ensure precise, resilient case allocation with zero bottlenecks from staff absence.	To establish a weekly Business Unit process for review of incident activity over preceding week and ensure appropriate allocation and progress.	BU Clinical Leads	30-Jun-26	All 3 Business units have established a weekly meeting to consider incidents from the preceding week, in relation to harm and risk but also incident management. This then feeds in to the weekly Executive Oversight meeting	100% of SPOFs mapped 100% of overdue incidents have appropriate investigator allocated 0 investigations stalled due to staff absence Weekly meetings to be in place	Lack of capacity to undertake actions Implementation in to practice not sustained
	To establish a weekly Exec oversight meeting with BU Clinical leads	Director of Nursing and AHPs	30-Jun-26	Weekly meetings have been set up from 12 June 2026		
	Complete proforma to identify and review all Single Points of Failure (SPOF)	BU Clinical leads	30-Jun-26	Proforma developed and sent with updated action plan 12/6/2026 - need returns by 30/6/26		
	Design and implement mandatory fail-safe re-allocation protocol	BU clinical leads and Head of Clinical Governance	01-Sep-26			
Right time Eliminate operational displacement by securing	Targeted focus on the 17 incidents that are not Pressure Ulcer and falls, with a mandated rapid review slot over weeks from 15 June to clear this backlog.	Deputy Director of Nursing & Quality	15-Jun-26	Review undertaken and all that meet criteria for rapid review have been booked	0 backlog of rapid reviews that are not PU or Falls by the end of June	Backlog not cleared: weekly escalation to DoN Failure to Protect

protected, ring-fenced investigation capacity	Meeting to be established to agree approach for the 62 Pressure Ulcer and Falls rapid review backlog	Executive Director of Nursing	12-Jun-26	Meeting held and agreed approach - action below.	2026 Backlog of 62 PU and Fall rapid review cleared by (date) Formal briefing on expectations of protected investigation time Power BI patient safety dashboard to be developed and compliance monitored through Trust Improvement Groups and accessible within other clinical forums	Ring-Fenced Time
	To book 2 x full days for table top review of backlog of PU and falls with patient safety specialist, subject matter expert and BU reps. Revise rapid review template from this process to ensure robust but sustainable process	Deputy Director of Nursing and Quality	31-Jul-26	PU booked for 6 July, Falls for 9 July		
	Benchmark decentralized model vs. dedicated team approach	Deputy Director of Nursing and Quality	01-Sep-26			
	Quantify hours required to undertake investigation	Patient Safety Manager	30-Jun-26	This piece of work has identified that rapid reviews are taking an average of seven hours per case. This is significantly longer than anticipated and intended and reflects a culture of comprehensive information gathering and detailed documentation rather than a truly rapid review approach. It is anticipated that the		

				tabletop review process will help establish a more streamlined proforma, enabling a proportionate and significantly shorter review process while maintaining the quality of learning and assurance.		
	If required discuss resource issue with responsible owner to agree next steps	Deputy Director of Nursing	As needed	No action required at this point (3 July 2026)		
	Agree BU process to protect time for investigators	BU Clinical Leads	30-Jun-26	As part of identifying single point of failures each Business Unit has considered cover for incident management and investigation processes and this has included mutual aid across roles and services		
Right ownership Embed data-driven	Establish weekly Executive oversight meeting for Business Units	Executive Director of Nursing	15-Jun-26	Weekly meetings have been set up from 12 June 2026	100% Business Unit adoption of incident dashboards.	Operational Resistance to Ownership

accountability and reduce administrative burdens	Agree additional incident management KPIs into the Trust's Integrated Performance Report (IPR)	Executive Director of Nursing	30-Jun-26	This has been completed and is being operationalised along with the Head of Business Intelligence	95% compliance with IPR incident management KPIs	
	Formally transition timeline accountability to Business Units	Executive Director of Nursing	30-Sep-26			

Key points for assurance:

- All actions scheduled for completion by 30 June 2026 have been delivered within the agreed timescales.
- All remaining actions remain on track for delivery. This includes the development of a suite of quality metrics that will strengthen organisational oversight through the inclusion of key incident management and investigation measures.
- Enhanced oversight and accountability at both Business Unit and Executive Director of Nursing level have improved organisational visibility of incident management backlogs and associated risks. Regular monitoring, governance review and escalation processes have supported the earlier identification and mitigation of risks, contributing to sustained improvements in backlog management and overall performance.
- A review of the rapid review process has identified that reviews currently require an average of seven hours per case. This includes clinical record review, staff memory capture, analysis and report completion. While this demonstrates a thorough and robust approach to information gathering and documentation, the time commitment is significantly greater than originally anticipated and is not fully aligned with the intended principles of a proportionate rapid review methodology. The implementation of the tabletop review process is expected to support the development of a more streamlined review template and methodology. This will facilitate a more proportionate and efficient review process, reducing the time required while maintaining the quality of learning, investigation outcomes and assurance.

Overall, the recovery plan continues to deliver the intended improvements, with completed milestones achieved on schedule and remaining actions progressing as planned. Governance arrangements have strengthened oversight and accountability, and work is underway to further improve the efficiency and proportionality of the review process while maintaining the quality of learning and organisational assurance.

Conclusion

While compliance levels remain below the desired standard, there is clear evidence of improvement in the 4 weeks since the last report. The Trust has built on its understanding of the systemic drivers of delay and has begun to see the positive impact of targeted interventions.

The continued shift from guidance, training and bespoke support toward strengthened processes, structural reform and enhanced oversight is contributing to a more controlled and responsive system. Sustained focus on these areas is expected to further improve performance, enabling the Trust to move toward a position of reasonable assurance and ensuring that learning is translated into timely patient safety improvements.

➢ 5 Recommendations

The Board is recommended to:

- Note the findings of this update report
- Confirm the level of assurance (i.e. Limited Assurance) based on the current update and reliance on operational capacity within services
- Note any implications for the Board Assurance Framework (BAF)

Sheila Sorby
Deputy Director of Nursing and Quality
4 July 2026

Committee Escalation and Assurance Report

Name of Committee:	Business Committee	**Report to:**	Trust Board 23 July 2026
Date of Meeting:	16 June 2026	**Date of next meeting:**	21 July 2026

Introduction

The meeting was quorate. The Committee welcomed an overview of two service re-design programmes for finance and administration services. Both programmes had resulted in positive outcomes which could be shared as exemplars to be used in other transition programmes. The Committee discussed and approved the final Horsforth site sale contract and the sale and approved and change of buyer for Otley Clinic. The Committee approved a request for the bid team to continue with developing the Leeds Mental Wellbeing Talking Therapies bid submission response for final approval by Trust Board on 18 June 2026.

Alert	Action
None at this meeting	.

Advise

- Quality & Value Programme update - The report focused on Month 1 from a performance and financial perspective. At April 2026, the Trust had identified £75k of its £9m recurrent savings target for 2026/27, movement on transactions was expected to improve from Month 2.
- The Committee received an overview of the Digital Key Performance Indicators which would be included in the Integrated Performance Report (IPR) from July 2026.
- Neighbourhood Model Update and Provider Partnership Update (Key Priority) –the Committee received a report which provided an update on LCH-led neighbourhood health projects, system collaboration through the Leeds Provider Partnership and enabling digital and workforce initiatives. The report included an insight into the developing milestone plan, which provided the Committee with an overview of the priority work and the outcomes that were expected to be achieved.
- Waiting List Update (Key Priority) – the Committee noted the continued progress to reduce long waits. The report included the requested spotlight on Children and Young People's Mental Health Services ND routine waits along with an update on the internal audit request for a review on ethnicity data quality.
- Financial - At the end of May 2026 (Month 2), the Trust was reporting a year-to-date surplus of £0.103m against a planned break-even position and was forecasting a break-even outturn in line with plan. £0.405m of recurrent savings had been delivered year to date against a target of £1.427m, with the remaining gap managed through non-recurrent measures. As at the end of May 2026, the Trust was reporting a year-to-date overspend on temporary staffing costs of £0.364m, with temporary staffing at 4.8% of gross staff costs: 1.3% above plan. The Committee noted that work was ongoing to reduce the spend on temporary staffing.
- Finance Redesign – the Committee welcomed the presentation and e Committee requested that the People and Culture Committee consider whether the coaching and learning methodology approach which had been used throughout the Finance Team re- design programme should be shared across the organisation as an exemplar to be used in other transition programmes.
-

Committee Escalation and Assurance Report

- Horsforth Clinic – the Committee approved the execution of the engrossment sale contract.
- Otley Clinic – the Committee approved proceeding with the sale of Otley Clinic to an alternative buyer in place of the original buyer, subject to legal completion on the previously agreed terms and the additional assurance regarding due diligence checks
- Leeds Mental Health and Wellbeing Service – Talking Therapies Bid- the Committee received an overview of the bid and the emerging submission. The Committee agreed that this was core work for the Trust and supported further work to be done before final approval by the Trust Board on 18 June 2026.

Assurance

- Service Spotlight - The Committee welcomed Aaron Wray, Head of Administration Services who presented an overview of the Admin Services Redesign Programme which covered 400 staff across the Trust. The majority were deployed across clinical services.
- BAF revised strategic risks update – the Committee received information about how the Board Assurance Framework had been developed for 2026/27 and set out the four strategic risks for which the Committee would have oversight. The Committee welcomed the inclusion of a new risk on Infrastructure.

Risks Discussed and New Risks Identified

None

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

Risk 2 Demand for Services: If we fail to respond to changes in population growth and presentation, and changing delivery models such as Neighbourhood Health, then the impact will be potential harm to patients due to long waits, inability to strengthen equity of access, additional pressure on staff, financial consequences and poor performance as measured through the National Oversight Framework.	12 (High)	Reasonable	Assurance provided around sound financial grip and control in relation to Q&V programme.
Risk 4 Financial Sustainability: There is a risk that a lack of financial efficiency and sustainability results in the destabilisation of the organisation and an inability to meet our objectives	12 (High)	Reasonable	
Risk 5 Failure to maintain business continuity: If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.	12 (high)	Reasonable	

Committee Escalation and Assurance Report

Risk 9 Infrastructure: If the Trust is unable to provide access to safe and fit for purpose digital and estate infrastructure then there is a risk that the quality and continuity of service provision will be compromised which may further impact achievement of all of the Trusts strategic goals and priorities.	12(High)	Reasonable	

Author:	Liz Thornton/Lynne Mellor
Role:	Corporate Governance Officer/Chair
Date:	16 June 2026

Committee Escalation and Assurance Report

Name of Committee:	Audit Committee	**Report to:**	Trust Board 23 July 2026
Date of Meeting:	7 July 2026	**Date of next meeting:**	6 October 2026

Introduction

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

Alert	Action
• The Committee received a report on the Data Security and Protection Toolkit Final Assessment Submission and the outcome of an Internal Audit assessment on supporting processes in the Trust. The Committee discussed the significant disparity between the self-assessment and the audit particularly around the back-up and restore of systems when failures occurred and the risks this posed to the Trust.	• **An action plan and trajectory to be developed to achieve full compliance. Processes and policies to be reviewed and strengthened. A further report made to Audit Committee in October 2026**

Advise

- Executive responses received on two previous Internal Audit Reports (Managing Long Term Sickness Absence and follow up on the MCA audit following consideration by the Quality Committee).
- Internal Audit Progress Report – one significant assurance final report had been issued and one draft report had been issued since the last meeting. The Audit plan for 2026/27 was on track for completion by 31 March 2027. Discussion around the increased workload pressures related to the merger. The potential impact on the delivery of the internal audit plan would be monitored carefully.
- Implementation of agreed recommendations from internal audit reports – the Committee discussed one overdue recommendation from the Emergency Preparedness, Resilience and Response audit which would be followed up following the meeting.
- A number of changes to the internal audit plan were discussed and either agreed or deferred for further discussion: CQC Preparedness -changes to scope accepted; Datix – deferred for further discussion; EQIA (split into two audits -deferred for further discussion – Committee emphasised the need to deliver the work on the EQIA expeditiously in order to validate assurances received and provide important learning towards the transition work.)
- External Audit – Audit External Audit Completion Follow Up Letter 2025/26 and the 2025-26 Annual Report were received.
- The Local Counter Fraud Specialist provided an update, noting that the Counter Fraud Functional Standards Return had been signed off by the Executive Director of Finance and Resources and submitted to the NHS Counter Fraud Authority.

Assurance

- Financial Controls – updates on Losses and Compensation, Tender and Quotation Waivers, and a full Contracts Register received.
- Board Assurance Framework –noted how various elements of the Board Assurance Framework (BAF) process had been carried out during the

Committee Escalation and Assurance Report

• Register of Gifts, Hospitality and Sponsorship Report – the Committee reviewed the annual summary of declarations on the register, noting no concerns last 12 months, and in particular the processes in relation to the 2026/27 amendments to the BAF. Noted the process report and reviewed the new strategic risk assigned to the Committee.
Risks Discussed and New Risks Identified
• N/A

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	Risk score (current)	Overall level of assurance provided that the strategic risk is being managed (or not)	Additional comments
Risk 5 Failure to maintain business continuity	12 (high)	Reasonable	The Committee noted overall confidence by management regarding the DSPT approach, due to progress and activity reported around the gaps and the aim for all to be addressed by Aug 26. Post implementation update to be reported to Committee as soon as possible. The overdue EPRR recommendation was noted, however assurance remained reasonable overall.

Author:	Liz Thornton, Khalil Rehman
Role:	Corporate Governance Officer / Committee Chair
Date:	9 July 2026

Committee Escalation and Assurance Report

Name of Committee:	Charitable Funds Committee	**Report to:**	Trust Board 23rd July 2026
Date of Meeting:	07 July 2026	**Date of next meeting:**	1 September 2026
Chair:	Alison Lowe	**Parent Committee:**	Trust Board

Introduction

This report identifies the key issues for the Board from the Charitable Funds Committee held on 7 July 2026. Quorate meeting with good debate on key topics.

Alert

Tightening financial projections and the need to support Charitable Funds Officer in identifying merger opportunities, ensuring the committee is not exposed to risks in the future.

Advise

- Charity Development Update - Reviewed the lack of staff engagement in charity events, noting that while numbers appeared low, those involved were highly committed. Ongoing income variability due to reliance on voluntary and event-based fundraising. Inconsistent awareness of the charity's role and impact across the organisation were discussed. Suggested broadening focus beyond Hannah House to increase engagement, such as considering projects involving the homeless team. Revisit financial forecasting and conduct sensitivity analysis to assess potential risks and required actions. Highlighted the potential to combine the unique role of Charitable Funds Officer with LYPFT's volunteer base, suggesting this could enhance future charity activities. Discuss offline how to apportion Charitable Funds Officer's costs if she undertakes additional integration work, to protect charity resources.

Assurance

- Charitable Funds Finance Report - The committee acknowledged associated risks and the need to potentially pause activities during the integration programme. Explore repurposing the COVID fund for a staff celebration event and fundraising platform, ensuring it fits within the charity's terms.

Risks Discussed and New Risks Identified

Financial Risk relating to merger – uncertainty regarding the future structure of charity, grant funding uncertainty, and rebranding costs –Interim Chief Executive Officer and Charitable Funds Officer to be involved in planning activities to help identify and maximise opportunities with LYPFT ahead of the merger.

Committee Escalation and Assurance Report

Author:	Rakhi Palliyath/ Alison Lowe
Role:	CG Officer/ Chair
Date:	08 July 2026

Agenda item:	2026-27 (12)
Title of report:	Integrated Performance Report
Meeting:	Trust Board
Date:	23 July 2026

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

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

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

Summary of Key Issues:

- We continue to see improvement in some of the more challenging areas of underperformance. Our performance against waiting times continues to improve. Namely:
    - We are exceeding the 78% target for the new community services.
    - The number of patients who have been waiting more than 52 weeks for consultant-led care in PND continues to improve.
    - We are also beginning to see improvements in the percentage of patient waiting more than 18 weeks for neurodevelopmental assessments in CAMHS.
- Sickness is now only 0.5% above target; significantly improved from a high of over 8%.
- It is likely that sickness continues to affect lower than target appraisal rates and is a contributory factor in the number of overdue PSIIs. Formal processes are being implemented that will ensure that actions are managed and monitored more effectively.
- There has been a spike in RIDDOR reportable health and safety incidents this month. 4 separate incidents have been reported which is the highest number per month over the last 2 years. However, the incidents are unrelated and there are no overarching themes.
- Our Data Quality Maturity Index (DQMI) score for our Mental Health Data Set is low. We are engaging with NHS England on this and hope to have resolution so that this doesn't adversely affect our NOF scoring too far into 26/27.
- In the NHS Oversight Framework LCH has maintained it segmentation for Q4. We end 2025/26 in Segment 3.
- The 2026/27 framework has now been released. A separate briefing paper has been prepared for Committees. There are a number of key changes including:
    - Organisations will no longer be benchmarked to determine their overall segmentation.
    - Urgent Community Response and CYP access to Mental Health services measures have been removed from the framework.

○ A number of new measures across the domains have been added to align the framework with the Medium-Term Plan

Previously considered by:	
Outcome of previous discussion/s:	

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

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	Consultant-led 52-week and 18-week standard waiting times both continue to achieve the target of 1 indicating no difference in likelihood of patients in IMD 1. There remains a higher likelihood that people living in IMD1 will wait longer for non-consultant led services than the rest of the population, but improvements continue.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	To seek any further assurances required To direct any further improvement work

List of Appendices:	Appendix 1 – MDC Methodology



Integrated Performance Report

NHS
Leeds Community Healthcare
NHS Trust

June 2026

Reporting on: May 2026



Introduction

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

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

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

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

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

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

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

Executive Summary

NHS Leeds Community Healthcare NHS Trust

Summary

We continue to see improvement in some of the more challenging areas of underperformance. Our performance against waiting times continues to improve. We report for the first time this month on the new community services 18-week target of 78%. We are exceeding that target and if maintained means we will sit in segment 1 in the NOF for this measure. This is driven by the ongoing hard work that is being put into managing waiting times. Not least with the patients who have been waiting more than 52 weeks for consultant-led care in PND which also continues to improve.

We are also beginning to see improvements in the percentage of patient waiting more than 18 weeks for neurodevelopmental assessments in CAMHS. This is due to additional capacity and redirection to Right to Choose.

Sickness is now only 0.5% above target; significantly improved from a high of over 8%. This is due to a number of different initiatives that have been put in place to deliver improvements including training on managing absence and occupational health guidance.

It is likely that sickness continues to affect lower than target appraisal rates and is a contributory factor in the number of overdue PSIIs. Formal processes are being implemented that will ensure that actions are managed and monitored more effectively.

There has been a spike in RIDDOR reportable health and safety incidents this month. 4 separate incidents have been reported which is the highest number per month over the last 2 years. However, the incidents are unrelated and there are no overarching themes.

Our Data Quality Maturity Index (DQMI) score for our Mental Health Data Set is low. We are engaging with NHS England on this and hope to have resolution so that this doesn't adversely affect our NOF scoring too far into 26/27.

Summary Performance

Data Quality : **Medium Assurance**

Performance: **Improving**

Top Highlights

Domain	KPI	Target	Actual	Performance	Assurance
Access to services	Percentage of patients currently waiting under 18 weeks - Community Sit Rep	>=78%	81%	H	P
Access to services	Percentage of Children currently waiting more than 18 weeks for a Neurodevelopmental Assessment	<=5%	81%	L	F
People & workforce	Total sickness absence rate (Monthly) (%)	<=6.5%	7%	H	F
Improving health and reducing inequality	percentage of open records with a valid, non-residual ethnicity code	>=95%	97%		P

Top Concerns

Domain	KPI	Target	Actual	Performance	Assurance
Patient safety	Number of overdue PSII actions	No Target	23	H	
Finance & productivity	Data Quality Maturity Index (DQMI) - MHSDS dataset score**	>=95%	88%		F
People & workforce	AfC Staff Appraisal Rate	>=90%	81%	L	F
People & workforce	'RIDDOR' incidents reported to Health and Safety Executive	No Target	4	H	

NHS Oversight Framework (NOF) Performance

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

NHS Leeds Community Healthcare NHS Trust

Summary

- **LCH has maintained it segmentation for Q4. We end 2025/26 in Segment 3.** Our overall metric score has improved to 2.57, but our ranking has slipped by 2 places.
- The 2026/27 framework has now been released. There are a number of key changes including:
  - Organisations will no longer be benchmarked to determine their overall segmentation.
  - Urgent Community Response and CYP access to Mental Health services measures have been removed from the framework.
  - A number of new measures across the domains have been added to align the framework with the Medium-Term Plan
- A separate briefing paper has been prepared for Committees.
- Work on the new measures is underway to identify data sources, establish current performance and align local reporting. This will include alignment of this report and inclusion of new measures.

Average score

2.57

Lower by 0.01 from previous quarter

Trusts are scored on up to 30 measures of performance (metrics).
Scores range from 1.00 (high performing) to 4.00 (low performing).

How has average score been calculated?

Trust in financial deficit?

No

No change from previous quarter

If an organisation is reporting a financial deficit or in receipt of deficit support, that organisation's segment can be no greater than 3.

How is financial deficit applied?

Segment

3 - Below average and/or financial deficit

Previous quarter's segment: 3

Each trust is assigned to a segment ranging from 1 – 4 based on average metric score and taking into consideration the financial deficit override.

How has segment been calculated?

Trust rank

45 out of 61

Previous quarter's rank: 43 out of 61

Trusts are ranked first on their segment and then their average score within that segment. Ranks range from 1 (the segment one trust with lowest average score) to 61 (segment four trust with the highest average score).
How has rank been calculated?

Performance domains

Access to services	4 - Low performing
Finance and productivity	3 - Below average
Effectiveness and experience	1 - High performing
Patient safety	1 - High performing
People and workforce	4 - Low performing

Average score by trust rank placement

View full league table

- Scores for individual measures are provided below.
- The improvement is primarily driven by stronger CYP access to mental health services and reduced waiting times.
- Updates on sickness, 52 week waits and staff survey performance are included in the main body of the report.

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Mar-26	2.11	%	-3.61 ↑	3.02	30 out of 42	0.19	
Access to services	Mental health care	Annual change in the number of children and young people accessing NHS-funded MH services	Apr 25 - Mar 26 vs Apr 24 - Mar 25	2.95	percentage points	-1.74 ↓	2.96	36 out of 50	8.76	
Effectiveness and experience	Effective out of hospital care	Urgent Community Response 2-hour performance	Q4 2025/26	87.96	%	0.14 ↑	1.84	17 out of 38	87.18	70
Finance and productivity	Finance	Planned surplus/deficit	2025/26 plan	0.00	%	0.00 →	1.00	16 out of 61	0.00	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 12 2025/26	0.39	%	-0.08 ↓	1.00	40 out of 61	0.49	
Finance and productivity	Finance	Combined finance	Q4 2025/26				1.00			
Finance and productivity	Productivity	Relative difference in costs	2024/25	117.58	%	0.00 ↓	3.70	54 out of 61	104.85	
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2025	7.01	out of 10	-0.04 ↓	1.40	9 out of 61	6.66	
People and workforce	Retention and culture	Sickness absence rate	Q3 2025/26	7.63	%	1.34 ↓	3.81	55 out of 61	6.22	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2025	6.92	out of 10	-0.03 ↓	2.85	38 out of 61	7.02	

Access to Services Domain Summary

Accountable Exec: Sam Prince

NHS Leeds Community Healthcare NHS Trust

Domain Summary Performance Data Quality : **High Assurance** Performance: **On track**

Summary

We continue to see strong improvements across this domain, although there remains further work to do to reach out targets of having no patient waiting more than 1 year for care to start.

The total number of people waiting for care stands at 24,658 at the end of May 2026, up from 22,973 at the end of February. However, the number of patients waiting more than 52 weeks continues to decrease, falling to 918 at the end of May 2026, down from 1,647 at the end of December 2025 and 3,430 at the end of August 2025, largely driven by significant reductions in PND waits.

The number of patients seen within 18 weeks continues to rise and now sits at 81%, and meeting the Medium Term Planning target. Six-weekly forecasts are now in place across all Community Sit Rep services, providing increased grip on trajectories, capacity planning and targeted recovery actions to support continued improvement in access performance.

Trust's performance against the Urgent Community Response Standard has seen a small drop to 83% in May. Our Children's Audiology Service had 1 breach with over 99% of patients seen within 6-weeks in May 2026. There is an ongoing issue with Data Quality in LMWS as has been reported in previous IPRs, which is continuing to be investigated.

Access to Services Domain Summary

Accountable Exec: Sam Prince

NHS Leeds Community Healthcare NHS Trust

KPI	Reporting Month	Target	Actual	Performance	Assurance
Total Patients Waiting for Care - Trust Wide	May-26	No Target	24658	L	
Number of patients currently waiting over 52 weeks - Trust Wide	May-26	0	918	L	F
Total Patients Waiting for Care - Consultant-Led	May-26	No Target	1588	L	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	May-26	>=92%	37%	H	F
Number of patients waiting more than 52 Weeks (Consultant-Led)	May-26	0	369	L	F
Total Patients Waiting for Care - Community Sit Rep	May-26	No Target	20842	L	
Percentage of patients currently waiting under 18 weeks - Community Sit Rep	May-26	>=78%	81%	H	P
Number of patients currently waiting over 52 weeks - Community Sit Rep	May-26	0	443	L	F
Total Patients Waiting for Care - Non Consultant-Led	May-26	No Target	473	L	
% Patients waiting under 18 weeks (non reportable)	May-26	>=78%	80%	H	P
Number of patients currently waiting over 52 weeks - Non-Consultant Led	May-26	0	445		F
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	May-26	>=99%	1		?
Community health services two-hour urgent response standard	May-26	>=70%	83%		P
Available virtual ward capacity per 100k head of population	May-26	No Target	7.8		

KPI	Reporting Month	Target	Actual	Performance	Assurance
Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care	May-26	0	0		P
% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	May-26	>=95%	50%		F
Number of Patients Accessing CAMHS	May-26	No Target	1264	H	
Percentage of Children currently waiting more than 18 weeks for a Neurodevelopmental Assessment	May-26	<=5%	81%	L	F
LMWS – Access Target; Local Measure (including PCMH)	May-26	24456 by year end	1766	L	P
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	May-26	No Target	63%	L	
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	May-26	>=95%	1		P
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	May-26	>=75%	87%		P
Total Patients Waiting for Care - Dental	May-26	No Target	912	L	P
Percentage of patients currently waiting under 18 weeks - Dental	May-26	>=92%	69%	H	F
Number of patients currently waiting over 52 weeks - Dental	May-26	0	24	L	F

Consultant-led RTT Waiting Times

Domain: Access to Services | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: 92% and 0 | Actual: 25% and 369 | SPC Variation: H L | SPC Assurance: F | Data Quality: High Assurance

What is the trend we see?

Both indicators are showing statistically significant improvements and the proportion of children on the case load waiting under 18 weeks is significantly increasing. The number of Children waiting over 52 weeks has fallen to under 400 by the end of May.

Most of those remaining children still waiting over 52 weeks to access the service now sit within the Complex PND Pathway. The vast majority of those who had been waiting for an Autism assessment have now had an appointment. The Complex list of 240 children up until this point has remained largely static.

What is being done about it?

Actions to reduce PND waiting times include validation of the waiting list to confirm ongoing need, secondary triage by ICAN clinicians against updated preschool diagnostic autism assessment criteria, and the use of locum Paediatricians to deliver assessments for those meeting the revised criteria, alongside a broader capacity and demand review. Following approval of the substantive staffing business case, the service has begun prioritising children on the Complex PND waiting list. Initial focus will be on those who have been waiting over 104 weeks for an appointment. This cohort had not previously been taken on due to the requirement for ongoing caseload management up to age 19. This approach will enable the service to begin offering first appointments to this group and support further reductions in long waits.

When do we expect to see improvement

The service has begun reworking trajectories with BI, focused on maximising current locum capacity during the interim recruitment period for substantive staff. The service is aiming to have cleared all 52 week waits by end of December 2026.

In time, the business case will support the service to reduce waiting times to below 18 weeks.

What are the risks to delivery?

Successful recruitment to the substantive staffing levels outlined in the business case is critical to reducing the waiting list to 18 weeks and sustaining this position. In the interim, reliance on locum capacity remains essential as any reduction in temporary locum cover would impact progress and limit the service's ability to reduce the waiting list.

Community Sitrep Waiting Times

Leeds Community Healthcare NHS Trust

Domain: Access to Services | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: 78% | Actual: 81% | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: **High Assurance**

What is the trend we see?

The Trust continues to meet the Medium Term Planning Target for Community Sit Rep Services of 78%. Performance has shown a slight drop from April, down to 81% from 82%, which is largely driven by a growing MSK waiting list.

The only services that are currently below the 78% target are PND, Children's OT, Podiatry and Community SLT.

What is being done about it?

A plan is in place for the PND waits, as covered on the RTT slide.
The MSK service is undergoing substantive recruitment and is also scoping the potential for additional admin resource to cope with the current backlog and options for use of non-recurrent underspend.
Recruitment is taking place in Children's OT to cover gaps due to Maternity Leave.
The Podiatry service is currently exploring options to re-establish Saturday clinics and additional clinical hours to further reduce the waiting list and improve 18-week performance.

What are the risks to delivery?

Growth the MSK waiting list has the potential to significantly impact our performance against this metric given the scale of the service.
SLT performance is very dependent upon successful recruitment in a challenging market.

When do we expect to see improvement

MSK recruitment isn't likely to improve the waiting list and position until Q3. PND is aiming to clear 52 weeks by the end of December 2026, which will significantly improve their performance against this metric.
Adult SLT is currently undergoing recruitment into posts, which will allow further reduction in the waiting list from October.
Improvements in Children's OT won't be seen until Q3 following successful recruitment.

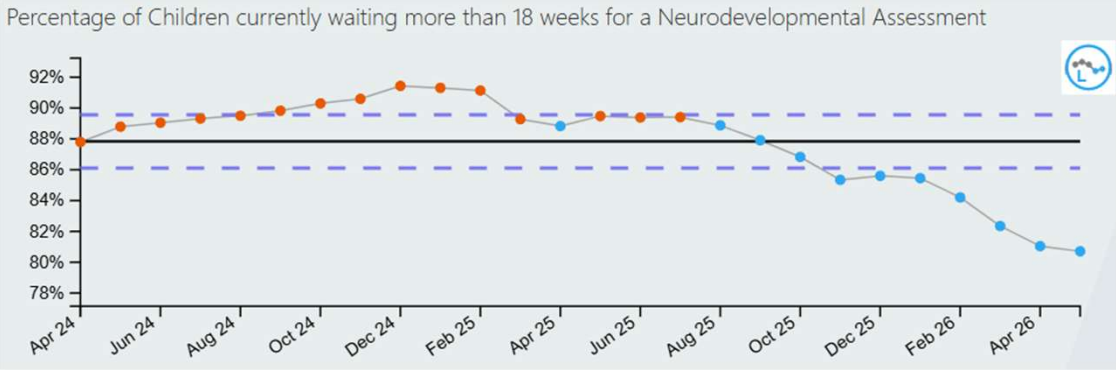
Neurodevelopmental Diagnostic Assessment Waiting Times

Domain: Access to Services | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: 5% | Actual: 81% | SPC Variation: | SPC Assurance: | Data Quality: **High Assurance**

What is the trend we see?

While there has been a statistically significant improvement in the proportion of children seen within 18 weeks, 512 children and young people are still waiting more than 52 weeks for an appointment. This number is falling and driving the positive changes above, but slowly.



What is being done about it?

The service has an agreement in place with the ICB to transfer children waiting over 36 and 48 months to Right to Choose (RTC) providers. Since March 2026, 60 of the longest waiting children and young people have been transferred.

The recently approved ND Business Case along with the transfers to RTC providers will allow the service to recruit the staffing required to reduce the routine waiting times down to below 18 weeks, although this will take time.

When do we expect to see improvement

Based on the current waiting list of 512 children (as of 2 June 2026), continuation of the RTC pathway at an average of five children per week would result in around 260 children being removed from the waiting over the next year. Combined with the additional 160 routine assessments delivered through the Business Case, this provides capacity for approximately 420 children over the next year. Allowing for new referrals and recognising that capacity and demand will fluctuate over time, it is anticipated that the current waiting list should be down to 18 weeks within 18 months.

What are the risks to delivery?

Reducing the waiting list to a sustainable 18-week level depends on successful recruitment into the substantive posts outlined in the agreed Business Case.

The number of children transferred each week is determined by provider capacity and follows clinical risk review and family consent. Whilst transfers have averaged approximately five children per week to date, this is not a fixed number and will vary depending on provider availability and clinical considerations.

Dental Service Waiting Times

Leeds Community Healthcare NHS Trust

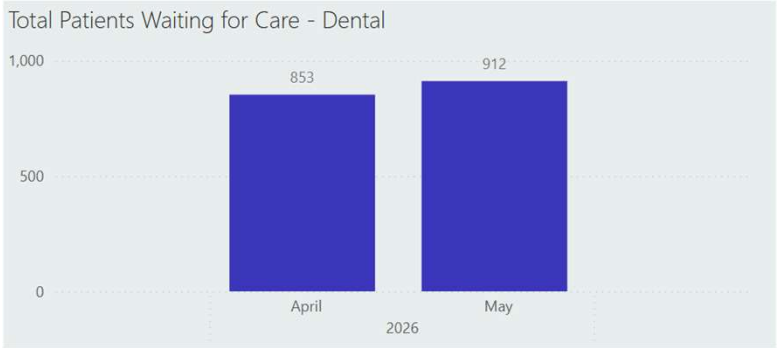
Domain: Access to Services | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: No Target and 0 | Actual: 912 and 24 | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: **Medium Assurance**

What is the trend we see?

The service has made significant progress in reducing the number of patients waiting over 52 weeks, with the current figure standing at 24, compared to 1,436 in January 2025. The remaining patients waiting over 52 weeks continue to be cleared, although at a much slower rate.

Following the transfer of patients to the LDI at the end of the last financial year the waiting list is now starting to grow again.



What is being done about it?

The service now has a robust monitoring process in place for long waiters. A dedicated member of staff reviews all +40wk waiters weekly, and notes are placed on each patient record to flag the importance of appointments (if are cancelled/not attended). Any still waiting over 52 weeks are escalated to admin team leader, Clinical Director, and Operational/Clinical Manager.

The service is also progressing internal validation processes and working with the BI team to improve visibility and reporting of waiting list data, which is currently managed through a separate clinical system.

Review of acceptance and access criteria also being completed, to ensure the right patients are being accepted/seen in the service.

When do we expect to see improvement

The remaining 52+ week waits are largely remaining due to last minute appointment cancellations and long-term sickness of a full-time dentist, which the service has put priority processes in place to address. All those waiting +52 weeks have appointments booked between 22/06 to 09/07. With monitoring in place, if any of these appointments are cancelled by the patient - these are rebooked as a priority.

What are the risks to delivery?

Patient cancellations or DNA/WNB's are largely the reason for those still waiting over 52 weeks. The service sends four reminders for appointments, including a letter, two texts and a telephone call the day before the appointment.

Staff sickness reduces capacity, when appointments have to be cancelled.

CAMHS Eating Disorders Waiting Times

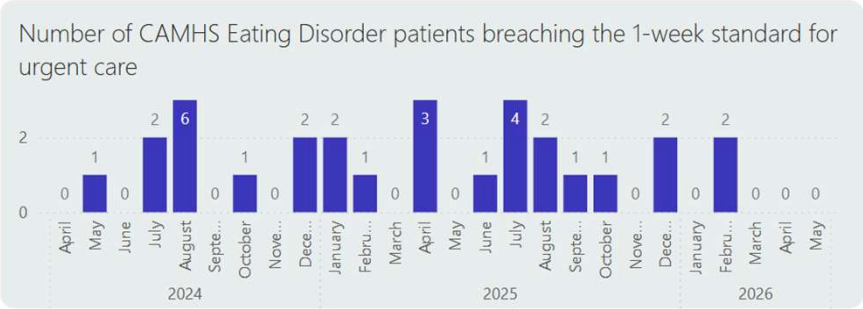
Leeds Community Healthcare NHS Trust

Domain: Access to Services | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: 0 and 95% | Actual: 0 and 50% | SPC Variation: | SPC Assurance: F | Data Quality: **High Assurance**

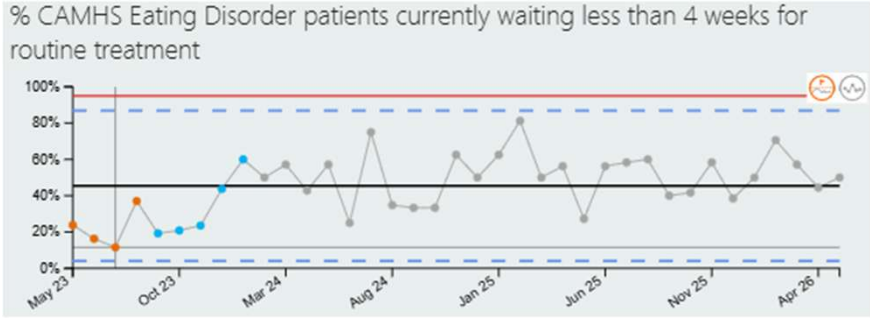
What is the trend we see?

The service has seen 0 breaches of the 1-week standard in the last 3 months.
Performance against routine target continues to be below target.



What is being done about it?

The ICB has recently provided additional funding to increase capacity for assessment appointments. All posts have now been recruited to and all but 1WTE band 6 have started. They will start in August 2026. An additional assessment clinic will be in place from week commencing 29th June 2026 bringing the number of clinics to 6 each week.
In the past week, there were more urgent referrals than routine which is unusual for this time of year which has meant a slight breach (7 days)



When do we expect to see improvement

Assessments will increase to 6 as of week commencing 29th June 2026 which will increase capacity and further reduce breaches.

What are the risks to delivery?

Delays in recruitment has meant that additional clinics have had to be delayed but now planned start w/c 29th June.

Delays in accessing assessment and treatment which could result in further deterioration. However, physical health monitoring is held by primary care so this is managed, and families can contact the service for support and guidance if needed.

Finance & Productivity Domain Summary

Accountable Exec: Andrea Osborne

NHS Leeds Community Healthcare NHS Trust

Summary

The first Productivity LCH Steering Group took place on the 20th May. The group is focussing on 7 services that were identified as priorities following analysis on relative costs and contact per WTE and informed by local knowledge. They are:

- Neurology
- Stroke
- Children's SLT
- Respiratory
- PND
- CUCs
- Children's OT and Children's Physio.

The current focuses of the group are improving the definition and recording of direct and indirect patient contacts (only direct patient contacts are examined in relation to productivity), effectively and consistently recording groups and how to reflect overall productivity whilst acknowledging in measures that only clinical staff deliver patient contacts and further dashboard development and engagement.

Implied productivity (a comparison of the increase in activity and the increase in costs) has been included as a contextual measure in this year's NOF. This means it will be calculated but not scored. Work is in progress to understand how the measure is calculated with a view to calculating and monitoring it locally.

The Data Quality Maturity Indec (DQMI) is also included in the NOF measures for 2026/27. Very early estimates have LCH in segment 4 for this measure. This is due to our lower scores for the Mental Health Data Set (MHDS), Admitted Patient Care Data Set (APC) and outpatient data set (CDS). Detail on the MHDS is provided in this section. Work is in progress on actions that should improve the APC and CDS performance in the near future.

A summary of the Trust's financial position is available on the following page.

Domain Summary Performance

Data Quality : High Assurance Performance: On track

KPI	Reporting Month	Target	Actual	Performance	Assurance
Data Quality Maturity Index (DQMI) - CSDS dataset score**	Feb-26	TBC	91%	H	
Data Quality Maturity Index (DQMI) - IAPT dataset score**	Feb-26	>=95%	98%	H	P
Data Quality Maturity Index (DQMI) - MHSDS dataset score**	Feb-26	>=95%	88%	F	P
Percentage Spend on Temporary Staff	May-26	No Target	4%		
Total agency cap (£k)	May-26	No Target	186.00		

Finance & Productivity Domain Summary

Accountable Exec: Andrea Osborne

NHS Leeds Community Healthcare NHS Trust

Income & Expenditure: As at the end of May 2026, the Trust is reporting a year-to-date surplus of £0.103m against a planned break-even position. This favourable variance is primarily driven by non-recurrent income from training, alongside increased recharge income for consumables and one-to-one patient care within Wharfedale. Income and expenditure are expected to align more closely with plan as the financial year progresses. The Trust is therefore forecasting a break-even position in line with plan.

Cash: The Trust's cash position remains strong, with a closing balance of £47.068m, lower than the planned figure by £1.098m. This was due to higher than planned payment of capital invoices from the previous financial year. The cash operating days, which is to pay short-term liabilities, is 81 days. Compliance with the Better Payment Practice Code (BPPC), our requirement to pay suppliers within 30 days or by the due date, is above target at 98.5% by both number and value of invoices.

Quality & Value Programme: The Trust has a savings target of £8.560m for 2026/27, comprising £2.460m carried forward from 2025/26 and £6.1m relating to the current year. Year to date, total recurrent savings of £0.406m have been achieved against a plan of £1.429m, with the balance achieved through non-recurrent grip and control measures. Business units are actively working to identify further savings opportunities and, where schemes have already been approved, progressing implementation. The Trust is forecasting to achieve its full savings target.

Temporary Staffing: As at the end of May 2026, the Trust is reporting a year-to-date overspend on temporary staffing costs of £0.364m, with temporary staffing at 4.8% of gross staff costs: 1.3% above plan. This is driven by vacancy and preceptorship cover within Neighbourhood teams and ongoing recruitment challenges across WYOI, Police Custody, 0–19 Services, and hard-to-fill medical roles in CAMHS and ICAN. The year-to-date position is above plan; however, costs are expected to align with plan as Neighbourhood vacancies are filled and vacant clinical posts are filled.

Prior Year	Key Financial Indicators	YTD Plan	YTD Actuals	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Varianc
(951)	Adjusted (Surplus)/Deficit	-	(103)	**(103)**	-	-	-
49,922	Closing Cash Balance	48,166	47,068	**1,098**	49,387	49,387	-
10,221	Capital Expenditure (CDEL)	2,767	-	**(2,767)**	8,358	8,358	-
	Quality & Value Programme 26/27						
11,921	Recurrent Savings	1,019	97	**922**	6,100	854	**5,246**
2,079	Non Recurrent Savings	-	922	**(922)**	-	5,246	**(5,246)**
	Quality & Value Programme 25/26 - Legacy						
	Recurrent Savings	410	309	**101**	2,460	2,140	**320**
	Non Recurrent Savings		101	**(101)**		320	**(320)**
14,000	**Total Savings**	**1,429**	**1,429**	**-**	**8,560**	**8,560**	**(0)**
	Temporary Staffing						
2,329	Agency	206	403	**197**	1,233	1,233	-
5,564	Bank	800	967	**167**	4,801	4,801	-
7,893	**Total Temporary Staffing**	**1,006**	**1,370**	**364**	**6,034**	**6,034**	**-**
177,598	**Total Gross staff Costs**	**28,267**	**28,422**	**155**	**169,652**	**172,376**	**2,724**
4.4%	**Temp Staffing Costs as a % of gross staff costs**	**3.6%**	**4.8%**	**1.3%**	**3.6%**	**3.5%**	**(0.1%)**

Data Quality Maturity Index (DQMI) - MHDS Dataset Score

Leeds Community Healthcare NHS Trust

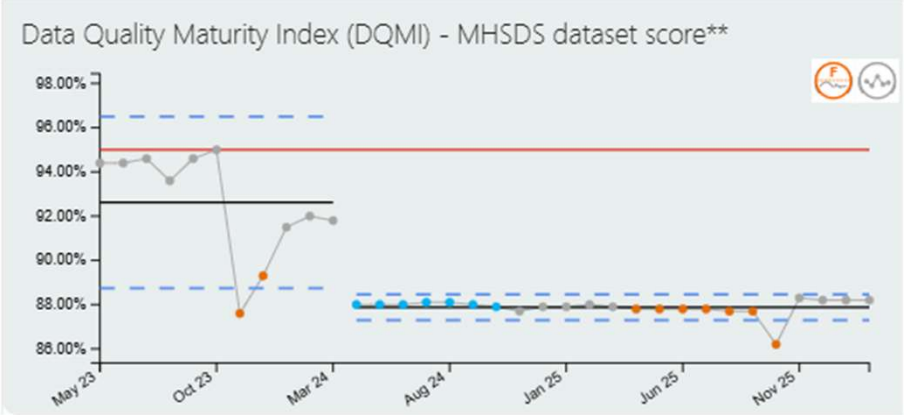
Domain: Finance & Productivity | Accountable Exec: Andrea Osborne | Author: Victoria Douglas-McTurk

Target: 95% | Actual: 88.2% | SPC Variation: | SPC Assurance: | Data Quality: High Assurance

What is the trend we see?

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

We are performing comparably well to other trusts. Our current (March) score is 86.8%. This is against a national average of only 44.5%.



What is being done about it?

We believe that underperformance here is caused by the denominator for these measures being doubled in error by NHS England. Contact has been made to try to rectify this, and we are awaiting a reply. Given inclusion of the DQMI in the 2026/27 NOF this reply has been chased and will be escalated if necessary.

When do we expect to see improvement

We had hoped to hear from NHS England before this report was written. Follow up emails have been sent. This will be escalated by the Warehousing Manager shortly if a response is not received.

What are the risks to delivery?

A continued slow response from NHS England in relation to rectifying data processing issues.

Effectiveness & Experience of Care Domain Summary

Accountable Exec: Heather McClelland

NHS Leeds Community Healthcare NHS Trust

Summary

Performance across all measures of experience – compliments, complaints and feedback, is consistent with previous months and within normal limits.

Some absence in the QPD team means that statutory requirements are being achieved (timeliness of response to complaints and investigations) but that improvement work both on the implementation of Parliamentary Health Service Ombudsman standards and on the Friends and Family Test have not been progressed.

A 6-monthly report on Patient Experience will be reported at Quality Committee in July.

Sub Domain Summary Performance

Data Quality : **Low Assurance**

Performance: Holding Steady

KPI	Reporting Month	Target	Actual	Performance	Assurance
Number of Compliments	May-26	No Target	60		
Total Number of Formal Complaints Received	May-26	No Target	5		
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	Mar-26	>=95%	92%		

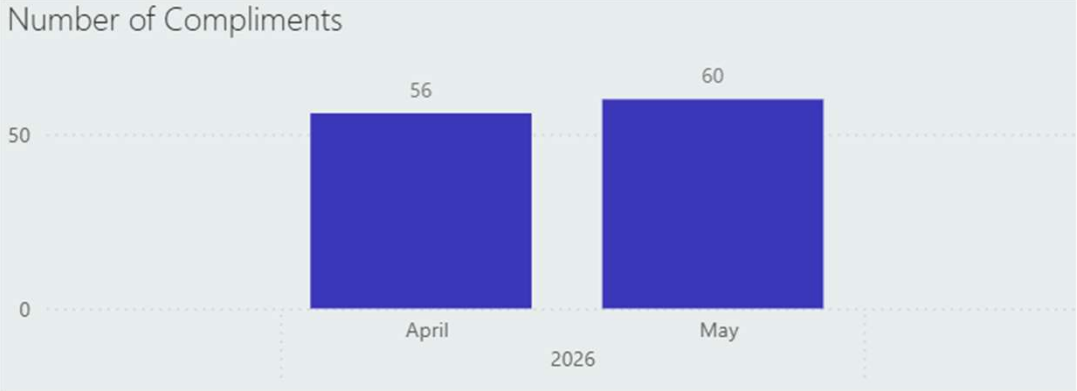
Number of Compliments

Domain: Effectiveness & Experience of Care | Accountable Exec: Heather McClelland | Author: Hayley Barker

Target: No Target | Actual: 60 | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

For the 2025/6 financial year end we received 900 compliments which equates to an average of 75 per month. There is currently no significant change within the data.



What is being done about it?

Services continue to be notified of feedback received for their review and are promoted to log compliments via DATIX.

What are the risks to delivery?

None currently known.

When do we expect to see improvement

From the inclusion of the compliments within the report this will allow the Trust and services to have more oversight of the numbers received and provide trend analysis.

Total Number of Formal Complaints Received

Leeds Community Healthcare NHS Trust

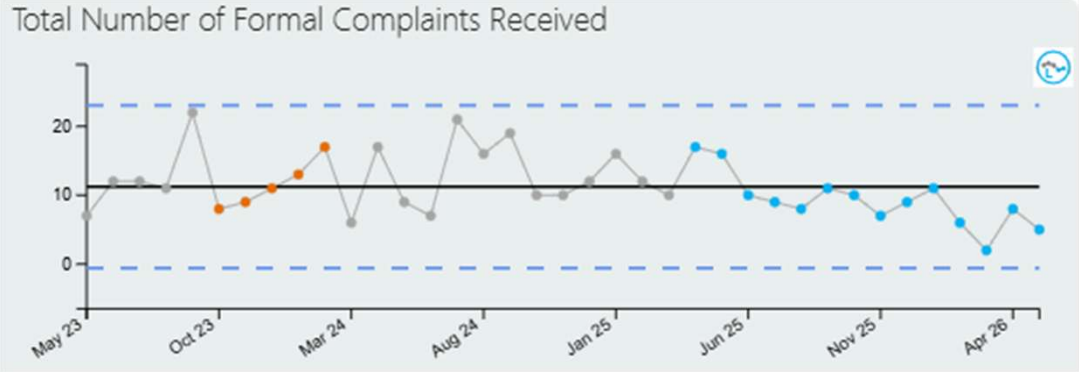
Domain: Effectiveness & Experience of Care | Accountable Exec: Heather McClelland | Author: Hayley Barker

Target: N/A | Actual: 5 | SPC Variation: | SPC Assurance: | Data Quality: **Low Assurance**

What is the trend we see?

The data continues to remain within the upper and lower control limits and is showing a continued trend of an improving nature. From June 2025 it is noted a trend of a lower number of complaints received.

This correlates to the commencement of the Parliamentary Health Service Ombudsman (PHSO) pilot. The pilot involved two services, CYMPHS and MSK. In December 2025, a further four services were added to the pilot. The services are ICAN, Neighbourhood Teams North, LMWS and Leeds Sexual Health.



What is being done about it?

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

When do we expect to see improvement

We aim to see a continued trend of improvement as the PHSO pilot will be involving further services.

What are the risks to delivery?

There has been a delay in the roll out of the PHSO pilot to further services due to staffing within the Patient Experience Team. Recruitment is currently underway with a Clinical Governance Officer in their induction and 1x post out to advert.

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

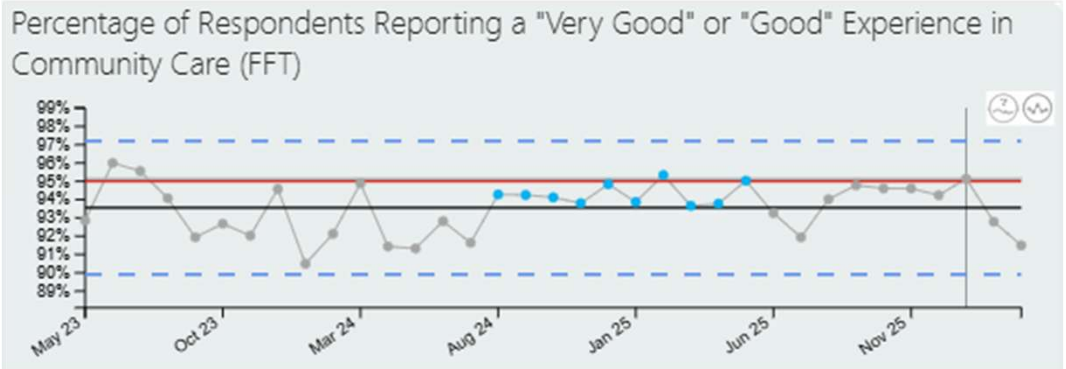
Leeds Community Healthcare NHS Trust

Domain: Effectiveness & Experience of Care | Accountable Exec: Heather McClelland | Author: Hayley Barker

Target: 95% | Actual: 92% | SPC Variation: | SPC Assurance: | Data Quality: **Low Assurance**

What is the trend we see?

There is currently no significant change within the data. The data continues to remain within the upper and lower control limits showing common cause variations. There has been a reduction noted in the last two months data documented which falls below the target.



What is being done about it?

Services continue to review and identify areas and services where "very good" and "good" has dropped below the expected target.

What are the risks to delivery?

The Patient Engagement Manager's work since May has been paused to support absence in the wider Clinical Governance Team. Work has subsequently been paused to standardise the FFTs for all services and move towards bespoke surveys for service specific feedback. The aim of this work is to provide increased data quality assurance and increase the ability to complete Trust wide analysis of the data.

When do we expect to see improvement

The aim for completion on standardisation of FFT is by end Quarter 2 2026/7.

Improving Health & Reducing Inequalities Domain Summary

Accountable Exec: Ruth Burnett

NHS Leeds Community Healthcare NHS Trust

Summary

Ethnicity data recording is a new measure and is significantly above the national benchmark (71.6%) for community trusts. Work to further improve recording is aligned to the implementation of About Me and supports delivery of the trusts Racial Equity in Care work plan.

Improvements in both consultant-led and non-consultant led services are being sustained, although non-consultant led services remain above target, meaning that people in IMD1 remain more likely to wait longer than the rest of the population.

Targeted work to support attendance at appointments continues, with analysis and oversight of improvement actions by Access LCH and productivity workstreams.

Domain Summary Performance

Data Quality : **Medium Assurance**

Performance: **On Track**

KPI	Reporting Month	Target	Actual	Performance	Assurance
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 18 week standard	May-26	<=1.0	0.92		
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 52 week standard	May-26	<=1.0	0.88	L	
Difference in access to services for patients living in IMD1 vs IMD2-10 - Non-Consultant 18 week standard	May-26	<=1.0	1.12		
percentage of open records with blank or null codes for ethnicity	May-26	0%	1%		
percentage of open records with residual ethnic codes	May-26	5%	2%		
percentage of open records with a valid, non-residual ethnicity code	May-26	95%	97%		

Percentage of Open Records with a Valid, Non-Residual Ethnicity Code

Domain: Improving Health & Reducing Inequalities | Accountable Exec: Ruth Burnett | Author: Victoria Douglas-McTurk

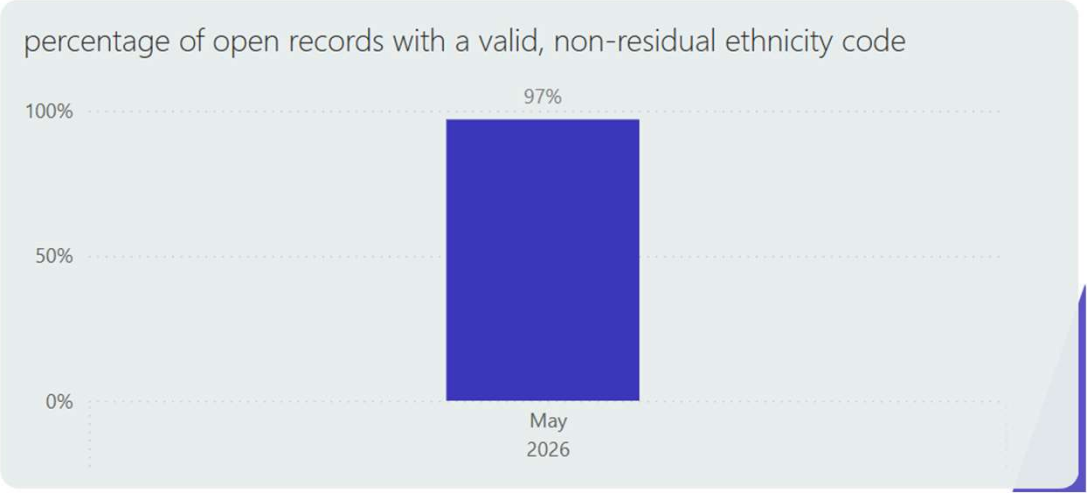
Target: No Target | Actual: 97% | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: **High Assurance**

What is the trend we see?

This measure is new to the IPR this year. Its inclusion was recommended by NHS England's statement on health inequalities, aligned to NHSE's ethnicity recording improvement framework, and fulfils a recommendation of the recent waiting list audit.

The measure examines how many of our patients who have an open referral with us have an ethnicity code of "not stated" or "not known". These codes are known as residual codes. We are significantly above the national benchmark (71.6%) for community trusts in ethnicity data with valid ethnic group codes. We have no patient records with null or blank ethnicity codes.

As this measure is a snapshot, taken at a specific point in time we currently have only one month's information. This will be added to in the coming months.



What is being done about it?

An initial analysis has been undertaken at a service level. Data quality reviews will be carried out with Services with rates below 95%. MSK and Podiatry will be key targets as these services contribute a very high proportion of non-residual codes. Ongoing implementation of About Me and the introduction of a digital patient questionnaire will support improvements by introducing self-reporting by patients who are digitally enabled and for staff capacity to support recording to be targeted to those who are digitally excluded.

This work will be overseen via Access LCH and forms part of the trust's Racial Equity in Care workplan.

We are aligning our improvement work to the national Ethnicity Recording Improvement Plan, using the 5 domains for improvement and assessing ourselves against the high impact actions for providers. Our Cultural Conversations programme supports staff to be more confident and skilled in talking about ethnicity and our About Me project increases patient and carer awareness of the purpose of recording data and trust in how it is used.

When do we expect to see improvement

In 3 months.

What are the risks to delivery?

High volumes of referrals could impact administrative capacity to collect and record the information. This is mitigated through implementation of About Me and the introduction of a digital patient questionnaire, and implementation of new admin structures.

Difference in Access to Services for Patients Living in IMD1 vs IMD2-10 - Consultant-Led 52 Week Standard

Leeds Community Healthcare NHS Trust

Domain: Improving Health & Reducing Inequalities | Accountable Exec: Ruth Burnett | Author: Em Campbell

Target: 1.0 | Actual: 0.88 & 0.92 | SPC Variation: | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

Consultant-led 52-week and 18-week standard waiting times both continue to achieve the target of 1 indicating no difference in likelihood of patients in IMD 1 (our most deprived areas) waiting longer than the rest of the population.

What is being done about it?

Work to support attendance at appointments continues, with specific focus on intersectionality with ethnicity and deprivation, aligned to our Racial Equity in Care work.

When do we expect to see improvement

Sustained improvement expected to continue.

What are the risks to delivery?

Risks to equitable improvements occur when improvements are not experienced equally, and improvements in some areas actually widen inequity. These risks are mitigated by continued equity analysis and focus on targeted improvements in Access LCH and productivity workstreams.

Difference in Access to Services for Patients Living in IMD1 vs IMD2-10 - 18 Week Standard

Leeds Community Healthcare NHS Trust

Domain: Improving Health & Reducing Inequalities | Accountable Exec: Ruth Burnett | Author: Em Campbell

Target: 1.0 | Actual: 1.12 | SPC Variation: | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

The reduction in likelihood of people in IMD1 (our most deprived areas) waiting longer for non-consultant led services than the rest of the population continues but is still above target.

What is being done about it?

Work to support attendance at appointments continues, with specific focus on intersectionality with ethnicity and deprivation, aligned to our Racial Equity in Care work. Further analysis of missed appointment data will support identification of further areas of focus and improvements that specifically address the barriers for people in minoirty ethnic groups and people with limited English proficiency.

When do we expect to see improvement

Actions to increase access to interpreters and translated information is expected to support attendance at appointments. Further analysis and engagement with communities to identify other improvement actions being undertaken in Q2 is expected to show improvements in Q3.

What are the risks to delivery?

Risks to equitable improvements occur when improvements are not experienced equally, and improvements in some areas actually widen inequity. Competing demands for service leadership risks capacity for implementing targeted improvements. These risks are mitigated by continued equity analysis and focus on targeted improvements in Access LCH and productivity workstreams.

Patient Safety Domain Summary

Accountable Exec: Heather McClelland

NHS Leeds Community Healthcare NHS Trust

Summary

Delivery of key metrics is in line with previous months, with no attributable infections and high rates of safety training compliance and completion of Duty of Candour.

One CAS alert remains open due to a significant number of historical risk assessments requirements. A paper outlining the options to handling this will be presented to QAIG.

Progress has been made with Patient Safety Investigation actions, with some change in month in each of the business units. Capacity in business units and corporate teams have led to delays in completing investigations and following up actions in a timely way. Risks have been included on the risk register as necessary.

Recent changes introduced to Incident management processes is already showing improvement in the timeliness of incident review and management, which will feed into the initiation of investigations as needed.

Domain Summary Performance

Data Quality : **Medium Assurance**

Performance: **Off Track**

KPI	Reporting Month	Target	Actual	Performance	Assurance
Number of Patient Safety Incident Investigations (PSII)	May-26	No Target	1		
Attributed MRSA Bacteraemia - infection rate**	May-26	0	0		P
Clostridium Difficule - infection rate**	May-26	3	0		P
Never Event Incidence**	May-26	0	0		P
CAS Alerts Outstanding**	May-26	0	1		
Compliance in Level 1 and 2 Patient Safety Training	May-26	>=95%	90%	H	F
Compliance with statutory Duty of Candour	May-26	100%	86%		F
Number of overdue PSII actions	May-26	No Target	23	H	

Number of Patient Safety Incident Investigations (PSII)

Leeds Community Healthcare NHS Trust

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

Target: No Target | Actual: 1 | Data Quality: High Assurance

What is the trend we see?

There have been three Patient Safety Incident Investigations concluded and approved by an Executive Director in April/May 2026.

PSII's in LCH are allocated a two, three or six month timescale at terms of reference meeting dependent on the complexity however continue to not consistently meet these timescales for completion due to ongoing operational pressures including:

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

What is being done about it?

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

A formalised extension process is now in place to ensure consistent oversight and escalation of delays. This will also ensure that extensions are considered and approved by the Head of Clinical Governance/Deputy Director of Nursing and Quality before the due date has passed.

Early actions are considered and developed at Rapid Review Meeting for incidents requiring a PSII to ensure early learning is translated into timely recommendations and actions to prevent delays to improvements in patient safety due to delayed PSII reports.

When do we expect to see improvement

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

What are the risks to delivery?

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

CAS Alerts Outstanding

Domain: Patient Safety - Medical Device Accountable Exec: Heather McClelland Author: Delphine Arinze

Target: 1 Actual: 1 Data Quality: High **Assurance**

What is the trend we see

The outstanding CAS Alert relates to the National Health Service National Patient Safety Alert: Medical beds trolleys, bed rails and lateral turning devices – risk of death from entrapment or falls.

Risk assessment for discharged patients remain a challenge due to limited resources. These patients were originally risk assessed prior to the Medicines and Healthcare products Regulatory Agency guidance issued on 31 August 2023.The equipment Portfolio and Clinical Lead have calculated that approximately 10 full-time staff would be required to meet the patient risk-assessment compliance requirement for 7, 000 patients.

What is being done about it?

MDSO has prepared a report on the Trust position to be reviewed by the Directors.
There is a meeting planned on 7 July 2026 to assess next steps on the alerts as non-concordance. Below is the overview and recommendation from the CAS meeting to share into the meeting:
There is a risk held – 1168 score 9: As a result of non-compliance with MHRA guidance, there is a risk of entrapment and death resulting in patient harm / injury.
There is difficulty achieving and maintaining concordance with the ongoing review element. This will be further explored at the July meeting.

When do we expect to see improvement

The time frame for improvement will be dependent on the options generated from the outcome of July meeting, appraised and the resulting actions

What are the risks to delivery?

However, this has been significantly reduced due the or progress of several actions so far; such as
Action 1. LP270 policy completed.
Action 2. training completed up to 76% of prescribers. Acceptable compliance standard is 75%.
Actions 3&4 remain under who now issue compliant equipment with service unique ID code and service date.
Action 5. assessment of atypical anatomy has been completed within CBU and SBU. Work is ongoing in ABU. The Medicine and Healthcare product Regulatory Agency flexibility is due to financial constraints, provided risk remains on risk register until full compliance is achieved.
Action 6 all patients on caseload have been assessed in line with guidance since January 2024 and documented. Assessment of discharged patients have not due to financial constraints.

Compliance In Level 1 and 2 Patient Safety Training

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

Target: 95% | Actual: 90% | SPC Variation: | SPC Assurance: | Data Quality: **Medium Assurance**

What is the trend we see?

Compliance with Level 1 and 2 Patient Safety Training has shown consistent improvement since April 2024, increasing from approximately 65% to around 90% by early 2026. The initial trajectory demonstrated strong early gains, with growth continuing at a steadier pace over time.

While performance has now exceeded the lower threshold (around 80–85%), it remains just below the 95% target.

What is being done about it?

The current trend is positive, with incremental improvements continuing month on month, indicating sustained engagement and progress across teams.

Maintaining this momentum will be key to closing the remaining gap to target, with Business Units continuing a focus on supporting completion and ensuring compliance is embedded as standard practice.

Monitoring of compliance is included within Trust performance processes.

When do we expect to see improvement?

Improvement is ongoing and consistent. If this rate continues, we'd expect to see further uplift over the next quarter, with progress continuing through the year as compliance becomes more embedded.

What are the risks to delivery?

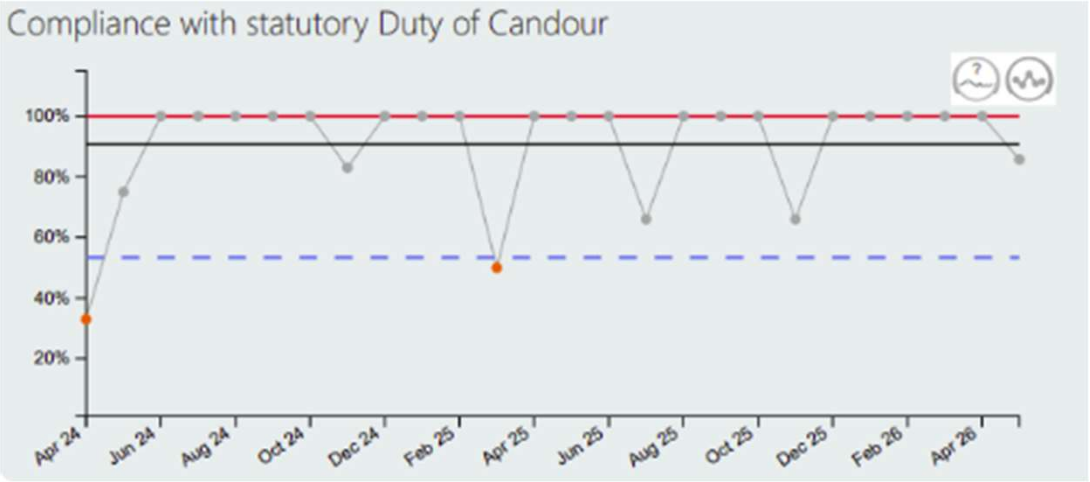
Duty of Candour

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

Target: 100% | Actual: 86% | Data Quality: **High Assurance**

What is the trend we see

The data shows common cause variation with no significant changes over the last 14 months however compliance with Statutory Duty of Candour internally set deadlines is inconsistent in meeting the target of 100%. In April there were two incidents confirmed at Rapid Review Meeting as requiring Statutory Duty of Candour both were assessed as compliant. In May there were seven, of these six were assessed as compliant and the remaining one for Adult Business Unit was recorded as a breach as the drafted letter was shared with the Patient Safety Team for Quality Assurance after the due date had passed.



What is being done about it?

Statutory Duty of Candour continues to be assessed and agreed as part of Rapid Review Meeting including confirmation of a responsible lead for completion. The One Minute Guide for Duty of Candour has recently been circulated to the Business Units for cascade and has been shared within MYLCH today. The Patient Safety Team follow an established process for reminders at day 5 and 7 with escalation at Day 8 if the draft letter has not been received. This is to ensure that incidents are on track to meet expected timescales for completion of Statutory Duty of Candour or, where the timescale is not met, that all steps have been taken to complete as soon as reasonably practicable. Training continues to be delivered to Incident Handlers across the trust with regular sessions now ongoing including a section on Statutory Duty of Candour.

When do we expect to see improvement

Over the last six months there were twenty-six incidents meeting the Statutory Duty of Candour. Whilst there has been one breach in May an overall improvement has been noted over the past six months with compliance at 100% between December 2025- April 2026. The recruitment to the post of Patient Safety Clinical Coordinator in the Patient Safety Workstream has supported the ability to ensure adherence to governance oversight and timely escalation.

What are the risks to delivery?

There is a risk that if Statutory Duty of Candour verbal and written communication is not completed as soon as reasonably practicable then the trust will not be compliant with CQC regulation 20.

The Patient Safety Clinical Coordinator post is only a fixed term contract until October 2026, and this role oversees the process including quality assurance until Day 8 where escalation is then made to the Patient Safety Manager, without this resource in the team, the ability to maintain effective and timely oversight would be reduced.

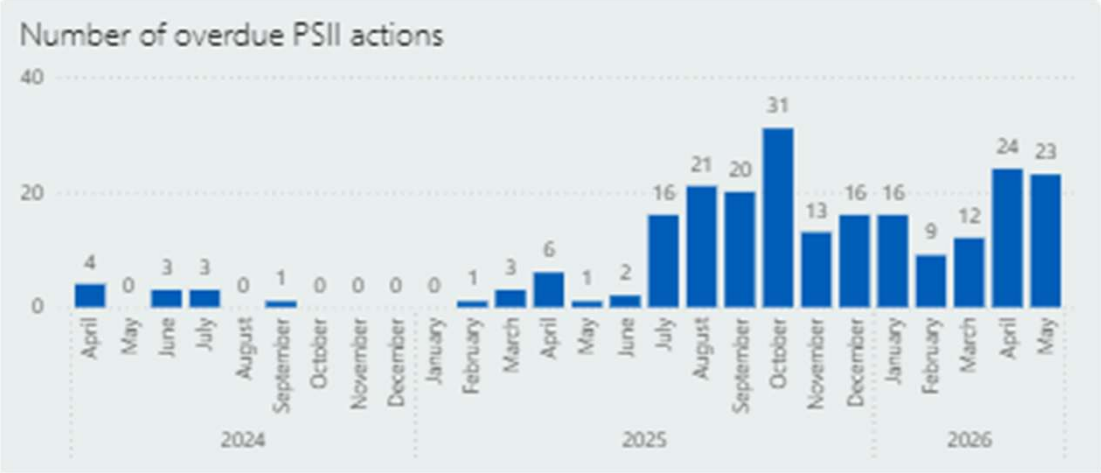
Number of Overdue PSII Actions

Leeds Community Healthcare NHS Trust

Domain: Patient Safety	Accountable Exec: Heather McClelland	Author: Sarah Yeomans
Target: No Target	Actual: 23	Data Quality: High Assurance

What is the trend we see?

There are twenty-three overdue PSII actions in the incident reporting system. Of the twenty - three actions ten are for the Adult Business Unit, eight for the Corporate Business Unit, three for Children Business Unit and two for the Specialist Business Unit. Some of these actions are significantly past the due date and were due for completion in March 2025 (1), October 2025 (2), December 2025 (5), January 2026 (3), March 2026 (4), and April 2026 (3), May 2026 (5).



What is being done about it?

The process for managing Overdue Patient Safety Incident Investigation (PSII) and Patient Safety Learning Response (PSLR) actions for clinical business units has been reviewed and updated, clearly outlining responsibilities across Clinical Governance and Business Units. A further process has been developed for PSII actions assigned to responsible leads within the Corporate Business Unit, these processes are now approved and awaiting review at the July 2026 Clinical and Corporate Policy Group to be updated into the PL404 LCH Patient Incident Management Policy.

These processes have been shared with Clinical Leads and Corporate Heads of Service alongside a list of the current overdue actions with a request that they are reviewed for update and closure or risk assessed with a request for extension.

The Patient Safety Team are now sending communications to PSII action responsible leads at the time they are assigned within the Incident management system to improve awareness of the allocated actions.

PSII actions should be considered for inclusion in business unit Performance Oversight Groups and/or individual team performance meetings.

When do we expect to see improvement

Since this data was pulled and the above action taken eight of the overdue actions have been closed. Adult Business Unit (4), Corporate Business Unit (2) and Specialist and Children Business Unit (1 each). An overall improvement can be expected when the Overdue Patient Safety Incident Investigation (PSII) and Patient Safety Learning Response (PSLR) actions is embedded.

What are the risks to delivery?

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

PSII actions will continue to become overdue without being adequately risk assessed if the Overdue Patient Safety Incident Investigation (PSII) and Patient Safety Learning Response (PSLR) actions process is not adhered to by the Business Units.

People & Workforce Domain Summary

Accountable Exec: Laura Smith and Jenny Allen

NHS Leeds Community Healthcare NHS Trust

Summary

The People & Workforce measures provide reasonable assurance that performance is improving overall. Sickness absence continues its positive downward trend and is now 7.0%, just 0.5% above the Trust target, reflecting the impact of focused management interventions, occupational health support and strengthened performance oversight. To note further detail on the work being undertaken and impact is included in the slides at the end of the IPR pack.

Appraisal compliance remains below target at 81% against a 90% target, but performance is broadly stable and remains significantly stronger than historic levels. Continued scrutiny through performance processes and targeted support to services are in place to improve compliance.

There were four RIDDOR-reportable incidents during the month, the highest monthly total seen in the last two years. These incidents were unrelated, with no common themes identified, and each is being investigated with appropriate actions and oversight through established health and safety governance arrangements.

Overall, the People & Workforce position is positive, with sustained improvement in sickness absence and established actions to address appraisal compliance. Whilst the increase in RIDDOR incidents requires monitoring, there is no indication of a systemic concern, providing the Board with assurance in terms of workforce wellbeing, management oversight and organisational culture.

Domain Summary Performance

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

KPI	Reporting Month	Target	Actual	Performance	Assurance
'RIDDOR' incidents reported to Health and Safety Executive	May-26	No Target	4		
AfC Staff Appraisal Rate	May-26	>=90%	81%	L	F
Staff Turnover	May-26	<=14.5%	9%	L	P
Starters / leavers net movement	May-26	>=0 in favour of starters	9		?
Statutory and Mandatory Training Compliance	May-26	>=90%	90%		?
The overall percentage of staff who have identified as BME (including exec. board members)	May-26	14%	15%	H	P
Total sickness absence rate (Monthly) (%)	May-26	<=6.5%	7%	H	?

‘RIDDOR’ Incidents Reported to Health and Safety Executive

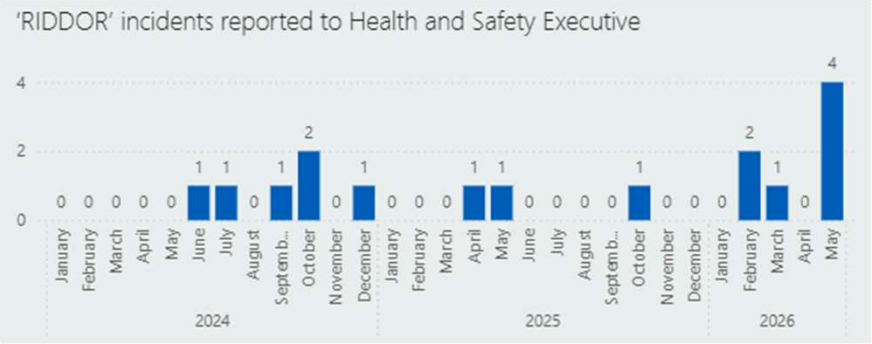
Domain: People & Workforce | Accountable Exec: Sam Prince | Author: Diane Allison

Target: 0 | Actual: 4 | Data Quality: **Medium Assurance**

What is the trend we see?

Not applicable - No trend established.

- A staff member fell over a pallet at Leeds Community Equipment Service
- A panel fell off a wall above a sink unit at Meanwood Health Centre, hitting a cleaner on the head
- A patient hadn't been rolled far enough, and the staff member extended too far, hurting their back
- Staff member suffered a fractured tooth having been assaulted by a prisoner at Hull Police Custody suite



What is being done about it?

Each RIDDOR incident is investigated by the Safety Team, and an appropriate action plan is agreed with the service manager.

Incidents are discussed at the Health and Safety Group.

What are the risks to delivery?

Unavailability of staff to carry out normal duties
Potential claims against the Trust
Health and Safety Executive investigation and enforcement action

When do we expect to see improvement

Workforce Total Sickness Absence rate (Monthly) (%)

Leeds Community Healthcare NHS Trust

Domain: People & Workforce | Accountable Exec: Laura Smith and Jenny Allen | Author: Katie Wilson

Target: 6.5% | Actual: 7% | SPC Variation: | SPC Assurance: | Data Quality: High Assurance

What is the trend we see?

There continues to be a downward trend in absence rates, although the rate of reduction is less steep than in previous months, reflecting both seasonal patterns and the impact of ongoing interventions. Absence is now within 0.5 percentage points of the Trust's target of 6.5%.

It is anticipated that this downward trend will continue; the overall reduction is largely driven by a significant decrease in short-term absences, while long-term absence remains an area of concern.

What is being done about it?

Data continues to support more detailed identification of the factors influencing both the occurrence and frequency of absence within individual teams.

A range of actions are in place to support services in managing sickness absence, including the bimonthly "Managing Absence with Confidence" training programme, alongside Occupational Health training and guidance to improve the consistency and effectiveness of referrals.

In addition, monthly "Compass" meetings bring together the People Services team to review absence data and target support to teams with consistently higher levels of absence, across both short- and long-term cases.

It is important to recognise that sickness absence is influenced by a range of systemic factors, including organisational culture, leadership capability and workload pressures, meaning improvement is not always immediate or linear.

When do we expect to see improvement

Absence rates continue to decline in line with seasonal trends observed in previous years as we move into the spring and summer months. With the introduction of targeted support for services experiencing higher levels of sickness absence, this downward trend is expected to continue, with the aim of reaching the target in the near term. Its important to note that the Trust is also undergoing significant organisational change, which may have a short-term impact on absence levels. Absence may increase where this change is not managed effectively.

What are the risks to delivery?

Reduced service capacity – fewer staff available can affect service delivery, patient care, and performance targets

Increased workload for remaining staff – leading to fatigue/ burnout, errors, and reduced productivity

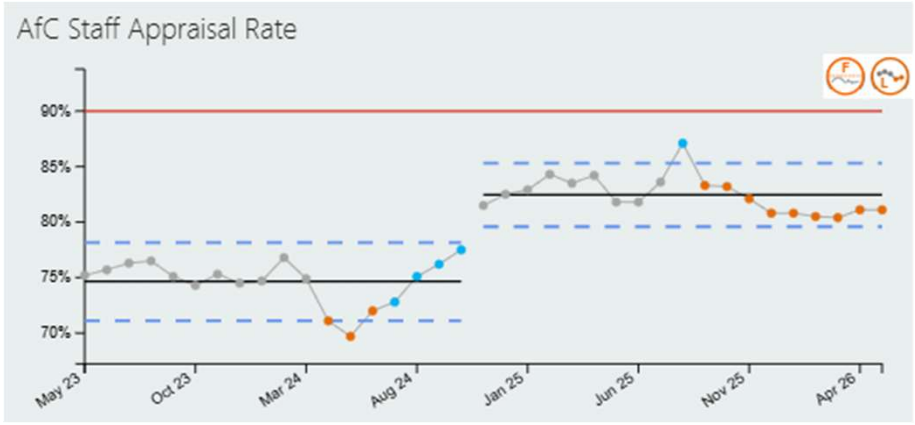
Reliance on temporary staffing – which may impact continuity and quality, as well as have impact financially due to increase in staffing costs due to overtime, bank or agency cover.

AfC Staff Appraisal Rate

Domain: People & Workforce | Accountable Exec: Laura Smith and Jenny Allen | Author: Catherine Hall

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

Appraisal compliance improved significantly following focused efforts across Business Units, reaching a peak in July 2025. Although the second half of 2025 showed a gradual decline, overall compliance was higher than at any point in the last two years, indicating that the underlying improvements are somewhat holding. Current data indicates that the rates are the same as reported in March 2026



What is being done about it?

A paper is being written for People and Culture Committee to look at lowering the target to 85% in line with LYPFT.

Consistently raised at Performance Panels to ensure focus on appraisals with targeted messaging and offers of support to those services that are significantly below target

When do we expect to see improvement

Improvement is expected given the focus and scrutiny applied at performance meetings

These factors could slow or disrupt progress:

1. **Competing operational priorities**. Workload pressures, particularly the recent organisational focus on sickness absence and staff engagement action planning may divert attention away from appraisal completion. Additionally increasing workload pertaining to the integration of both Trusts could affect, particularly Corporate functions appraisal rates
2. **Inconsistent local ownership**. Different teams place varying levels of emphasis on compliance, leading to uneven performance and slower overall improvement.
3. **Limited managerial capacity**. Managers with large spans of control may struggle to complete appraisals on time without additional support or clearer prioritisation.

Digital Key Performance Indicators – Summary April 2026

NHS Leeds Community Healthcare NHS Trust

Summary

- This is the first set of Digital KPIs to be reported and should be considered a baseline and targets and measures will be refined through further reporting periods.
- We continue to demonstrate a mature and effective approach to information governance, cyber security, and IT service delivery.
- SAR and FOI requests are largely completed within statutory timeframes, with exceptions monitored and managed.
- Since the 1st February 2026, 100% of cyber alerts were acknowledged within the NHSE 48-hour requirement and resolved within 14 days of acknowledgement.
- Patching performance remains positive
- Performance around incident detection and response times are subject to internal resource.
- IT service desk performance continues to meet ITIL based service responsiveness standards.

Domain	Metric	Apr 26			Comment
		Value	Target	RAG	
Patch Compliance	Confidential				
Exposure Score	Confidential				
Cyber Alerts	Acknowledged within 48 hrs	100%	100%	G	National Target
	Remediated within 14 days	-	100%	G	National Target
SIEM	Confidential				
Service Desk	Calls Answered	90.2%	>=85%	G	ITIL Standard
	Average Answer Time	2 mins	2 mins	G	ITIL Standard
	Abandonment	9.8%	<= 5%	A	Local Standard
SAR Performance	Late – not within 1 calendar month	0	0	G	National Target
FOI Performance	Late > 20 working days	0	+95%	G	National target

Digital Key Performance Indicators – Service Desk Queue Performance February-April 2026

Leeds Community Healthcare NHS Trust

April 2026
1,550 calls offered : 90.2% answered
Average answer time: approx. 2 mins 24 secs
Service Level: 69%
Abandonment: 9.8% (mainly long abandons) after around 4 mins

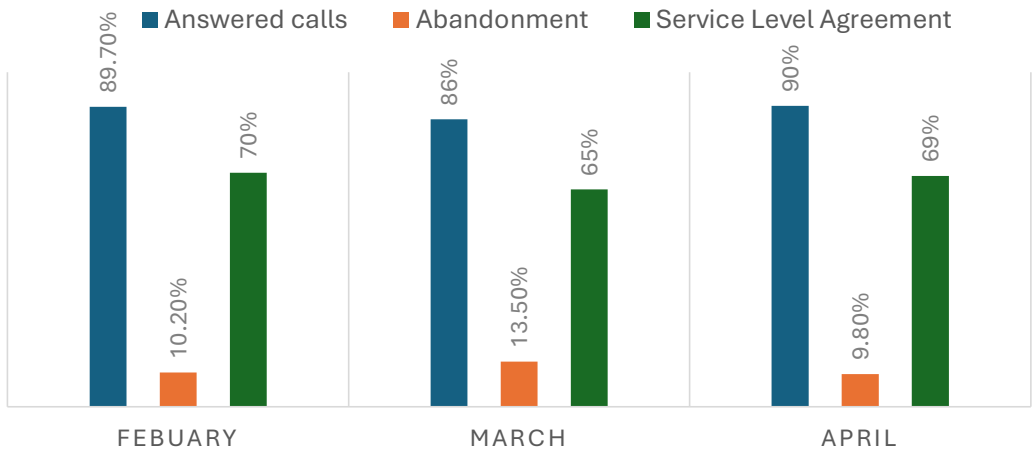
Queue Performance by Month

[Lch_Acd1] P364 - IT Main Calls

01/04/2026 - 30/04/2026 - 08:00 - 18:00

Created on 06/05/2026 16:38:31 by MarkDwyer

Activity period	ACD calls offered	ACD calls handled	Calls abandoned (short)	Calls abandoned (long)	Calls interflowed	Calls requeued	Queue unavailable	Answered by ACD group 1	Answered by ACD group 2	Answered by ACD group 3	Answered by ACD group 4	Average speed of answer (hh:mm:ss)	Average delay to abandon (hh:mm:ss)	Average delay to interflow (hh:mm:ss)	ACD handling time (hh:mm:ss)	Average ACD handling time (hh:mm:ss)	Abandon %	Service level %	Answer %
April	1550	1398	14	152	0	75	9	1398	0	0	0	00:02:24	00:04:12	00:00:00	179:27:25	00:07:42	9.8%	69.4%	90.2%
Totals	**1550**	**1398**	**14**	**152**	**0**	**75**	**9**	**1398**	**0**	**0**	**0**	**00:02:24**	**00:04:12**	**00:00:00**	**179:27:25**	**00:07:42**	**9.8%**	**69.4%**	**90.2%**



IT Service Desk Performance
Performance shows overall stability across February to April, with April reflecting a balance across the measures and results remaining broadly consistent over the period. Efforts to reduce the number of calls abandoned are through adjustments to the 1s Line staff rota to provide more staff to handle calls during peak times.

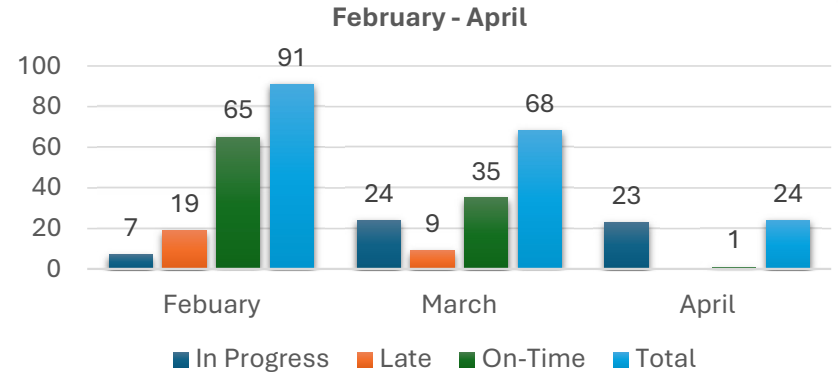
Targets:
>=85% of call answered
Average Answer time <=2 mins
Abandonment <=5%

Digital Key Performance Indicators – Subject Access Requests (SARs) February –April 2026

There is an indication of a reduction in SARS in the period, but not enough data substantiate if this is only a temporary trend.

The number of late responses for the latter months can increase as the SARs age.

SARs ordinarily are required to be responded to within one calendar month unless they are complex or the requestor has submitted multiple requests.



Target: 0 late

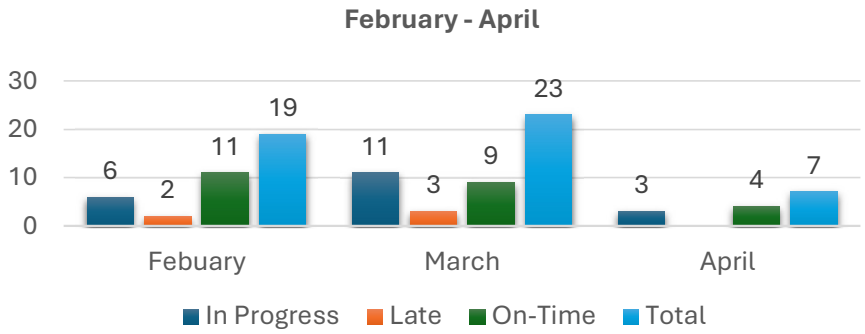
Digital Key Performance Indicators – Freedom of Information Requests (FOIs)

A dedicated initiative to reduce the number of late FOIs in both the Finance and IT departments has been in operation over the past 9 months and performance has improved.

The volume of FOIs are unpredictable.

There is anecdotal evidence that FOI requests are becoming more complex in their nature, requiring more effort to respond.

FOI's are required to be responded to within 20 working days, however an extension are permitted where public interest exemptions need to be considered.



Target: Good - 95% or more responded within 20 working days, Adequate 90%-95% within 20 working day, Unsatisfactory fewer than 90% within 20 working days

NHS Leeds Community Healthcare NHS Trust

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

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

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

Leeds Community Healthcare NHS Trust

Agenda item:	2026-27 (13i)
Title of report:	NHS Oversight Framework 2026/27 – Briefing Paper
Meeting:	Trust Board
Date:	23rd July

Presented by:	Andrea Osborne, Director of Finance
Prepared by:	Victoria Douglas-McTurk, Assistant Director of Insight and Intelligence

Purpose of the report:		
This report provides an overview of changes in the NOF framework for 2026/27.	Approval	
	Discussion	
	Assurance	x

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

Summary of Key Issues:

- Organisations will no longer be benchmarked to determine their overall segmentation.
- Urgent Community Response and CYP access to Mental Health services measures have been removed from the framework.
- A number of new measures across the domains have been added
- Implied productivity growth, % of safety incidents causing harm and % patients to acquire a new grade 3 or 4 pressure ulcer have been included as a contextual measure which means it will be monitored, but won't contribute to scoring.

Previously considered by:	
Outcome of previous discussion/s:	

Link to strategic goals: (Please tick any applicable)	
Work with communities to deliver personalised care	x

Use our resources wisely and efficiently	x
Enable our workforce to thrive and deliver the best possible care	x
Collaborating with partners to enable people to live better lives	x
Embed equity in all that we do	x

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

Recommendation(s)	- To seek any further assurances required - To direct any further improvement work

List of Appendices:	Appendix 1 – Full list of NOF measures and their scoring method

NHS Oversight Framework

Briefing Paper for 2026/27 – 22nd June 2026

1. Background

The NHS Oversight Framework was introduced in 2025/26. It provides a new mechanism to manage the performance of NHS organisations. Organisations are allocated to segments (1 to 4 – 1 being the highest and consistently performing) based on a capability assessment and their performance in key metrics. In 2025/26 LCH improved its performance in relation to the framework and moved from segment 4 to segment 3 and were allocated a capability rating of Amber/Green.

This paper outlines the key changes that have been bought in for the framework in 2026/27.

2. Key Changes for 2026/27

a. Oversight Approach

Previously, could be allocated to segment 5 based on the outputs of the segmentation score and capability assessment. Segment 5 has now been scrapped. However, the NOF core architecture and oversight approach has been maintained into 2026/27. The level of support and intervention by NHS England will be determined by an organisation's segmentation and capability score. Organisations with poorer segmentation and capability scores will receive more interventions and more formal approaches from NHS England. The approach NHS England take will be reviewed on a quarterly basis.

ICBs will be assessed for the first time this year.

The NOF domains have changes slightly this year. effectiveness and experience of care has been split into 2 domains and improving health and inequalities has been renamed. They are now:

- population health and inequalities
- access to services (providers only)
- allocating resources (ICBs only)
- effectiveness of care
- experience of care
- patient safety
- finance, productivity and innovation
- people

b. Scoring Methodology

i. Overall Segment Score

Organisations are now allocated to segments based on their metric score alone. They are no longer benchmarked against other organisations. Hard boundaries have now been set for the overall average metric score. These boundaries have been

based on mean average metrics score for 25/26 and 1 standard deviation from this score. The boundaries are as follows:

Segment	Average metric score
1	below 1.94
2	1.94 to 2.33
3	2.34 to 2.77
4	above 2.77

ii. Individual Measure Segment Scores

Rather than benchmarking performance for all measures. There are now 4 ways in which scores for measures will be derived:

- target and spread: where there is a defined target organisations achieving that target will score 1.00. Remaining organisations are evenly scored between 2.00 and 4.00 based on their relative performance
- banded scores: specific criteria are defined and converted to a segment, for example a score of 1.00 would apply to an organisation achieving between 80% and 100%, a score of 2.00 would apply to an organisation achieving between 60% and 79.9%, etc
- floor and spread: a defined lower acceptable limit is set and every organisation failing to achieve that limit scores 4.00. Remaining organisations are evenly scored between 1.00 and 3.00 based on their relative performance
- even spread: there is no defined performance threshold; organisations are ranked evenly between 1.00 and 4.00 based on their relative performance

c. Changes to Measures

The measures have been updated to align more closely to the Medium-Term Plan. Overall, we will be assessed against more measures. The full list of measures along with their scoring mechanism is provided in appendix 1.

i. Measures Removed

We will no longer be assessed against:

- CYP access to mental health services
- 2 hour Urgent Community Response.

We are currently in segments 3 and 2 respectively for these measures. Removal of these measure may negatively impact our overall segmentation if we do not score at a similar level in the new measures.

ii. Measures Added

It is not immediately clear from the guidance exactly which measures LCH will be assessed against. The list below is based on opinion informed by the guidance released and engagement events to date. NHS England have been contacted and asked to confirm whether this list is correct.

- % of total children's and young persons' mental health patients waiting over 104 weeks for contact (NB this measure excludes neuro developmental waits)
- % of patients waiting less than 18 weeks for community care

- % of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages)
- NHS staff survey advocacy rate
- % of intermediate care beds occupied by patients without criteria to reside
- % of NHS Talking Therapies patients completed a course of treatment and achieving reliable recovery
- % of urgent crisis response patients to receive face to face care within 24 hours (mental health)
- % of clinical trials set up within 90 days
- Data Quality Maturity Index
- National Education and Training Survey satisfaction rate
- NHS staff standards score
- Healthcare Worker Flu Vaccination Rate
- Temporary staffing cost relative band

These measures and their scoring mechanisms are given in appendix 1.

As the detail has only been released recently there is little insight at present about these measures and our potential segmentation at this point. What we do know is:

- We will be in segment 1 for % of total children's and young persons' mental health patients waiting over 104 weeks for contact as we have 0 patients waiting that long outside neuro developmental assessment pathways
- We are currently achieving 81% of patients being seen within 18 weeks in the services reported to the community sit rep. This means we will score 1 for this measure.
- Reliable recovery for NHS Talking Therapies stands at 48.5% for Q1 to date. This relates to a score of 3.
- Our overall DQMI score in March 2026 is 87.5%. By current estimations this puts us in segment 4, but there are likely to be some quick actions that can be taken to improve this.

Further information will be shared via the IPR as it becomes available.

iii. Contextual Measures

Three contextual measures are included this year. This means that these measures will be calculated and used to inform capability ratings, but they will not be used to inform the scores that define the segment. They are:

- Implied productivity growth
- % of safety incidents causing harm
- % patients to acquire a new grade 3 or 4 pressure ulcer

iv. Measures Remaining

For the sake of completeness, the measures that we will continue to be assessed against are listed below our Q4 segment is provided in brackets:

- % of cases waiting over 52 weeks for community care (3)
- NHS staff survey raising concerns sub-score (1)
- Planned surplus or deficit (1)
- Variance to plan year-to-date (1)

- Relative cost difference (National Cost Collection Index) (3)
- Sickness absence rate (4)
- NHS staff survey engagement theme score (3)

3. Next Steps

The Business Intelligence Team is actively reviewing each of the new measures with a view to establishing our current performance and areas for focus. This work includes identifying the national data set and ensuring local reporting is in line with this. Where measures are not currently reported on these will be introduced as organisational KPIs and assessed in the IPR.

The outcome of this work, analysis to date and the actions being taken to improve performance will reported in the IPR due at committees in September.

Publication of the Q1 figures for the NHS Oversight Framework is currently expected around the 27th August.

Appendix 1 – Full list of NOF measures and their scoring method

Abridged from NOF 2026-27 technical annex

<table>
<tr><th>Domain</th><th>Measure</th><th>Scoring Method</th></tr>
<tr><td colspan="3">Access to services</td></tr>
<tr><td>Existing</td><td>% of cases waiting over 52 weeks for community care</td><td>Even spread</td></tr>
<tr><td>New</td><td>% of patients waiting less than 18 weeks for community care</td><td>Target and spread: 1.00:>=78%.</td></tr>
<tr><td>New</td><td>% of total childrens and young persons mental health patients waiting over 104 weeks for contact</td><td>Banded Scores: 1.00: ≤5%. [NB this excludes neurodevelopmental waits]</td></tr>
<tr><td>New</td><td>% of people accessing mental health services with at least 2 contacts and a paired outcome score (all ages)</td><td>Banded Scores:
<table>
<tr><td></td><td></td><td>CYP metric score</td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td>1: ≥28%</td><td>2: 20–27%</td><td>3: 13–19%</td><td>4: ≤12%</td></tr>
<tr><td rowspan="4">Adult metric score</td><td>1: ≥12%</td><td>1</td><td>2</td><td>2</td><td>3</td></tr>
<tr><td>2: 8–11%</td><td>2</td><td>2</td><td>3</td><td>3</td></tr>
<tr><td>3: 4–7%</td><td>2</td><td>3</td><td>3</td><td>4</td></tr>
<tr><td>4: ≤3%</td><td>3</td><td>3</td><td>4</td><td>4</td></tr>
</table>
</td></tr>
<tr><td colspan="3">Experience of care</td></tr>
<tr><td>New</td><td>NHS staff survey advocacy rate</td><td>Even spread</td></tr>
<tr><td>New</td><td>% of intermediate care beds occupied by patients without criteria to reside</td><td>Even spread</td></tr>
<tr><td colspan="3">Effectiveness of care</td></tr>
<tr><td>New</td><td>% of NHS Talking Therapies patients completed a course of treatment and achieving reliable recovery</td><td>Banded Scores: 1.00: >=52%</td></tr>
</table>

Domain	Measure	Scoring Method
Patient safety		
New	% of urgent crisis response patients to receive face to face care within 24 hours (mental health)	Even spread
Existing	NHS staff survey raising concerns sub-score	Even spread
Finance, productivity and innovation		
New	% of clinical trials set up within 90 days	Target, floor and spread: 1.00 >=95%, 4.00 <=80%. All other organisations scored between 2 and 3 based on value.
New	Data Quality Maturity Index	Even spread
Existing	Planned surplus or deficit	Banded Scores: 1.00: 0% or surplus
Existing	Variance to plan year-to-date	Banded Scores: 1.00: on plan or better
Existing	Relative cost difference (National Cost Collection Index)	Target and spread: 1.00:<=100

Domain	Measure	Scoring Method
People		
New	National Education and Training Survey satisfaction rate	Even spread
New	NHS staff standards score	Even spread
New	Healthcare Worker Flu Vaccination Rate	Even spread
New	Temporary staffing cost relative band	Bank and Agency spending is scored separately using the following criteria: 1 Overall spending as a % of total paybill is below average and spending in the current year is on track to meet target 2 Overall spending as a % of total paybill is above average and spending in the current year is on track to meet target 3 Overall spending as a % of total paybill is below average but spending in the current year is off track to meet target 4 Overall spending as a % of total paybill is below average and spending in the current year is off track to meet target* The matrix below is then used to determine the overall score:
Existing	Sickness absence rate	Even spread
Existing	NHS staff survey engagement theme score	Even spread

		Agency			
		1	2	3	4
Bank	1	1	1	2	3
	2	1	2	2	3
	3	2	2	3	4
	4	3	3	4	4

* We believe this is a mistake on NHS England's part and 4 should read "Overall spending as a % of total paybill is above average and spending in the current year is off track to meet target". We have informed NHSE.

Agenda item:	2026-27 (13ii)
Title of report:	NOF Update - Sickness Absence
Meeting:	Trust Board Meeting Held In Public
Date:	23 July 2026

Presented by:	Catherine Hall - Associate Director People Solutions
Prepared by:	Elfie Astbury – People Projects Manager Alan Sewell – Associate Director, People Operations

Purpose of the report:		
To provide the Board with an update on the Sickness Absence Improvement Project, including current performance and progress in strengthening organisational oversight, management grip and accountability for sickness absence across the Trust.	Approval	
	Discussion	
	Assurance	X

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

Summary of Key Issues:

- Sickness absence continues to move in the right direction following the winter peak, although overall absence (6.6%) remains above target. Anxiety, stress and depression remain the largest contributor to absence (2.4%).
- The project has largely transitioned from developing interventions to embedding a more proactive, intelligence-led approach to sickness absence management.
- Stronger mechanisms are now in place to monitor sickness absence across the organisation, providing greater visibility, oversight, grip and control through the Intervention Compass, enhanced reporting and the Unavailability Dashboard.
- Work is underway to increase monitoring of sickness absence triggers and return-to-work conversations, alongside continuing to support managers through training, guidance and wellbeing support.

Previously considered by:	Summary of progress was previously considered by the Public Board in May 2026

Outcome of previous discussion/s:	Updates and progress noted.

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

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

Recommendation(s)	It is recommended that the Board: • Note the current sickness absence position and positive direction of travel. • Note the progress made in strengthening organisational oversight, visibility and management grip of sickness absence. • Receive assurance that appropriate monitoring, reporting and governance arrangements are in place to support continued improvement.

List of Appendices:	Appendix 1 – NOF Sickness Absence update

NHS
Leeds Community Healthcare
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NOF Sickness Absence Improvement Project - update

Update for Public Board

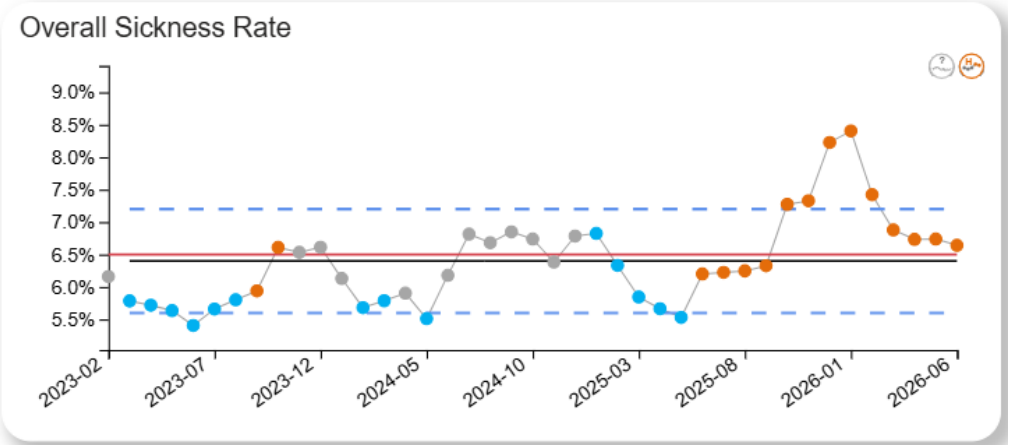
23rd July 2026

Current Position

Leeds Community Healthcare NHS Trust

Where we are now

- Sickness absence rates continue to move in the right direction. Whilst overall absence (6.6%) remains above target, both short and long-term sickness absence have shown gradual improvement over recent months.
- Anxiety, stress and depression remain the leading reason for absence (2.4%). Musculoskeletal absence has reduced to 0.7% but remains the second largest driver of long-term sickness absence.
- The project has largely transitioned from developing tools and interventions to embedding a proactive, intelligence-led approach to sickness absence management, enabling earlier identification of hotspot services and more targeted interventions through routine management processes and governance arrangements.
- We now have much stronger mechanisms in place to monitor sickness absence across the organisation, providing greater visibility, organisational oversight and management grip.



What we are doing well

- The Sickness Absence Support Framework ("Intervention Compass") has been successfully introduced and is supporting a more consistent and targeted approach to intervention across services.
- Monthly Intervention Monitoring and Compass meetings are now established, strengthening organisational oversight, accountability and governance of sickness absence interventions
- The Unavailability Dashboard is providing timely intelligence on sickness absence trends, supporting earlier identification of hotspot services and more targeted intervention activity.
- Partnership working between People Business Partners and Clinical Psychology has strengthened, improving support available to managers supporting staff with mental health-related absence.
- Strengthened communication and signposting of wellbeing support available to staff and managers, including renewed promotion of the Thrive@Work service, supporting earlier access to mental health and musculoskeletal interventions
- Internal Audit provided significant assurance on the Trust's approach to managing long-term sickness absence & recognised the positive contribution of the Sickness Absence Project in strengthening oversight, reporting and management arrangements.

Where we are focusing next

- Continue testing and refining the Support Framework ("Intervention Compass"), before transitioning arrangements into business as usual
- Increase monitoring of sickness absence triggers and return-to-work conversations, alongside strengthening support available to managers to help ensure these are completed consistently.
- Further strengthen organisational oversight and management grip through enhanced reporting, dashboard development and targeted support to hotspot services.

Key Developments

Leeds Community Healthcare NHS Trust

- The improvement project aims to reduce sickness absence by implementing a systematic improvement programme that integrates policy clarification, clear accountability, capability development, and cultural change to achieve measurable and sustainable improvements in organisational health and absence rates.
- This project has delivered a range of interventions and is now focused on embedding them and strengthening organisational oversight.

Guidance, policy and process	• Managing Absence with Confidence training continues to be delivered successfully, with strong demand, positive evaluation feedback and a waiting list for future sessions. Delivery dates are now scheduled through to the end of the year. • Work continues to strengthen the sickness panel process following recommendations from the Task and Finish Group. Progress has been made in developing a more consistent panel allocation process and improving support and guidance for panel participants. Work is also underway to define management information requirements to strengthen oversight of panel activity and outcomes. • Development of policy adherence monitoring has progressed, with reporting requirements defined and dashboard functionality built to support monitoring of key indicators, including return-to-work conversations and attendance management activity following sickness absence triggers. Testing and refinement is ongoing prior to implementation. • Communications and signposting of wellbeing services have been strengthened, including increased promotion of Thrive@Work and wider support available to managers and staff.
Occupational Health	• Occupational Health performance remains below expectations; however, the provider has acknowledged the issues identified and is implementing improvement actions. The Trust continues to work closely with the provider through monthly review meetings and a strengthened governance framework. An escalation route via the People Partnering Team has been established for ill health capability and ill health retirement cases, and greater use of the Occupational Health advice line is being promoted to ensure formal referrals are targeted appropriately. The provider has also committed to more regular performance reporting, providing greater transparency and assurance regarding progress.
Employee Assistance Programme	• Awareness and utilisation of wellbeing support services has improved following communications activity, webinars and wider promotion through the project. • This workstream has now transitioned into business as usual arrangements, with ongoing promotion and monitoring sitting outside of the project structure.
Organisational Health	• Organisational Health activity has been incorporated into the Sickness Absence Support Framework ("Intervention Compass"), ensuring support is targeted using an intelligence-driven approach. • Team Reviews have been developed to support structured conversations between managers and People Partners where sickness absence remains elevated. • Partnership working between People Business Partners and Clinical Psychology colleagues has strengthened, improving support available to managers supporting staff experiencing mental health-related absence • Organisational Health activity continues within identified hotspot services. Wetherby YOI: diagnostic has been completed and findings presented to WYOI leadership team, Dental: fieldwork completed, report drafted, aiming to present findings and recommendations at the end of July. Wharfedale: a full Organisational Health Index not indicated following a series of discussions with leadership team. Targeted support received from Clinical Psychology, Senior People Consultants and Freedom to Speak Up focused on staff wellbeing, workforce support, security arrangements and management of challenging inpatient behaviours. This targeted approach has enabled the team to focus on immediate priorities while strengthening staff support and wellbeing across the wards.
Data, reporting & intelligence	• The Sickness Absence Support Framework ("Intervention Compass") is now operational and is being used to identify hotspot services, target support and monitor progress through monthly review cycles. • The Unavailability Dashboard is now live and providing daily intelligence, giving significantly greater visibility of sickness absence trends and supporting earlier intervention where concerns emerge. • New monitoring arrangements are being introduced to provide greater assurance that absence triggers are acted on and return-to-work conversations are being completed consistently. • A monthly stakeholder report has been introduced to improve visibility of sickness absence trends, organisational hotspots and intervention activity.

Committee Escalation and Assurance Report

Name of Committee:	People & Culture	**Report to:**	Trust Board 23rd July 2026
Date of Meeting:	10th June 2026	**Date of next meeting:**	7th October 2026

Introduction

The meeting was supported by a clear agenda and a comprehensive set of papers, which enabled thorough and informed discussion. There were positive and productive conversations around the 'Staff Story' and the Network Chair.

Alert	Action
• Sustainability Annual Report - Challenges due to the lack of a dedicated sustainability lead noted.	To confirm recruitment timeline for the Sustainability role with LYPFT and report back to Committee in October

Advise

- People KPI and data – Committee received updated workforce KPIs, including appraisal rates, absence trends, and bank and agency usage. Discussed the balance between targets and patient safety, the use of real-time data, and the need for consistent metrics and improved training compliance. A detailed report to be prepared on where agency and bank staff are being used, including reasons, for review by the committee in October.
- Staff Network – Karen Lai (REN Chair) provided an update on staff networks, highlighting current challenges related to external events, increased ER cases, and the need for greater managerial support for staff participation with the network meetings. Committee discussed the importance of proactive communication, scenario planning, and building resilience among staff.

Assurance

- Temba Ndirigu, Clinical Lead for SBU shared his personal and professional journey from Zimbabwe to clinical leadership in the NHS. Committee noted more systematic support for talent development, the value of storytelling for culture change, and the potential to revive and embed reverse mentoring and allyship schemes within the Trust.
- Quality and Value - Human Factors Trend – No immediate or systemic workforce risks linked to the Q&V programme. Workforce indicators across most services remain stable. Increasing numbers of employee relations cases, including those linked to discrimination and sexual safety.
- People Strategy and Headline Update - update on the internal people strategy, national workforce reforms, and the trust integration programme, highlighting ongoing work in inclusion, technology upgrades and the significant upcoming requirement to re-evaluate all band 5 nursing job descriptions.
- FTSU Guardian Summary Report - Verbal update. Noted the decision not to mandate training, the ongoing embedding of staff voice, and the development of a cross-functional group to address sexual safety concerns.

Committee Escalation and Assurance Report

- Staff Survey Board Workshop - provided the Committee with further data analysis and follow-up actions from the Board Workshop on Staff Survey/WRES and WDES. It was noted that despite high appraisal completion rates, a significant proportion of staff felt appraisals did not help them improve in their roles.
- Trust Integration Programme – People and Culture elements - Discussed about critical deliverables for People & Culture workstream. An external partner, CoCreate, has been commissioned to support the cultural change work.
- National Oversight Framework – Sickness Absence – Committee received updates. Progress on both was steady with improvements being made. The update also set out key areas of focus for the coming period. Also noted the 'Managing Long Term Sickness Audit report' where Significant Assurance had been provided.
- Guardian of Safe Working Hours Report – Q3/Q4 and Annual Report – Provided the Committee with an update around national changes to terms and conditions for resident doctors, exception reporting reforms and local implementation. Committee welcomed Dr Baljit Karda, the Guardian of safe working from June 2026.

Risks Discussed and New Risks Identified

Risk of not having a sustainability lead.

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

The Committee provides the following levels of assurance to the Board on these strategic risks:	Risk score (current)	Overall level of assurance provided that the strategic risk is being managed (or not)	Additional comments
Risk 3 Culture of Engagement and Inclusivity If we fail to foster and support an organisational culture of learning, continuous improvement, inclusivity, and speaking up—particularly during periods of organisational change—there is a risk of reduced staff engagement and could impact on our ability to provide high-quality, safe care for the people who use our services.	9 (high)	Reasonable	
Risk 6 Staff health and wellbeing There is a risk that insufficient focus on the health, wellbeing, and engagement of staff will lead to increased sickness	12 (high)	Reasonable	Noted the ongoing risk around the need to appoint a Sustainability Manager. The positive aspects from the Employee story were highlighted.

Committee Escalation and Assurance Report

absence, burnout, and workforce instability. This may result in reduced capacity and diminished quality of care.			

Author:	Helen Robinson/Rachel Booth
Role:	Company Secretary/Committee Chair
Date:	19/06/26

Agenda item:	2026-27 (15)
Title of report:	**Significant Risks and Risk Assurance Report**
Meeting:	Trust Board
Date:	23 July 2026

Presented by:	Dr Sara Munro
Prepared by:	Anne Ellis, Risk Manager

Purpose of the report:		
The report provides the Trust Board with an overview of the Trust's clinical and operational risks currently scoring 15 or above, and an overview of the risks scoring 12. This is based on information extracted from the Datix risk module on 1 July 2026.	Approval	
	Discussion	
	Assurance	✓

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

Summary of Key Issues:
At the date of this report (1 July 2026): • There are 121 open risks on the risk register, 27 of which have been managed to the target level. • One risk scores 15 (extreme) and 19 risks score 12 (high) • There are 3 risks that score 12 or above that have been the same score for more than 12 months (static). • Patient harm is the most common risk theme, followed by compliance with standards and legislation and demand exceeding capacity.

Previously considered by:	Risk Management Group 16 June 2026 Quality Committee 14 July 2026 Business Committee 21 July 2026
Outcome of previous discussion/s:	See Committee Chair Assurance Reports

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

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

Recommendation(s)	• Note the changes to the significant risks since the last risk report was presented to the Board; and • Consider whether the Board is assured that planned mitigating actions will reduce the risks.

List of Appendices:	No appendices

Significant Risks and Risk Assurance Report

1. Introduction

1.1 The risk register report provides the Board with an overview of the Trust's material risks currently scoring 15 and above (extreme risks). It summarises all risk movement, the risk profile, themes and risk activity since the last risk register report was received by the Board (May 2026).

1.2 The Board's role in scrutinising risk is to maintain a focus on those risks scoring 15 or above (extreme risks) and to be aware of risks currently scoring 12 (high risks).

1.3 The report seeks to reassure the Board that there is a robust process in place in the Trust for managing risk. Themes identified from the risk register have been aligned with the BAF strategic risks to advise the Board of potential weaknesses in the control of strategic risks, where further action may be warranted.

2. Risk register movement

2.1 The table below summarises the movement of risk since the last risk register report.

	Current	Previous (May)
Total Open Risks	121	123
Risks Scoring 15 or above	1	2
New Risks	12	17
Closed Risks	14	15
Risk Score Increasing	4	0
Risk Score Decreasing	9	10

2.2 There is one extreme risk on the risk register (scoring 15 or more), a reduction from two. The following updates have been provided to risks scoring 15 (extreme) since the last risk register report in May 2026.

Risk	Risk Type	Current Score	Months at current score	Risk Appetite
1383: Mind Mate Neurodevelopmental Referral Triage Waiting List	**Operational**	**15**	**9**	**Cautious (4 – 6)**
As of June 2026, Northpoint reported that 1,154 families remain on the neurodevelopmental (ND) waiting list. A staged plan has been agreed for those still awaiting assessment. This will involve reviewing information held across clinical systems to identify families who wish to proceed with either a neurodevelopmental assessment or a needs-led approach. Where individuals are deemed clinically suitable, they will be offered the opportunity to progress to a provider of their choice. Clinical oversight of risk will be maintained throughout this process, with clinicians continuing to monitor and manage any identified risks. (Update: 26/06/2026)				
1179: Impact/Management of routine Neurodevelopmental (ND) Assessment Waiting List	**Operational**	**Reduced from 15 to 9**	**1**	**Cautious (4 – 6)**
The risk title has been amended to reflect routine neurodevelopmental (ND) assessments, as this risk relates specifically to the routine ND pathway. All complex ND assessments continue to be completed within the agreed 18-week timeframe. The risk score has been reduced from 15 to 9 to better reflect the current risks associated with the routine ND waiting list. This reduction recognises that, for most children and young people awaiting assessment, the level of risk is known to the service and is being appropriately managed (updated 08/06/2026). The reduction in risk score was reported to the Risk Management Group (RMG) in June through the CBU risk register update.				

3. Summary of risks scoring 12 (high)

3.1 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by the Board is not limited to extreme risks. Senior managers are sighted on services where the quality of care or service sustainability is at risk; many of these aspects of the Trust's business being reflected in risks recorded as 'high' and particularly those scored at 12. The Quality and Business Committees have oversight of risks categorised as 'high' (risks scored at 8 – 12).

3.2 The table below shows the 12-month trend for the risks currently scoring 12 and 15+

Ref	Title	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
1383	Mind Mate Neurodevelopmental Referral Triage Waiting List				15 →	15 →	15 →	15 →	15 →	15 →	15 →	15 →	15 →
954	Diabetes Service waiting times	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
1125	National supply issues with enteral feeding supplies by Nutricia	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
1221*	Likelihood of a cyber attack	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
1313**	Climate Adaptability Resilience Planning	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
1336	The reporting of Health and Safety, Fire Safety, Security and Moving and Handling accidents and incidents	12 →	12 →	6 ↓	6 →	6 →	6 →	6 →	6 →	6 →	6 →	6 →	12 ↑
1357	Capacity of PSII trained investigators										12 →	12 →	12 →
1366	Manual STI test requests risk patient safety and increase operational burden					12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →

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

**Risk 1313 – The Trust will describe its compliance with Task Force on Climate-Related Financial Disclosures (TCFD) within the 2025/26 annual report and accounts. If the Auditors are satisfied with the Trust's declaration this risk will be closed.

Ref	Title	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
1373	Complaint actions						12 →	12 →	12 →	12 →	12 →	12 →	12 →
1379	Civil unrest / protests, staff safety					12 →	12 →	12 →	12 →	12 →	12 →	12 →	12 →
1395	Decommissioning and disposing risk of non-concordance with the organisational process for medical devices.				12 →	9 ↓	9 →	9 →	9 →	9 →	9 →	9 →	12 ↑
1412	Delayed development of EQIA					9 →	9 →	9 →	9 →	9 →	9 →	9 →	12 ↑
1444	Clinical governance vacancies/absences and increased demand										12 →	12 →	12 →
1462	Occupational health support and compliance										12 →	12 →	12 →
1467	Clinical And Safeguarding Supervision Portal (CASSP) - Compliance Data										12 →	12 →	12 →
1470	Staff shortages and high demand in the Triage Hub and Response Team leads to patients not receiving timely and necessary care.										12 →	12 →	12 →

Ref	Title	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
1473	Water Safety										12 →	12 →	12 →
1487	ICAN Admin Typing Backlog											12 →	12 →
1489	Achievement of financial balance 2026/27												12 →
1490	Availability of capital 2026/27												→

3.3 Since the previous report in May, the number of risks with a score of 12 has increased from 16 to 19. This reflects the addition of three new risks scoring 12 and a further three existing risks that have increased to a score of 12. Offsetting this increase, one risk previously scored at 12 has reduced to below 12 and two risks scoring 12 have been closed.

3.4 In the previous report, one risk scoring 12 or above had remained at the same score for more than 12 months and was therefore classified as static. Since then, this risk has reduced to below a score of 12. However, three additional risks have now exceeded the 12-month threshold without a change in score, resulting in an overall increase in the number of static risks since the last reporting period.

When risk scores have been static for over 12 months, the detail is escalated to the Board Committees. Static risks are also a standing agenda item at the Risk Management Group (RMG). A risk that remains static over several months, may be an indication that further work is needed to control the risk. Highlighting risks that have been static in score focusses discussion on whether more can be done to manage a static risk, or whether the risk should be accepted at the level it has reached.

4. Risk profile – all risks

4.1 The total number of risks on the risk register is currently 121. Of these there are 52 clinical risks and 69 operational risks. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	2	1	0	0	3
4 - Major	1	5	6	0	0	12
3 - Moderate	2	25	30	13	0	70
2 - Minor	0	11	17	3	1	32
1 - Negligible	1	1	1	1	0	4
Total	4	44	55	17	1	121

5. Risks by theme and correlation with Board Assurance Framework strategic risks*

5.1. For this report the high risks (scoring 8 and above) on the risk register have been themed where possible according to the nature of the hazard and the effect of the risk and then linked to the strategic risks on the Board Assurance Framework. This themed approach gives a holistic view of the risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance on the management of risk.

5.2 Themes within the current risk register are as follows:

Theme One: Patient Safety	
The strongest theme across the whole risk register is the risk to patient safety for example, because of capacity exceeding demand, primary care industrial action, and process transformation. Specifically, 30 risks relate to patient safety[1]	The strategic risks directly linked to patient safety are: 1. High Quality Care 2. Demand for Services
Theme Two: Compliance with Standards/Legislation	
The second strongest risk theme is compliance with standards/ legislation[2]. This includes health and safety, compliance with information governance and cyber security, and business continuity and emergency planning.	All strategic risks have an associated compliance element relating to applicable standards, regulations, and legislation.
Theme Three: Demand for Services	
There is also a risk theme relating to demand for services exceeding capacity, due to an increase in service demand and high numbers of referrals[3]	The strategic risks directly linked to demand for services are: 2. Demand for services 6. Staff Health and Wellbeing 7. Failure to reduce inequalities experienced by the population we serve 8. System change (including Trust Integration Programme)
Theme Four: Transformation of services - Impact	
Three risks relate to transformation of services and concern the impact on staff and patients and equity of care[4]	The strategic risks directly linked to the Quality and Value programme are: 1. High Quality Care 4. Financial Sustainability 7. Failure to reduce inequalities experienced by the population we serve 9. Infrastructure

[1] Risks: 1109, 1125, 1168,1169, 1187, 1196, 1285, 1307, 1319, 1353, 1354, 1356, 1357, 1365, 1366, 1369, 1373, 1374, 1392, 1393, 1395, 1414, 1419, 1426, 1437, 1453, 1470, 1478, 1485, 1487

[2] Risks: 902, 1206, 1221, 1242, 1313, 1336, 1379, 1400, 1415, 1422, 1428, 1434, 1444, 1462, 1463, 1465, 1467, 1468, 1473, 1479

[3] Risks: 772, 954, 1098, 1179, 1311, 1383. 1433

[4] Risks: 1412, 1459, 1490

6. Next steps

Risks will continue to be managed in accordance with the risk management policy and procedure, and the Board will receive an update report at the meeting to be held on 17 September 2026.

7. Recommendations

The Board is recommended to:

- Note the changes to the significant risks since the last risk report was presented to the Board; and
- Consider whether the Board is assured that planned mitigating actions will reduce the risks.

Author: Anne Ellis, Risk Manager
Date written: 3 July 2026

Agenda item:	2026-27 (16)
Title of report:	Board Assurance Framework 2026-27
Meeting:	Trust Board Held In Public
Date:	23 July 2026

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

Purpose of the report:		
This report summarises the process undertaken to review the BAF in readiness for the 26/27 financial year, and shares the draft Strategic Risks and suggested risk appetite with the Board for review and approval.	Approval	✓
	Discussion	
	Assurance	

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

Summary of Key Issues:
• Comprehensive process undertaken for reviewing the BAF for 2026/27 with individual Directors, Trust Leadership Team, and the assurance Committees which oversee strategic risks. • Quarterly reviews will continue throughout 2026/27.

Previously considered by:	The draft strategic risks have been reviewed in Trust Leadership Team, Business, Quality, Audit and People and Culture Committees during June/July 2026. Further to this, the Audit Committee reviewed the process for developing the 26/27 BAF in July 2026 and was satisfied that it had been robust.
Outcome of previous discussion/s:	Committees were satisfied with the proposed strategic risks, and suggested risk appetite levels for new risks, and reviewed the detail for any gaps in controls or sources of assurance.

Link to strategic goals: (Please tick any applicable)	
Work with communities to deliver personalised care	✓
Use our resources wisely and efficiently	✓
Enable our workforce to thrive and deliver the best possible care	✓

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

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes		What does it tell us?	
	No	✓	Why not/what future plans are there to include this information?	The Trust continues to have a strategic risk focussing on reducing inequalities experienced by the population we serve

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

List of Appendices:	Appendix 1 – BAF_2026-27 Appendix 2 – Draft Risk Appetite Statement for 2026-27

Board Assurance Framework 2026/27

1. Introduction

1.1 The Board Assurance Framework (BAF) provides a robust foundation to support our understanding and management of the risks that may impact on the delivery of our strategic objectives for 2026/27.

1.2 Overall responsibility for the Board Assurance Framework (BAF) sits with the Chief Executive, with the Company Secretary coordinating the movement of the document through its governance pathway and providing check and challenge to the content.

1.3 The Board of Directors is responsible for reviewing the BAF to ensure that there is an appropriate spread of strategic objectives and that the main risks have been identified.

1.4 Each strategic risk within the BAF has a designated (Executive) Director lead, whose role includes routinely reviewing and updating the risks on a quarterly basis:
• Testing the accuracy of the current risk score based on the available assurances and/or gaps in assurance
• Monitoring progress against action plans designed to mitigate the risk
• Identifying any risks for addition or deletion
• Where necessary, commissioning a more detailed review or ‘deep dive’ into specific risks.

2. Review of Strategic Risks

2.1 Following a discussion in April 2026 of the Trust's strategic framework for 2026/27, a full review of the BAF has been undertaken by the Trust Leadership Team to ensure that it is reflective of the associated high-level risks aligned to the objectives. The BAF in Appendix A is now populated with the nine strategic risks for the next year, and Board sub-Committees with responsibility for overseeing strategic risks have reviewed and agreed their proposed risks and sources of assurance during June/July 2026. Approval is now sought from the Board for the BAF for 2026/27.

2.2 The draft strategic risks were reviewed in parallel between Leeds and York Partnership NHS Foundation Trust and Leeds Community Healthcare NHS Trust, with a view towards bringing the two Board Assurance Frameworks together upon integration. Strategic Risk 9: System change (including Trust Integration Programme) is mirrored on both BAFs, and further work will be undertaken during 2026/27 to develop an integrated BAF for the new organisation.

2.3 The risk appetites were most recently reviewed by the Board in January 2026, and the appetites for the new strategic risks (SRs 3, 8 and 9) were proposed by the Trust Leadership Team in May 2026. Further detail on the risk appetite for each strategic risk can be found in Appendix 2.

2.4 During 2026/27 the Board will continue to review the full BAF on a quarterly basis, including the latest assessment of the Trust's strategic risks, key changes since the last review, and the levels of assurance agreed by Committees between Board meetings. It will also continue to receive assurance reports via the Committees on whether the risks are being effectively controlled.

3. Recommendations

The Board is recommended to:

- Note the process for review of the strategic risks, gaps in controls and sources of assurance for 2026/27.
- Approve the Strategic Risks for 2026/27 or make recommendations for further amends.
- Review and approve the risk appetite for all 2026/27 strategic risks.

Helen Robinson
Company Secretary

10 July 2026

Board Assurance Framework (BAF) 2026/2027

Introduction

The Board Assurance Framework (BAF) provides the Board with a register of strategic risks that have the potential to impact on the achievement of the Trust's strategic objectives (goals) and gives assurances that the risks are being managed effectively. The Framework highlights key controls and assurances.

Where gaps are identified, or key controls and assurances are insufficient to manage the risk to acceptable levels (within the Trust risk appetite), action needs to be taken. Planned actions will enable the Board to monitor progress in addressing gaps or weaknesses and to ensure that resources are allocated appropriately.

The risk appetite relates to the Trust's willingness to take risks / opportunities to achieve the strategic goals, the risk tolerance score indicates the maximum acceptable risk. Risk appetite and risk tolerance are used to support decision making at a strategic level.

Assurance

The Board receives the BAF quarterly. The risks aligned to the Board Committees are also reported to the relevant Committee bi-monthly, where the relevant Committee agrees a level of assurance for each risk.

The BAF provides the basis for the preparation of a fair and representative Annual Governance Statement. It is the subject of annual review by both Internal and External Audit.

Trust Objectives (Strategic Goals)

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

Trust Priorities for 2026/27 (Wildly Important Goals)

- Support rollout of the Neighbourhood Health Model across the Leeds system including active participation in the National Neighbourhood Health Implementation Programme.
- Drive improvements in our National Oversight Framework position through staff engagement, reducing waiting lists, minimising sickness absence, and boosting productivity.
- Transform our services through Year 3 of the Quality and Value programme to deliver more effective, equitable, and financially balanced patient care and embed continuous quality improvement as standard practice through a QI-enabling plan.
- Oversee and implement the integration of LYPFT and LCH to improve patient care delivery and optimise resources.

Risk Scoring

Each strategic risk is assessed (measured) in terms of consequence (how bad could it be) and likelihood (how likely is it to happen). The risk score is calculated by multiplying the consequence by the likelihood.

To maintain an objective and consistent approach across the organisation, the Trust's risk assessment matrix is used to 'score' each risk, see below:

LIKELIHOOD / CONSEQUENCE	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost Certain (5)
Catastrophic (5)	5	10	15	20	25
Major (4)	4	8	12	16	20
Moderate (3)	3	6	9	12	15
Minor (2)	2	4	6	8	10
Negligible (1)	1	2	3	4	5

Summary of Strategic Risks as of 21 May 2026

Ref	Strategic Risk	Lead Director	Current Score (May 2026)	Target Score (2026/27)	Position at the start of 2026/27
1	**High Quality Care:** If we fail to identify, deliver, and sustain high-quality care – supported by a strong culture of learning and continuous improvement in relation to patient care - there is an increased risk of unsafe or ineffective services. This may lead to preventable harm, poor patient outcomes, and a diminished patient experience.	Executive Director of Nursing and Allied Health Professionals	16	12	The current risk score remains unchanged from the position at the end of 2025/26, as there has been no material shift in the level of risk or strength of controls. The Trust continues to operate under significant pressure in balancing financial requirements alongside the need to maintain and improve clinical quality. While quality oversight processes are in place and providing assurance on key trends and themes, there remains insufficient evidence of sustained improvement to support a reduction in the risk score. The impact of the Quality and Value (Q&V) transformation programme has not yet been fully realised, and forthcoming Trust integration activity is expected to introduce further organisational change, which may affect consistency in delivery of high-quality care. In addition, there is increased risk associated with recent changes in Executive leadership and the current position of the clinical governance team due to capacity constraints. Given these factors, the likelihood and consequence of the risk remain unchanged, and the current risk score is maintained.
2	**Demand for services:** If we fail to respond to changes in population growth and presentation, and changing delivery models such as Neighbourhood Health, then the impact will be potential harm to patients due to long waits, inability to strengthen equity of access, additional pressure on staff, financial consequences and poor performance as measured through the National Oversight Framework.	Executive Director of Operations	12	12	At the start of 2026/27, the risk remains at the target score of 12, reflecting a moderate and controlled level of risk with effective mitigations in place. Demand across services continues to increase, placing ongoing pressure on waiting lists. However, there has been progress in reducing backlogs, and the Trust is working towards eliminating 18+ week waits by March 2027. While improvements are evident, reductions in waiting times are not yet consistent across all services, and some areas remain above the Trust's risk appetite for patient care, requiring focused action. The Trust also remains in NOF segment 3, meaning further sustained improvement is needed. Overall, the score reflects that risks are being managed effectively, with patient safety and quality maintained, although continued effort is required to achieve consistent performance.
3	**Culture of Engagement and inclusivity:** If we fail to foster and support an organisational culture of learning, continuous improvement, inclusivity, and speaking up—particularly during periods of organisational change—there is a risk of reduced staff engagement and could impact on our ability to provide high-quality, safe care for the people who use our services.	Chief Executive Officer / Director of People	9	6	There is strong evidence that a positive and open culture is being actively promoted. Staff survey results and Freedom to Speak Up (FTSU) reporting indicate that staff feel able to raise concerns, contributing to a culture of transparency and continuous learning. These mechanisms support early identification of issues and enable timely intervention. Structured assurance processes are also in place, including a programme of Board member service visits, which provide direct oversight of frontline services and reinforce leadership visibility and engagement with staff. Intention planning supports proactive focus on areas requiring improvement, while the organisation demonstrates responsiveness to identified "hot spot" areas through targeted actions. Despite these strengths, there remains a possible risk due to the scale and complexity of services and variation in operational pressures, which can impact consistency in culture across all areas. Should this risk materialise, the consequence is assessed as moderate, as any deterioration in culture could impact the quality and safety of care, though existing controls are likely to mitigate more severe outcomes.
4	**Financial sustainability:** There is a risk that a lack of financial efficiency and sustainability results in the destabilisation of the organisation and an inability to meet our objectives.	Executive Director of Finance and Resources	12	8	The scale of financial challenge across the NHS is significant, rising demand for services and inflationary cost pressures are increasing the levels of efficiency and productivity required of all organisations. The Trust has established a Quality and Value programme that has supported successful delivery of the financial plan in 2025/26 with increasing emphasis on recurrent savings. This means the Truist is entering the 2026/27 financial year in a strong financial position. Whilst delivery of the financial plan is not without risk, we have a strong operational plan that supports the conditions to deliver financial balance.
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.	Executive Director of Operations	12	8	At the start of 2026/27 there is no change to the risk score. Actions relating to climate adaptability, business continuity and EPRR resilience are ongoing. While there are no material gaps in relation to cyber, the external environment warrants retaining the current score of 12.
6	**Staff health and wellbeing:** There is a risk that insufficient focus on the health, wellbeing, and engagement of staff will lead to increased sickness absence, burnout, and workforce instability. This may result in reduced capacity and diminished quality of care.	Director of People	12	9	The sickness reduction programme is well underway and aligns with the broader theme of organisational health. An evidence-based approach has been developed and successfully tested within a specific service and is now being rolled out across other services. This approach utilises data and evidence relating to sickness absence, enabling targeted interventions where they are most needed. The latest Staff Survey results have been maintained across all People Promise themes compared to last year. This is a positive outcome, particularly in the context of ongoing Quality & Value (Q&V)

Ref	Strategic Risk	Lead Director	Current Score (May 2026)	Target Score (2026/27)	Position at the start of 2026/27
					work and the recent announcements regarding the Trust Integration Programme and should be recognised as an achievement. However, given the scale and pace of organisational change, alongside continued (albeit reducing) high levels of sickness absence, the risk score appropriately remains at 12. Should sickness rates continue to decline, there is a clear trajectory to support a reduction of this risk score to 9.
7	**Failure to reduce inequalities experienced by the population we serve:** If the Trust fails to address the inequalities built into our own systems and processes, there is a risk that we are inadvertently delivering unfair access or care and exacerbating inequalities in health outcomes within some cohorts of the population.	Medical Director	12	9	• Likely (4) as inequity is (inadvertently) embedded within existing systems and processes and therefore continuation of business as usual is likely to create inequity. • We have identified some areas where inequality exists in our current services and processes and as our breakdown of data analysis increases awareness of inequity, we can drive action to reduce inequalities. • Consequence is both outcomes for population at risk of inequity and consequence for the Trust (e.g. for failure to comply with statutory duties relating to equity) • Work has begun to embed action to address inequity, but change is slow for such a pervasive issue At the start of 2026/27 there is no change to the risk score. Actions are on-going in relation to the development of health equity data dashboard and strategy. It should be noted that the changes at ICB/DHSC, integration with LYPFT and development of the Provider Alliance impacts on the ability of the city to prioritise health equity development work. In addition, the Public Health Consultant role has been vacant since August 2025.
8	**System change (including Trust Integration Programme):** There is a risk that the Trust is unable to deliver on its medium-term plan if it cannot adequately engage in, influence and adapt to the significant changes that are taking place within NHSE/DHSC, the West Yorkshire ICB and the Trust Integration programme with LYPFT.	Chief Executive	8	3	At the start of 2026/27, the risk score of 8 is carried over from 2025/26. There is no change to the risk score due to scale of changes at the ICB, the Trust integration programme with LYPFT and uncertainty on changes at NHSE/DHSC. The Trust remains actively involved in shaping the Leeds provider partnership and joint committee. The Trust will maintain oversight of capacity to respond to changes.
9	**Infrastructure:** If the Trust is unable to provide access to safe and fit for purpose digital and estate infrastructure then there is a risk that the quality and continuity of service provision will be compromised which may further impact achievement of all of the Trusts strategic goals and priorities.	Executive Director of Finance and Resources	12	6	The risk has been assessed as 12 due to the potential major impact of poor-quality estate and digital infrastructure on service provision, particularly in the context of emerging service delivery models such as neighbourhood health. Limitations in the current estate may reduce the organisation's ability to support more integrated, community-based models of care. This risk is also linked to SR5, as the digital infrastructure remains vulnerable to cyber threat. Following assessment of the existing controls, the likelihood of this risk materialising is considered possible. At the start of the year, the risk relating to the organisation's ability to invest in and modernise estate and infrastructure is heightened, particularly where estate constraints may not support evolving service models. This is driven by uncertainty at the beginning of the year regarding the availability of capital for 2026/27, which may limit the organisation's capacity to deliver the required improvements.

Strategic Risk 1:

High Quality Care:

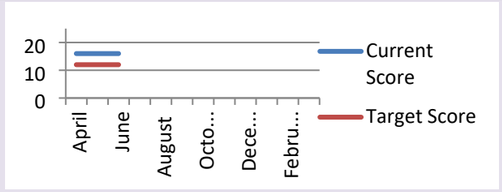
If we fail to identify, deliver, and sustain high-quality care – supported by a strong culture of learning and continuous improvement in relation to patient care - there is an increased risk of unsafe or ineffective services. This may lead to preventable harm, poor patient outcomes, and a diminished patient experience.

Lead Director/risk owner: Executive Director of Nursing and Allied Health Professionals

Committee with oversight: Quality Committee

Date last reviewed: 8/5/26

Risk Rating
(likelihood x consequence)
Current score:
4 x 4 = 16
Target score (end of 2025/26):
3 x 4 =12



Risk Appetite	Cautious
Tolerance score	4-6
Status: In or out of Appetite	Out

Rationale for Current Risk Score:
The current risk score remains unchanged from the position at the end of 2025/26, as there has been no material shift in the level of risk or strength of controls. The Trust continues to operate under significant pressure in balancing financial requirements alongside the need to maintain and improve clinical quality. While quality oversight processes are in place and providing assurance on key trends and themes, there remains insufficient evidence of sustained improvement to support a reduction in the risk score.
The impact of the Quality and Value (Q&V) transformation programme has not yet been fully realised, and forthcoming Trust integration activity is expected to introduce further organisational change, which may affect consistency in delivery of high-quality care. In addition, there is increased risk associated with recent changes in Executive leadership and the current position of the clinical governance team due to capacity constraints.
Given these factors, the likelihood and consequence of the risk remain unchanged, and the current risk score is maintained.

Rationale for Target Score (including any constraints to reaching risk appetite within the next 12 months):
The current elevated risk score of 16 reflects the Trust's position in relation to the Quality and Value (Q&V) transformation programme, where the full scope and impact of changes to patient pathways are not yet fully understood. In addition, the Trust Integration Programme introduces further uncertainty regarding the potential effects on care quality, consistency, and patient outcomes.
Given this uncertainty, it is appropriate to maintain a higher level of risk in the short term. As transformation activity progresses and mitigation actions begin to take effect, the risk is expected to reduce to 12 by the end of 2026/27. This reduction will be supported by improved clarity on programme delivery, strengthened oversight arrangements, and emerging evidence of improvement, although some residual uncertainty will remain.
Due to the scale, complexity, and timeframe of these transformation programmes, it is not anticipated that the risk will fall within the organisation's risk appetite within the 2026/27 period. A further reduction towards the target score of 6 is expected in subsequent years, as improvements are embedded, sustained outcomes are evidenced, and the impact of organisational change becomes clearer.
This phased approach (16 → 12 → 6) reflects a realistic and controlled trajectory for risk reduction, aligned to the pace of transformation and system change.

Controls *(what are we currently doing about the risk?)*:

- Learning and Development Strategy
- Annual Clinical Audit Programme
- IPR (medicines management)
- Health Equity Strategy
- Clinical Risk Management
- Infection Prevention and Control (IPC) Strategy
- Clinical Supervision
- Quality Challenge+ & Process
- Quality Strategy
- Engagement Principles
- EQIA process
- Safeguarding Strategy
- Children's strategy
- Patient Safety Incident Response Framework (PSIRF) and Plan (PSIRP)
- Research and Development Strategy
- CQC preparedness and single assessment framework processes
- Patient Safety Partners playing active part in Trust safety
- Service re-design steering group
- Corporate redesign steering group
- Q&V Board
- Trust movement to Statistical Process Controls (SPC) reporting including safety domains
- AAA reporting from business units and clinical governance workstreams to QAIG
- Quarterly Patient Safety Summits
- Internal audit schedule
- Organisation wide approach to change inc. quality improvement
- Professional registration procedures
- NICE guidance monitoring
- Mortality review process
- Duty of candour monitoring process
- Quality improvement programme – in response to incidents / external recommendations
- Patient experience process

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
There is a gap in control in relation to the implementation of the new CQC Single Assessment Framework, aligned with the Quality Challenge+ programme. Actions are in play to comply with best practice and CQC requirements.	Executive Director of Nursing and AHP's.	July 2026
As a result of Quality and Value service redesign, a gap in control has been identified relating to the leadership structure. To address this, a leadership restructure is underway. This will be a two-year process – the target date relates to part one of the process.	Executive Director of Nursing and AHP's and Executive Director of Operations	Sept 2026
Due to concerns raised about the mortality review process and independent review of the end-to-end process has commenced with changes planned to be implemented by Q3.	Executive Director of Nursing and AHP's.	Oct 2026

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance

• IPC Board Assurance Framework
• Health Equity report
• (Patient) Engagement report
• Service spotlights at Committee
• Business cases for new service or service transformation (quality scrutiny)
• Patient safety (including patient safety incident investigations) update report
• Safeguarding annual report
• Learning and development report
• IPC Annual report
• Quality Account
• PSIRP (Y2/3 org plan)
• Quality Strategy Report
• AAA reporting from business units and clinical governance workstreams to QAIG
	• Performance Brief (safe, caring effective)
	• Mortality report
	• QAIG assurance reports and minutes
	• Risk report
	• Safeguarding Committee minutes and AAA report to Quality Committee
	• IPC Committee minutes and AAA report to Quality Committee
		• Internal Audit:
		  ○ CQC Inspection Preparedness (Q2)
		  ○ Quality and Clinical Governance (Q4)
		  ○ Safeguarding Sexual Safety (Q2)
		  ○ Recording and Learning from deaths (Q2/3)
		  ○ Datix (Q2)
		• Patient experience report: complaints, concerns, and feedback
		• Regulatory inspection reports

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
There is a gap in assurance in relation to consistent, timely availability of data across services through to Board. To address this gap testing of data capture will be finalised and embedded into services.	Executive Director of Nursing and AHP's.	Sept 2026

Link to Risk Register (material scoring 12 or above):

1179: Impact/Management of Neurodevelopmental Assessment Waiting List (15)
1383: Mind Mate Neurodevelopmental Referral Triage Waiting List (15)
954: Diabetes Service waiting times (12)
957: Increase in demand in the adult speech and language therapy service (12)
1125: National supply issues with enteral feeding supplies by Nutricia (12)
1357: Capacity of PSII trained investigators (12)
1366: Manual STI test requests risk patient safety and increase operational burden (12)
1373: Complaint actions (12)
1384: Mind Mate Mental Health Referral Triage Waiting List (12)
1395: Decommissioning and disposing risk of non-concordance with the organisational process for medical devices (12)
1412: Delayed development of EQIA (12)
1444: Clinical governance vacancies/absences and increased demand (12)
1467: Clinical and Safeguarding Supervision Portal (CASSP) – Compliance Data (12)
1470: Staff shortages and high demand in the Triage Hub and Response Team leads to patients not receiving timely and necessary care.

Strategic Risk 2:

Demand for services:

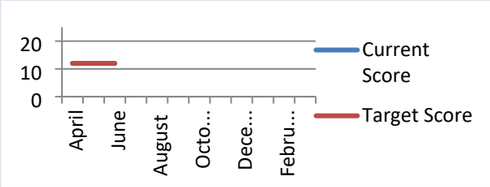
If we fail to respond to changes in population growth and presentation, and changing delivery models such as Neighbourhood Health, then the impact will be potential harm to patients due to long waits, inability to strengthen equity of access, additional pressure on staff, financial consequences and poor performance as measured through the National Oversight Framework.

Lead Director/risk owner: Executive Director of Operations

Committee with oversight: Quality and Business Committees

Date last reviewed: 12/5/26

Risk Rating
(likelihood x consequence)
Current score:
3 x 4 = 12
Target score (end of 2026/27):
3 x 4 = 12



Risk Appetite	Seek
Tolerance score	15-20
Status: In or out of Appetite	In

Rationale for current risk score:
At the start of 2026/27, the risk remains at the target score of 12, reflecting a moderate and controlled level of risk with effective mitigations in place.
Demand across services continues to increase, placing ongoing pressure on waiting lists. However, there has been progress in reducing backlogs, and the Trust is working towards eliminating 18+ week waits by March 2027.
While improvements are evident, reductions in waiting times are not yet consistent across all services, and some areas remain above the Trust's risk appetite for patient care, requiring focused action. The Trust also remains in NOF segment 3, meaning further sustained improvement is needed.
Overall, the score reflects that risks are being managed effectively, with patient safety and quality maintained, although continued effort is required to achieve consistent performance.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The target risk score of 12 reflects the Trust's intention to maintain a controlled and stable level of risk, recognising the ongoing pressures associated with demand and waiting times. While further improvement is expected, it is not considered appropriate to reduce the risk below this level as this could constrain service delivery and transformation activity.
The current score of 12 is within risk appetite, with the defined tolerance range set at 15–20. As the current score sits below this threshold, it demonstrates that the Trust is operating in a controlled and relatively risk-averse position compared to its stated appetite.
This position suggests there is capacity to take on additional measured risk to support innovation and transformation, provided that controls remain effective and patient safety and quality of care are not compromised.
Maintaining the target score at 12 therefore supports a balanced approach, enabling continued progress in reducing waiting times and improving services, while ensuring risks remain well managed and within acceptable limits.

Controls *(what are we currently doing about the risk?)*:

- Waiting list management and clinical triage within each service
- Communication with patients
- Incident monitoring and analysis
- Demand and capacity planning tool
- Continued support of 'harder to engage' populations through existing services
- Cancelled and rescheduled visits monitoring and action
- Commissioner involvement at Contract Management Board
- Performance panels
- Business continuity plans
- Winter plan 2024/25
- Review of capacity in Neighbourhood teams
- Front of House training for awareness of hearing and sight impediments – 4 sessions / year
- Neurodiversity assessments waiting list – right to choose offered to parents
- Access LCH Group
- Waiting List Dashboard – size and length of wait and by IMD deciles – drives investigation and actions
- Northpoint contract / contract management – MindMate SPA

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
There is a gap in control relating to the management of waiting lists. The Quality and Value programme is a three-year programme that includes the following to improve the waiting list position: • Transformation programme to improve prioritisation and flow, • Service review, review of access criteria and ways of providing services. • A continue pipeline of business cases will be maintained to address specific services as funding allows. Completed year 1, different services have been included for year 2.	Executive Director of Operations	Year 3 Mar 2027
Further actions to address the gap in control relating to the management of waiting lists include: • Waiting list initiatives have been identified and costed and are in the process of implementation with a view to eliminating 52 week waits and where possible 18+ week waits by end March 2027. • Waiting lists that require external support (neurodevelopmental assessment), working with the System to agree where routine children will go if not eligible for LCH service.	Executive Director of Operations	31 March 27
There is a gap in control relating to the ability to optimise staffing to align workforce with patient demand. To address this the Trust is implementing e-allocate. In the process of being implemented.	Executive Director of Operations	Dec 2026

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Service spotlight/focus (QC/BC) • Business cases (BC) • Change programme report (BC)	• Risk register report (QC/BC) • Patient Safety (including patient safety incident investigations) update report (QC)	• Patient Experience report (complaints, concerns, claims) (QC) • Scrutiny Board minutes (TB)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by

• Performance panel (BC) – Sept 2024 BC position statement on waiting lists • Waiting List report (BC) • Access LCH process – (BC) • Organisation Strategy Update (BC/QC) • Waiting List dashboard (BC) • NOF metric assurance and oversight reporting (Board)	• Performance Brief (Responsive: waitlists) (QC/BC) • Mortality report (QC) • Safe staffing report (QC/BC) • Significant contracts performance (BC) • Health Equity report (QC/BC)		

Link to Risk Register (material risks scoring 12 or above):

1179: Impact/Management of Neurodevelopmental Assessment Waiting List (15)
1383: Mind Mate Neurodevelopmental Referral Triage Waiting List (15)
954: Diabetes Service waiting times (12)
957: Increase in demand in the adult speech and language therapy service. (12)
1384: Mind Mate Mental Health Referral Triage Waiting List (12)
1470: Staff shortages and high demand in the Triage Hub and Response Team leads to patients not receiving timely and necessary care. (12)

Strategic Risk 3:

Culture of Engagement and inclusivity:

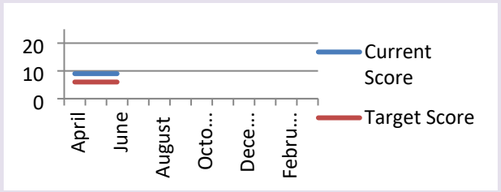
If we fail to foster and support an organisational culture of learning, continuous improvement, inclusivity, and speaking up—particularly during periods of organisational change—there is a risk of reduced staff engagement and could impact on our ability to provide high-quality, safe care for the people who use our services.

Lead Director/risk owner: Chief Executive Officer / Director of People

Committee with oversight: People and Culture Committee

Date last reviewed: 8/5/26

Risk Rating
(likelihood x consequence)
Current score:
3 x 3 = 9
Target score (end of 2025/26):
2 x 3 = 6



Risk Appetite	Cautious
Tolerance score	4-6
Status: In or out of Appetite	Out

Rationale for current risk score:
There is strong evidence that a positive and open culture is being actively promoted. Staff survey results and Freedom to Speak Up (FTSU) reporting indicate that staff feel able to raise concerns, contributing to a culture of transparency and continuous learning. These mechanisms support early identification of issues and enable timely intervention.
Structured assurance processes are also in place, including a programme of Board member service visits, which provide direct oversight of frontline services and reinforce leadership visibility and engagement with staff. Intention planning supports proactive focus on areas requiring improvement, while the organisation demonstrates responsiveness to identified "hot spot" areas through targeted actions.
Despite these strengths, there remains a *possible* risk due to the scale and complexity of services and variation in operational pressures, which can impact consistency in culture across all areas. Should this risk materialise, the consequence is assessed as *moderate*, as any deterioration in culture could impact the quality and safety of care, though existing controls are likely to mitigate more severe outcomes.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
As this is a newly identified strategic risk, a cautious risk appetite has been proposed, this aligns to the risk appetite for SR1 (Quality Care) and SR6 (Workforce). The target score of 6 sits at the upper end of this risk appetite. The ambition is to reduce the likelihood from *possible* to *unlikely* through a continued focus on responding proactively to identified "hot spot" areas and the implementation of intention plans to drive improvement. The potential impact of the integration programme on organisational culture remains uncertain at this stage and will require ongoing monitoring and evaluation.
While the consequence remains *moderate*, reflecting the potential impact on quality and safety should the risk materialise, strengthening of controls and cultural maturity is expected to reduce the probability of occurrence.

Controls *(what are we currently doing about the risk?)*:

- Ask Sara event
- Trust Leadership Network re-established
- Integration engagement events
- Learning and Development Strategy
- Performance Monitoring (Well-led domain)
- Clinical Supervision
- Quality Challenge+ and process
- Board Service visits framework
- Engagement principles
- Service re-design steering group
- Corporate redesign steering group
- Medical staff appraisal process
- Engagement with staff networks
- Staff side engagement through JNCF and JNC
- Freedom to Speak Up Guardian and Champions
- WRES and WDES action plans
- Staff survey locally owned action plan and corporate actions
- People and Culture Committee engagement KPIs

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Service spotlights at Committee (QC/BC) • Learning and development report (QC/TB) • Staff survey analysis at service level via annual staff survey results (PCC) • Sickness absence service level deep dives via sickness absence project update to PCC	• IPR – Well-led (PCC) • 6-monthly Well-Led updates to Board • People and Culture Committee workforce deep dives • CEO report to Board (Board) • People Key Performance Indicators and Data (including well-led Performance Brief Data) (PCC) • Freedom to Speak Up Guardian reports (PCC/TB) • People Inclusion Plan (PCC) • Workforce report (3 x per year) (PCC) • EDI/inclusion action plan updates to PCC • Risk report to P&CC	• Patient experience report: complaints, concerns, and feedback (QC/TB) • Quarterly and annual staff survey results (PCC)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by

	• Annual report to Board (Board) • Medical Director's Report (appraisals info) (QC and Board)		

Link to Risk Register (material operational risks scoring 12 or above):
1379: Political Climate / protests, staff safety (12)
1459: Workforce risks due to scale of organisational change (9*)

*Although this risk scores 9 and falls below the usual threshold of 12 for material risks, it has been included due to its direct relevance and potential impact on this strategic risk.

Strategic Risk 4:

Financial sustainability:

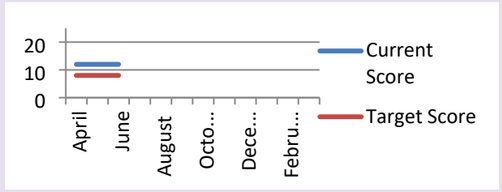
There is a risk that a lack of financial efficiency and sustainability results in the destabilisation of the organisation and an inability to meet our objectives.

Lead Director/risk owner: Executive Director of Finance and Resources

Committee with oversight: Business Committee

Date last reviewed: 5/5/26

Risk Rating
(likelihood x consequence)
Current score:
3 x 4 = 12
Target score (end of 2026/27):
2 x 4 = 8



Risk Appetite	Open
Tolerance score	8-12
Status: In or out of Appetite	In

Rationale for current risk score:
The scale of financial challenge across the NHS is significant, rising demand for services and inflationary cost pressures are increasing the levels of efficiency and productivity required of all organisations. The Trust has established a Quality and Value programme that has supported successful delivery of the financial plan in 2025/26 with increasing emphasis on recurrent savings. This means the Truist is entering the 2026/27 financial year in a strong financial position. Whilst delivery of the financial plan is not without risk, we have a strong operational plan that supports the conditions to deliver financial balance.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months)
The appetite for this risk is open (8-12), whilst remaining compliant with statutory requirements. This will enable the Trust to take measured financial risks that will support innovation and transformation to achieve long-term financial sustainability, improvements to service delivery, patient safety and quality of care. The target score is 8 is at the low end of this appetite.

Controls *(what are we currently doing about the risk?)*:

- Board Approved Annual Plan, revenue, and capital
- Financial controls including budgetary controls are in place with routine performance monitoring and assessment of financial risk/mitigations to inform achievement of the financial plan
- Staff Cost Controls including ECF Process, agency, and temporary staffing controls in place
- Financial Policies (incl. but not limited to SFIs/ Scheme of Delegation /)
- Training programme for Non-Finance Managers
- Quality & Value Programme - Established & Embedded
- Budget Setting Process & Procedures clearly defined.
- Internal Audit assessment of Q&V programme structure (Part 1 and 2)
- Maintenance of Medium-Term Financial Plan
- LCH productivity group established

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
There is a gap in control around medium-term financial planning and identification of recurrent savings for year 2 and 3. To address this the following actions have been identified:		
1. Develop a systematic approach to using benchmarking data to inform the Q&V programme	EDFR	End of Q1 26/27
2. Implementation of IPR process	EDFR	June 26
3. Financial modelling to inform development of full business case (FBC) in relation to Trust integration programme.	EDFR	October 2026

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance

• Procurement Strategy update report
• Performance Panel process
• Quality & Value Programme Board reporting
• Strategy and planning updates (BC)
• Operational Plan Update (BC)
• National Cost Collection report (BC)
	• In Year Financial reporting (performance against plan and forecast out-turn)
	• Financial performance summary report on formal partnerships
	• Risk register report
	• Audit Committee – Reporting of compliance with policies and self-assessment arrangements for financial sustainability
	• Qtly counter fraud report (AC)
	• Fraud annual report (AC)
	• Fraud self-review toolkit (AC)
		• Internal audit
		  ○ Key Financial Controls (Q2)
		  ○ Patient Level Information and Costing System (PLICS) Data Collection (Q3/4)
		• External Audit – Value for Money Assessment
		• National Oversight framework

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
There is a gap in assurance that the Q&V programme delivers recurrent efficiency savings. Reporting on Q&V is well established through committees. There is a gap around triangulation of efficiency savings on performance. To address this the new approach to IPR reporting needs to be embedded.	EDFR	September 2026

Link to Risk Register (material risks scoring 12 or above):
1489: Achievement of financial balance 2026/27 (12)
1490: Availability of capital 2026/27 (12)

Strategic Risk 5:

Failure to maintain business continuity:

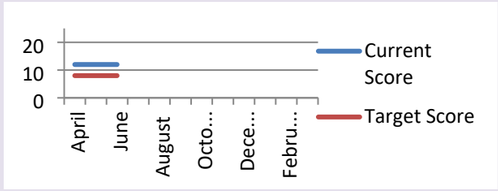
If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.

Lead Directorate/risk owner: Executive Director of Operations

Committee with oversight: Business and Audit Committees

Date last reviewed: 11/5/26

Risk Rating
(likelihood x consequence)
Current score:
3 x 4 = 12
Target score (end of 2026/27):
2 x 4 = 8



Risk Appetite	Minimal
Tolerance score	1-3
Status: In or out of Appetite	Out

Rationale for current risk score:
At the start of 2026/27 there is no change to the risk score. Actions relating to climate adaptability, business continuity and EPRR resilience are ongoing. While there are no material gaps in relation to cyber, the external environment warrants retaining the current score of 12.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The risk appetite for this risk is minimal, the target score for 2026/27 has been set above appetite as an interim target until the actions are progressed. After which further progress is expected toward aligning with risk appetite in 2027/28.

Controls *(what are we currently doing about the risk?)*:

- ICS mutual aid support systems
- Major incident plan
- On-call rota and on-call escalation procedure
- Emergency Preparedness, Resilience and Response (EPRR) framework
- System testing / desk top exercises
- Trust command structure (Gold, Silver, Bronze)
- Business Continuity Plans (and IT disaster recovery plans)
- Information Governance Approval Group (data use and cyber related matters)
- Annual review of cyber resilience
- Data back-up systems (means of data recovery in the event of an attack)
- Technical controls secure the IT estate and data from unintended disclosure, theft or ransom
- Annual data security statutory/mandatory training for all staff
- CareCert Weekly plus High Severity Alert Notifications for up-to-date alerts from NHS Digital to highlight risks
- SIEM (Security Information and Event Management)
- Sustainability and Climate Adaptability Steering Group
- Joint working between LCH and LYPFT EPRR teams

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
There is a gap in control in relation to testing of EPRR arrangements. An exercising programme has been developed for 2026/27 to address this and will be implemented during 2026/27.	Executive Director of Operations	31 March 2027
Implement and monitor delivery of the Internal Audit action plan for Emergency Preparedness, Resilience and Response (EPRR) to address identified control gaps to strengthen the control framework.	Executive Director of Operations	31 March 2027

Assurances *(how do we know if the things we are doing are having an impact?)*:

4. Service Level Assurance	5. Specialist Support / Oversight Assurance	6. Independent Assurance
• Emergency preparedness (annual) including self-assessment (BC then Board) • EPRR quarterly compliance updates to Business Committee and Board • Cyber Security Report (AC) • Sustainability and Climate Adaptability Steering Group AAA report (BC)	• Scrutiny of Major Incident Plan (annual) (BC then Board) • Reports regarding major incident exercises and deep dives (included in Emergency preparedness report (annual) (BC then Board) • Performance Brief (Responsive) (BC) • Information Governance Approval Group minutes (AC)	• Internal audit (BC/AC) ○ Cyber security (Q 2/3) • Assurance from external contractors re: cyber security resilience recovery • Penetration Tests Results (AC)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by

• Digital strategy update (BC)	• Statutory/mandatory training compliance (Performance Brief) (BC) • Information Governance and Data Security Reporting to Audit Committee (AC)		
Link to Risk Register (material operational risks scoring 12 or above): 1221: Likelihood of a Cyber Attack (12) 1313: Climate Adaptability Resilience Planning (12)			

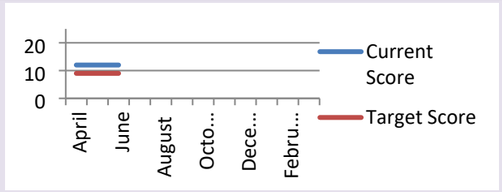
Strategic Risk 6:
Staff health and wellbeing:
There is a risk that insufficient focus on the health, wellbeing, and engagement of staff will lead to increased sickness absence, burnout, and workforce instability. This may result in reduced capacity and diminished quality of care.

Lead Director/risk owner: Director of People

Committee with oversight: People and Culture Committee

Date last reviewed: 14/5/26

Risk Rating
(likelihood x consequence)
Current score:
4 x 3 = 12
Target score (end of 2025/26):
3 x 3 = 9



Risk Appetite	Cautious
Tolerance score	4-6
Status: In or out of Appetite	Out

Rationale for current risk score:
The sickness reduction programme is well underway and aligns with the broader theme of organisational health. An evidence-based approach has been developed and successfully tested within a specific service and is now being rolled out across other services. This approach utilises data and evidence relating to sickness absence, enabling targeted interventions where they are most needed.
The latest Staff Survey results have been maintained across all People Promise themes compared to last year. This is a positive outcome, particularly in the context of ongoing Quality & Value (Q&V) work and the recent announcements regarding the Trust Integration Programme and should be recognised as an achievement.
However, given the scale and pace of organisational change, alongside continued (albeit reducing) high levels of sickness absence, the risk score appropriately remains at 12.
Should sickness rates continue to decline, there is a clear trajectory to support a reduction of this risk score to 9.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The risk appetite for this risk is cautious. The target score for 2026/27 has been set above appetite as an interim position, recognising that actions are still in progress. Further progress is expected as these actions are embedded, with the intention of moving closer to alignment with the defined risk appetite during 2027/28.
By the end of 2026/27, there will be greater clarity regarding the impact of the Quality and Value programme (end of year 3), alongside the progression of the Trust Integration Programme. This will allow sufficient time for associated controls to be implemented and embedded effectively.
It is anticipated that the likelihood of the risk will reduce as staff engagement improves and there is increased clarity in both the external context and ongoing internal organisational changes.
This phased reduction in risk score (12 → 9 → 6) reflects a realistic and controlled trajectory, aligned with the pace of transformation and system-wide change.

Controls *(what are we currently doing about the risk?)*:

- Workforce strategy framework – implementation and monitoring
- Workforce planning; including in relation to tender bids as well as organisational change, linked to Q&V and Trust Integration Programmes
- Enhanced Vacancy control process – safeguards clinically essential roles
- Establishment and Vacancy Control process across LCH and LYPFT
- Business unit workforce plans
- Apprenticeship scheme
- Guardian for safe working hour's role
- Digital tools for efficiency: e-rostering, e-Allocate
- Performance panel scrutiny and case conferences for longest standing/highest complexity absence cases
- Workforce and staff side expertise on Q&V programme board and relevant workstreams
- NOF sickness improvement project
- Series of health and well-being initiatives
- Coaching and mentorship schemes
- Approach to leadership development
- Organisational change policy
- People Task Group - cross cutting group across organisational change
- Legally compliant People policies
- HR conferences to review new case law impact on policies
- Active management of Occupational Health contract
- Staff survey intention plans
- Access to legal advice
- Recruitment and Selection procedures

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
As a result of gaps in control identified through the staff survey, targeted engagement with services in response to staff survey engagement scores will take place.	DoP	Jun 26
Implement and monitor delivery of the Internal Audit action plan for sickness absence to address identified control gaps to strengthen the control framework.	DoP	30 Sept 2026

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Service spotlight/focus • Sickness absence service level deep dives via sickness absence project update to PCC	• IPR (staff turnover figures, recruitment timescales, sickness absence, appraisal rate) • Safe staffing report • Guardian for safe working hours report	• Internal Audit Sickness Absence – Significant Opinion

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by

• Staff survey analysis at service level via annual staff survey results (PCC) • Organisational health deep dive in hot spot services (PCC)	• Priorities Quarterly Report • Sickness project plan update (PCC) • People Key Performance Indicators and Data Q&V assurance report • CEO report to Board • Medium term plan Update (PCC)		

Link to Risk Register (material risks scoring 12 or above):

957: Increase in demand in the adult speech and language therapy service (impact on staff) (12)
1379: Civil unrest / protests, staff safety (12)
1444: Clinical governance vacancies/absences and increased demand (impact on staff) (12)
1462: Occupational health support and compliance (12)
1470: Staff shortages and high demand in the Triage Hub and Response Team leads to patients not receiving timely and necessary care (impact on staff) (12)

1459: Workforce risks due to scale of organisational change (9*)

*Although this risk scores 9 and falls below the usual threshold of 12 for material risks, it has been included due to its direct relevance and potential impact on this strategic risk.

Strategic Risk 7:

Failure to reduce inequalities experienced by the population we serve:

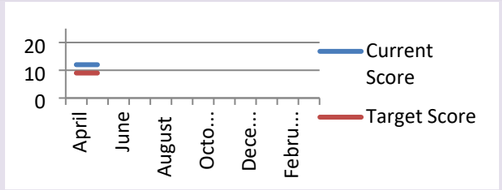
If the Trust fails to address the inequalities built into our own systems and processes, there is a risk that we are inadvertently delivering unfair access or care and exacerbating inequalities in health outcomes within some cohorts of the population.

Lead Director/risk owner: Medical Director

Committee with oversight: Quality Committee / Trust Board

Date last reviewed: 28/4/26

Risk Rating
(likelihood x consequence)
Current score:
4 x 3 = 12
Target score (end of 2026/27):
3 x 3 = 9



Risk Appetite	Seek
Tolerance score	15-20
Status: In or out of Appetite	In

Rationale for current risk score:

- Likely (4) as inequity is (inadvertently) embedded within existing systems and processes and therefore continuation of business as usual is likely to create inequity.
- We have identified some areas where inequality exists in our current services and processes and as our breakdown of data analysis increases awareness of inequity, we can drive action to reduce inequalities.
- Consequence is both outcomes for population at risk of inequity and consequence for the Trust (e.g. for failure to comply with statutory duties relating to equity)
- Work has begun to embed action to address inequity, but change is slow for such a pervasive issue

At the start of 2026/27 there is no change to the risk score. Actions are on-going in relation to the development of health equity data dashboard and strategy. It should be noted that the changes at ICB/DHSC, integration with LYPFT and development of the Provider Alliance impacts on the ability of the city to prioritise health equity development work. In addition, the Public Health Consultant role has been vacant since August 2025.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The risk appetite reflects an appetite to seek opportunities for collaboration with people and communities to ensure their experience influences equitable approaches to innovation and transformation. The target is lower than appetite due to financial and capacity factors at play to seek opportunities and put in place controls to reduce the likelihood of inequity. After which further progress is expected toward reaching the target and aligning with risk appetite.

Controls *(what are we currently doing about the risk?)*:

- Elevation of the equity agenda to a Trust strategic objective
- We have a strategy and action plan and links with Quality and Value programme
- Programmes of work delivering on statutory duties
- Development of measurement framework for equity
- Member of Tackling Health Inequalities Oversight Group
- Process and governance for Equity and Quality Impact Assessment (EQIA) within the Quality and Value Programme
- Equality Delivery System (EDS) requirements met
- Armed Forces Covenant requirements met
- Veteran Aware accreditation
- Bi-monthly Racial Equity in Care Group meetings oversee Patient and Carer Race Equality Framework (PCREF). Reporting to Health Equity Leadership Group
- Health Equity Leadership Group (reporting into QAIG)
- Equity measures in Access LCH and Productivity workstreams

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
There is a gap around our ability to consistently meet / fully understand our current position relating to reasonable adjustments and accessible information. The new person-centred care template, 'About Me' was launched in January 2026, but gaps remain in the consistent completion of this and in availability of reporting for services to understand their position in regard to completion. Service and trust-level reporting will be available by June 2026, which will then enable targeted support to services with lowest completion rates.	Medical Director	30 June 26
There is a gap in availability, analysis and use of data to undertake equity analysis and take mitigating action. Progress against this action: A reporting development plan has been laid out in the 5-year tactical plan. This aligns to the measurement. Year one (2026/27) includes implementation of KPIs that use the Health Equity Index to assess difference in waiting times by ethnicity, IMD, LD, armed forces and people with a disability. Reporting on the KPIs is included in the BI plan and planned for completion by December 2026.	Chairs of relevant Committees Head of Business Intelligence and Performance	31 Dec 2026
There is a gap in control in relation to the implementation of the Health Equity Index (action from Citywide Group), Implementation of the Health Equity Index is planned for 2026/27 as per the 5-year tactical plan for equity. Work to obtain and understand the technical requirements for implementation is underway.	Head of Business Intelligence and Performance	31 Mar 2027
There is a gap in control in relation to capacity to progress developments across the city due to the Public Health Consultant role being vacant. Part of this role will be covered through a short-term appointment for 6 months.	Medical Director	1 June 2026

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• Equity report (statutory duties) to QAIG • Service/Business Unit performance reporting including focus on equitable approaches to waiting lists • Organisation Strategy Update (BC/QC)	• Report to Board including equity measurement framework	• EQIA Internal Audit (Q1) • External reporting on statutory duties • CQC

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
There is a gap in assurance in relation to system health inequality data as the Trust does not have access to the West Yorkshire ICB population health management data. To address this the Trust will obtain access to the data and make available to appropriate LCH staff.	Medical Director	June 2026
There is a gap in assurance in that the health equity strategy 2021-2024 does not meet the recommendations of the NHS Providers report: United against health inequalities; moving in the right direction (May 2024). To address this the strategy is being revised to produce a health inequalities tactical plan. The draft health inequalities tactical plan was presented at the Trust Board meeting on 6 November 2025, further work paper to be taken to the Board to address the comments raised. Workshop deferred by Board from March to May 26. A reporting development plan has been laid out in the 5-year tactical plan. Year one (2026/27) includes implementation of KPIs that use the Health Equity Index to assess difference in waiting times by ethnicity, IMD, LD, armed forces and people with a disability. 3 specific KPIs relating to completeness of ethnicity recording will be added in accordance NHSE statement on inequalities.	Medical Director	End of Q3 2026/27
There is a gap in assurance regarding the EQIA methodology, in that the EQIA process may not be applied consistently across all service changes (such as clinical service changes vs nonclinical service changes), projects, or cost improvement plans. This inconsistency can lead to gaps in assessing equity and quality impacts, resulting in decisions that unintentionally disadvantage certain patient groups or staff. To address this an Internal Audit of the EQIA methodology is underway.	Medical Director	July 2026 Audit Committee

Link to Risk Register (material risks scoring 12 or above):
1383: Mind Mate Neurodevelopmental Referral Triage Waiting List (15)
1384: Mind Mate Mental Health Referral Triage Waiting List (12)
1412: Delayed development of EQIA (12)

Strategic Risk 8

System change (including Trust Integration Programme):

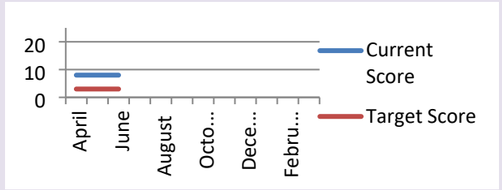
There is a risk that the Trust is unable to deliver on its medium-term plan if it cannot adequately engage in, influence and adapt to the significant changes that are taking place within NHSE/DHSC, the West Yorkshire ICB and the Trust Integration programme with LYPFT.

Lead Director/risk owner: Chief Executive

Committee with oversight: Trust Board

Date last reviewed: 8/5/26

Risk Rating
(likelihood x consequence)
Current score:
2 x 4 = 8
Target score (end of 2026/27):
1 x 3 = 3



Risk Appetite	Seek
Tolerance score	15-20
Status: In or out of Appetite	In

Rationale for current risk score:
At the start of 2026/27, the risk score of 8 is carried over from 2025/26. There is no change to the risk score due to scale of changes at the ICB, the Trust integration programme with LYPFT and uncertainty on changes at NHSE/DHSC. The Trust remains actively involved in shaping the Leeds provider partnership and joint committee. The Trust will maintain oversight of capacity to respond to changes.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The risk appetite for this risk reflects an appetite to seek opportunities across current and future services through system-wide partnership and seek risks associated with collaborative and new ways of working. The target is lower than appetite due to the changes to be made in relation to the Leeds Provider Review which will support future opportunities for collaboration. After which further progress is expected toward reaching the target and aligning with risk appetite.

Controls *(what are we currently doing about the risk?)*:

- Work with Local Care Partnerships
- Involvement in Leeds Clinical Senate
- Integrated nursing programme
- Leeds One Workforce Strategic Board
- Community Services Collaborative
- Third Sector Strategy
- MHLDA collaborative (and CiC)
- Attendance at Primary Care Partnership, which oversees joint working in City
- Leading response to intermediate care procurement model
- TOR and MOU for major partnership arrangements
- Social Care Alliance Board – chaired by LCH CEO and Social Services
- Established governance workstreams for transition programme
- Transition Committee
- Board to Board with LYPFT
- Joint executive meetings with LYPFT
- CEO on WYICB Board
- Executives leading on system redesign of strategic commissioning
- Involvement in projects for WY ICS
- Leeds Committee of the ICB member
- MoU / ToR Leeds Provider Partnership Joint Committee / co-designing governance workstreams
- Joint executive roles with GP Confed
- Integrated Neighbourhood Health pilot and future design
- Wildly Important Goals – oversight and reporting through SLT
- IPR / schedule of assurance reports to maintain oversight on delivery of Trust medium-term plan / objectives

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
There is a gap in control in relation to the changes at NHSE region. No immediate action in relation to external changes other than keeping informed	N/A	N/A

Assurances *(how do we know if the things we are doing are having an impact?)*:

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• CEO report to Board (TB) • 6 monthly financial performance summary report on formal partnerships (part of Performance Brief) (TB) • Third Sector Strategy update reports (TB) • Medium term plan update (BC/QC)	• Minutes and updates from Mental Health Committees in Common (TB) • Reports from ICB (when available) • Reports from Leeds Committee of ICB (when available) • Risk register (QC/BC/TB) • Scrutiny of new partnerships arrangements at committees (QC/BC)	• Minutes from Scrutiny Board (TB) • Board capability self-assessment and rating by NHSE (amber/green) • Medium-term plan rated as compliant by NHSE • Feedback on Strategic Outline Case • Assurance to Audit Committee against the Internal audit plan (AC)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by

	• MHLDA Committees in Common minutes and report (TB) • Place based partnership maturity assessment (with ICB)	•	
Link to Risk Register (material risks scoring 12 or above): There are currently no material risks recorded on the risk register that align with this strategic risk.			

Strategic Risk 9:

Infrastructure:

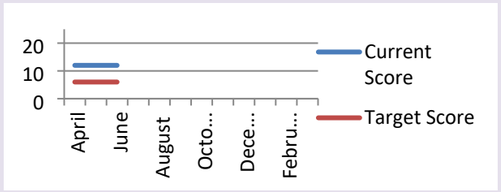
If the Trust is unable to provide access to safe and fit for purpose digital and estate infrastructure then there is a risk that the quality and continuity of service provision will be compromised which may further impact achievement of all of the Trusts strategic goals and priorities.

Lead Director/risk owner: Executive Director of Finance and Resources

Committee with oversight: Business Committee

Date last reviewed: 5/5/26

Risk Rating
(likelihood x consequence)
Current score:
3 x 4 = 12
Target score (end of 2026/27):
2 x 3 = 6



Risk Appetite	Cautious
Tolerance score	4-6
Status: In or out of Appetite	Out

Rationale for current risk score:
The risk has been assessed as 12 due to the potential major impact of poor-quality estate and digital infrastructure on service provision, particularly in the context of emerging service delivery models such as neighbourhood health. Limitations in the current estate may reduce the organisation's ability to support more integrated, community-based models of care.
This risk is also linked to SR5, as the digital infrastructure remains vulnerable to cyber threat. Following assessment of the existing controls, the likelihood of this risk materialising is considered possible.
At the start of the year, the risk relating to the organisation's ability to invest in and modernise estate and infrastructure is heightened, particularly where estate constraints may not support evolving service models. This is driven by uncertainty at the beginning of the year regarding the availability of capital for 2026/27, which may limit the organisation's capacity to deliver the required improvements.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
As this is a newly identified strategic risk, a cautious risk appetite has been proposed, this aligns to SR1, delivery of quality care. The target score is 6 is at the high end of this appetite.

Controls *(what are we currently doing about the risk?)*:

- Implementation of enabling strategies e.g. Digital, Estates
- Technical controls secure the IT estate and data from unintended disclosure, theft or ransom: Software patching regime, smooth walls and firewalls, NHS Digital Advance Threat Protection Service, Multi Factor Authentication
- Digital Maturity Assessment Framework
- Health and Safety Group (HSG)
- Sustainability and Climate Adaptability Steering Group (SCASG)
- Estates Steering Group (newly established)
- Water Safety Group / Infection Prevention Group
- Premises Assurance Model
- Digital Programme Board
- Health and Safety Management System
- Engagement in Trust Integration Programme
- Planned Preventative Maintenance

Gaps in controls / Mitigating actions *(what more should we be doing?)*:

Action	Owner	Due by
There is a gap in control in relation to the strategies that enable / support financial sustainability, the following actions are in place to strengthen: 1. There is no long-term estates strategy - proposed 2-year transition plan pending development of a new estates strategy post integration will be taken to the Business Committee in May 2026. 2. Finalise year 2 priorities in the Digital Strategy (BC May)	EDFR	May 2026 May 2026

Assurances *(how do we know if the things we are doing are having an impact?)*:

7. Service Level Assurance	8. Specialist Support / Oversight Assurance	9. Independent Assurance
• Digital strategy update • Estates strategy update • HSG AAA • Sustainability and Climate Adaptability SG AAA • Estates and Facilities PM report (1/4ly) • Premises Assurance Model update • Health and Safety compliance report	• ERIC (Estates Return Information Collection – report • Periodic Condition and Statutory Compliance Check	• Digital Maturity Assessment Framework • Patient Led Assessments of Care Environment (PLACE)

Gaps in sources of assurances / Mitigating actions *(what additional assurances should we seek)*:

Action	Owner	Due by
To improve assurance on Digital infrastructure, Digital KPIs are in development.	CDIO	July 2026
Internal Audit provided Limited Assurance following the DDAT Strategy audit. An assurance report on implementation of the recommendations will be taken to the Business Committee.	CDIO	Oct 2026
To improve assurance on Estates, embed reporting and oversight from the Estates Steering Group	EDFR	Oct 2026

Link to Risk Register (material operational risks scoring 12 or above):
1313: Climate Adaptability Resilience Planning (12)
1473: Water Safety (12)
1490: Availability of capital 2026/27 (12)

Leeds Community Healthcare NHS Trust

Board Risk Appetite Statement – Updated for 2026/27 Strategic Risks

Risk 1 High Quality Care: If we fail to identify, deliver, and sustain high-quality care – supported by a strong culture of learning and continuous improvement in relation to patient care - there is an increased risk of unsafe or ineffective services. This may lead to preventable harm, poor patient outcomes, and a diminished patient experience.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
Delivering equitably high-quality services is at the heart of the Trust's way of working. The Trust is committed to the provision of consistent, personalised, safe and effective services. The Trust is supportive of innovation and will accept some risks to patient and service user experience if they are consistent with the achievement of patient safety and quality improvements. The Trust has a **cautious** appetite to risk that could compromise the delivery of equitably high quality, safe services.					
Risk 2 Demand for Services: If the Trust fails to respond to population growth and presentation, and the consequent increase in demand, then the impact will be potential harm to patients, inability to strengthen equity of access, additional pressure on staff, financial consequences and reputational damage.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
The Trust is supportive of innovation and transformation and looks to **seek** measured risks in pursuing innovation and transformation of current working practices without compromising the quality of patient care.					

Leeds Community Healthcare NHS Trust

Risk 3 Culture of Engagement and inclusivity:
If we fail to foster and support an organisational culture of learning, continuous improvement, inclusivity, and speaking up—particularly during periods of organisational change—there is a risk of reduced staff engagement and could impact on our ability to provide high-quality, safe care for the people who use our services.

Avoid	Minimal	**Cautious**	Open	Seek	Mature

The Trust has a **cautious** risk appetite for its culture of engagement and inclusivity, recognising that a positive, inclusive, and open learning culture is essential to delivering high-quality, safe care and supporting an effective workforce. We have low tolerance for behaviours or conditions that undermine psychological safety, equality, diversity, or the ability of staff to speak up, and we will only accept limited, short-term variation in engagement during periods of change where this is proactively managed with clear recovery plans. We are committed to maintaining a just culture, promoting openness and continuous improvement, and taking timely action where there are signs of disengagement or cultural decline that could impact staff wellbeing or patient outcomes.

Risk 4 Financial Sustainability:
There is a risk that a lack of financial efficiency and sustainability results in the destabilisation of the organisation and an inability to meet our objectives.

Avoid	Minimal	Cautious	**Open**	Seek	Mature

Our appetite for financial risk is **open,** whilst remaining compliant with statutory requirements. We strive to deliver our services within the budgets set out in our financial plans and are open to measured risks that will support innovation and transformation to achieve long term financial sustainability, improvements to service delivery, patient safety and quality of care. We will ensure that all such financial responses deliver optimal value for money. We adopt a zero-tolerance approach to fraud.

Leeds Community Healthcare NHS Trust

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.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
The Trust has a **minimal** risk appetite to business continuity risks impacting on maintaining Category 1 (C1) rated critical service elements, information security and cyber security. In responding to such incidents, Category 2 and 3 service elements could be temporarily stood down to provide additional capacity to support critical C1 service elements.					
Risk 6 Staff health and wellbeing: There is a risk that insufficient focus on the health, wellbeing, and engagement of staff will lead to increased sickness absence, burnout, and workforce instability. This may result in reduced capacity and diminished quality of care.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
While we will not accept risks which may compromise the safety of our staff or that contradict our Trust values, we acknowledge that transforming services to ensure their future sustainability will require changes in staffing models and an agile, resilient workforce. We have a **cautious** appetite to risks associated with the implementation of new models of working where these enhance or improve patient safety, quality of care or service delivery. We will support our people to adapt and thrive during change.					

Leeds Community Healthcare NHS Trust

Risk 7 Failure to reduce inequalities experienced by the population we serve: If the Trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently delivering unfair access or care and exacerbating inequalities in health outcomes within some cohorts of the population					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
The Trust is committed to promoting equity in access, experience, and outcomes. The Trust will **seek** opportunities for collaboration with people and communities to ensure their experience influences equitable approaches to innovation and transformation, such as for the Quality and Value Programme. To deliver outcomes that are inclusive of an equity focus.					
Risk 8 System change (including Trust Integration Programme): There is a risk that the Trust is unable to deliver on its medium-term plan if it cannot adequately engage in, influence and adapt to the significant changes that are taking place within NHSE/DHSC, the West Yorkshire ICB and the Trust Integration programme with LYPFT.					
Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
We are committed to bringing value and opportunity across current and future services through system-wide partnership and **seek** risks associated with collaborative and new ways of working. This includes seeking opportunities to work with partners to deliver the neighbourhood health model and other drivers outlined in the 10-year plan, alongside the integration with LYPFT.					

Leeds Community Healthcare NHS Trust

Risk 9 Infrastructure:
If the Trust is unable to provide access to safe and fit for purpose digital and estate infrastructure, then there is a risk that the quality and continuity of service provision will be compromised which may further impact achievement of all the Trusts strategic goals and priorities.

Avoid	Minimal	Cautious	Open	Seek	Mature

Our appetite for risks relating to digital and estate infrastructure is **cautious**, recognising the critical role these systems and environments play in supporting the delivery of safe, high-quality care (aligned to SR1)**.** We have a low tolerance for risks that could compromise patient safety, service continuity, regulatory compliance, or the effectiveness of service delivery. Notwithstanding this cautious position, we are open to measured and well-managed risks that support innovation and transformation, including the adoption of new **t**echnologies and estate developments that enhance service delivery, improve patient outcomes, and strengthen long-term sustainability.

Leeds Community Healthcare NHS Trust

Risk Appetite Target Scores

The risk appetite is defined by the 'Good Governance Institute risk appetite for NHS organisations' matrix, which Leeds Community Healthcare Trust has adopted. This has been aligned to the Trust's own risk assessment matrix as shown in the table below.

Good Governance Institute matrix	Risk appetite level	Risk target score (range)
Avoid: Avoidance of risk and uncertainty is a key organisational objective	**Zero**	**Nil**
Minimal: (As little as reasonably possible) Preference for ultra-safe delivery options with low inherent risk and only for limited reward potential	**Low**	**1-3**
Cautious: Preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward.	**Moderate**	**4-6**
Open: Willing to consider all potential delivery options and choose, whilst also providing an acceptable level of reward (and VFM)	**High**	**8-12**
Seek: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	**Extreme**	**15-20**
Mature: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.	**Extreme**	**25**

Agenda item:	2026-27 (18)
Title of report:	Learning from deaths
Meeting:	Trust Public Board Held in Public
Date:	23 July 2026

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

Purpose of the report:		
To provide the Board with an overview of Learning from Deaths activity and mortality surveillance for Quarter 1 2026/27, including mortality review findings, themes identified from case reviews, child death review activity, and progress against the Learning from Deaths improvement plan.	Approval	
	Discussion	
	Assurance	X

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

Summary of Key Issues:

- During Q1 2026/27, the Trust was notified of 821 deaths, with 616 deaths reviewed and 101 identified as requiring a Level 2 mortality review. Independent structured reviews were undertaken where additional learning opportunities were identified, and cases were presented through the Mortality Case Review process.
- Key learning themes identified from mortality reviews included recognition and management of deteriorating patients, communication and coordination between services, and end-of-life planning.
- Mortality surveillance data shows overall deaths remain within expected control limits, with variation across neighbourhoods consistent with known population demographics, deprivation, and health inequalities.
- An improvement programme is underway to strengthen mortality review processes, standardise approaches across services, improve visibility of

structured judgement reviews, and enhance organisational learning. Progress has been made in process mapping and stakeholder engagement; however, some actions remain in progress, and the policy review is currently at risk due to the need to agree terminology and align processes with partner organisations.

Previously considered by:	Quality Committee
Outcome of previous discussion/s:	Clarification on number of deaths reviewed requested. This has been reviewed. Reviewing the Trust data has shown that the previous count was number of deaths by service. A reduction from 821 to 787 has been identified by a strict unique patient count. 384 reviews were caried out, the number is lower than previously reported, 616, again because of the count of services where a review was completed rather than the number of patients in scope. An audit will be completed to confirm in scope patients have not been missed. The data received continues to cause challenges to accurate reporting of figures. Learning and themes remain unchanged.

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

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

Recommendation(s)	• Note and consider the mortality and Learning from Deaths information presented for Quarter 1 2026/27. • Receive assurance regarding the ongoing development of mortality review processes and organisational learning arising from deaths.

List of Appendices:	1: Data pack, 2: Improvement plan

1. Learning from adult deaths in quarter 1 2026/2027

The paper provides an overview on mortality data recorded during quarter 1, financial year 2026/2027. All deaths of services users who have had contact with the Trust's services are reviewed by the clinical teams that meet the criteria as agreed within the Trust's Learning from Deaths policy in alignment with the national guidelines on learning from deaths (2017). In Q1, LCH was notified of 821 deaths, of which 39 were in scope for Level 2 Mortality review and 11 were considered for further discussion and consideration of further learning were presented at the Mortality Case Review Group. (table 1)

Financial Quarter	Total Deaths	Total in scope Deaths reviewed	Deaths subject to Level 2 review "fact finding and initial learning"	Number progressed to Structured Case Review	Number of deaths progressed to After Action Review	Number of deaths investigated as a Patient Safety Incident Investigation	Number of deaths reported on Datix as "a death thought more likely than not due to problems in care"
Q1 Apr–Jun 26	787	384	78	3	1	3	3
Q2 Jul – Sep 26							
Q3 Oct – Dec 26							
Q4 Jan – Mar 27							
2026/27 YTD	787	384	78	3	1	3	3

Table 1. Mortality Reviews

Deaths defined as in scope include:

- Where LCH is the main provider of care and the death was unexpected as per the NHS England definition of a patient safety event.
- Where LCH is the main provider of care and the death meets criteria for a structured review as per the Learning from Deaths Policy.
- Where LCH is not the main provider of care, but concerns have been raised regarding the care we have provided.

All in scope deaths receive a comprehensive level 2 review by the service whereby the team:

- Review cause of death, if known from death certificate
- Explain why review indicated (which inclusion criteria it meets)
- Confirm family involved in process, including Duty of Candor where appropriate.
- Describe if care was delivered in line with service expectations.
    - Areas of good care identified.

    - Concerns regarding care
- Describe if any learning has been identified from the review.
- Identify if a further review is required according to level of concerns.
    - Structured review
    - After action review
    - PSII

If opportunity for further learning and improvement of Trust systems and processes are identified, a structured review is commissioned for an independent senior clinician to review and present the case at the monthly Mortality Case Review meeting. After action and PSSI investigations are commissioned as soon as identified regardless of the stage of mortality review.

In Q1, a total of 78 deaths were reviewed at level 2 and 12 presented at the Mortality Case Review Meeting following a structured independent review.

The national guidance for learning from deaths states that “deaths with severe mental illness” must have a mortality review. There is no definition for what qualifies as a “severe mental illness” therefore all Leeds Mental Health Service (LMWS) deaths are subject to a level 2 review, aligned to the LYPFY “fact finding” review. Ten deaths were recorded by LMWS for 2025/26, all were subject to a Level 2 review. One death triggered the commissioning of a review by LYPFT.

The table 2 below shows the breakdown of deaths 2026/27 by criteria for review.

	CHILD Deaths		ADULT Deaths						
	Expected	Un-expected	Expected	Un-expected	Inpatient / CCB	LD/ASD	LMWS	Family concerns	Coroner/ MD requests
Q1 26	2	3	40	38	0	3	1	0	0
Q2 26									
Q3 26									
Q4 27									
2026/27 YTD	2	3	40	38	0	3	1	0	0

Table 2: Deaths by review category

Themes identified at the Mortality Structured reviews include;
- Identification of deteriorating patients
- Communication between services (internal and external)
- End of life planning
-

A QAIG workshop is planned to review the themes that are common to Mortality Reviews, incidents and other learning opportunities.

2. Learning from child deaths in quarter 1 2026/2027

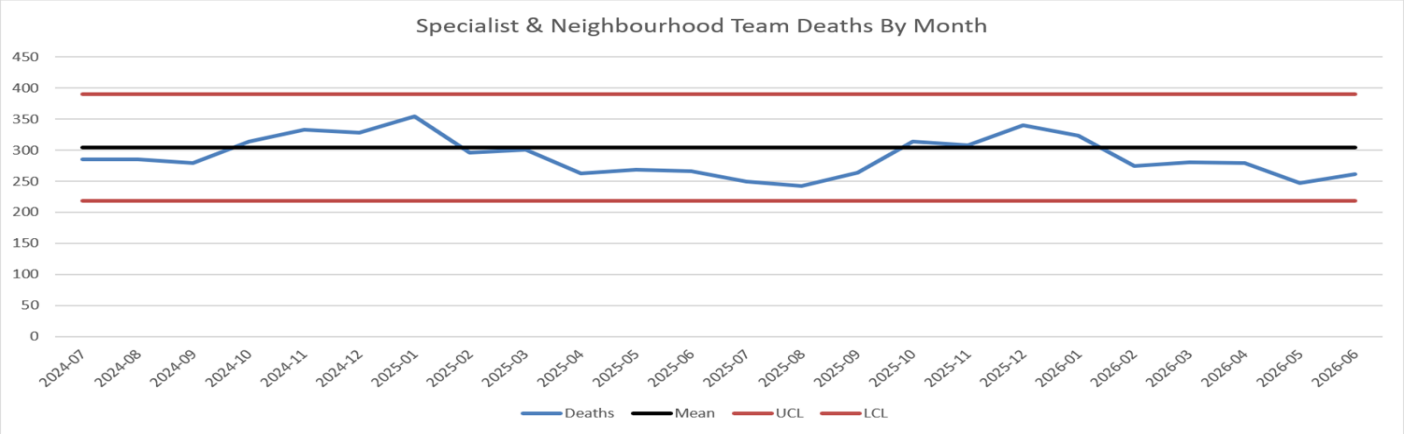
Between April and June 2026, 5 child deaths were reported. Of these, 3 were unexpected deaths (SUDIC) and 2 were expected. All deaths progressed appropriately through the Child Death Rapid Review process, ensuring timely multi-agency scrutiny and learning.

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

3. Mortality Surveillance quarter 1 2026/2027

SPC charts below detail the deaths reported over a two-year reporting period 2024-2026. The current number of deaths for the whole Trust falls within upper and lower process limits and shows expected seasonal variation with fewer deaths noted over the summer months. (figure 1).

Figure 1. total deaths



Surveillance in mortality patterns continues at the neighbourhood level. With the Neighbourhood Health Model work is required to realign the data from the current model to the new model as boundaries evolve. Figures 2 a-d (appendix 1) show the variation in mortality rates for the neighbourhood teams. Analysis of the SPC charts for individual teams shows variation within control limits and no abnormal patterns emerging.

3.1. Equity

Deaths by neighbourhoods shows variation in line with known health inequalities, more deaths being reported in neighbourhoods with older populations and greater deprivations (Figure 3, appendix 1).

Despite the variation in deprivation and ethnicity across the neighbourhoods over 80% of patients achieve their Preferred Place of Death (PPD) (Figures 4a&b, appendix 1). This appears to be an upward trend from 2024/25 financial year and demonstrates the trust's commitment to supporting patients at End of Life

4. Learning from Deaths Improvement plan

A city-wide project to have ReSPECT forms on Leeds Care Record is in progress, however, the implementation has been delayed until September.

Improvement plan has been agreed, table 3 (appendix 2), following review of process by LYPFT. Mapping of processes required to identify if real or assumed gaps based on different terminology.
Challenge of terminology leading to confusion between organisations. Broadly same process followed but commissioning of Structured Judgement Reviews (SJR) /After Action Reviews (AAR) /Patient Safety Incident Investigations (PSII) more transparent at LYPFT.
Main identified gap is visibility of how SJRs are commissioned from level 2 reviews and how learning is shared. Agreed update to mortality tracker to include learning and actions from level two reviews with progress tracker to increase visibility.

Risk in limited number of staff trained and available for independent review leading to delays in targets of SJR completion is noted at LYPFT as well as LCH.

5. Conclusion

This paper provides a summary of mortality data reported in Q1 2026/2027. Ongoing work will be undertaken through the remainder of this financial year to ensure we have further robust processes in place, to ensure effective alignment with LYPFT, enabling us to draw out themes and learning following deaths and ensure we are engaging compassionately with bereaved families and carers.
As well as identifying learning from deaths, work will be undertaken to ensure this feeds into improvement workstreams to enable us to consider improvements to systems and processes and evaluate the impact of any changes.

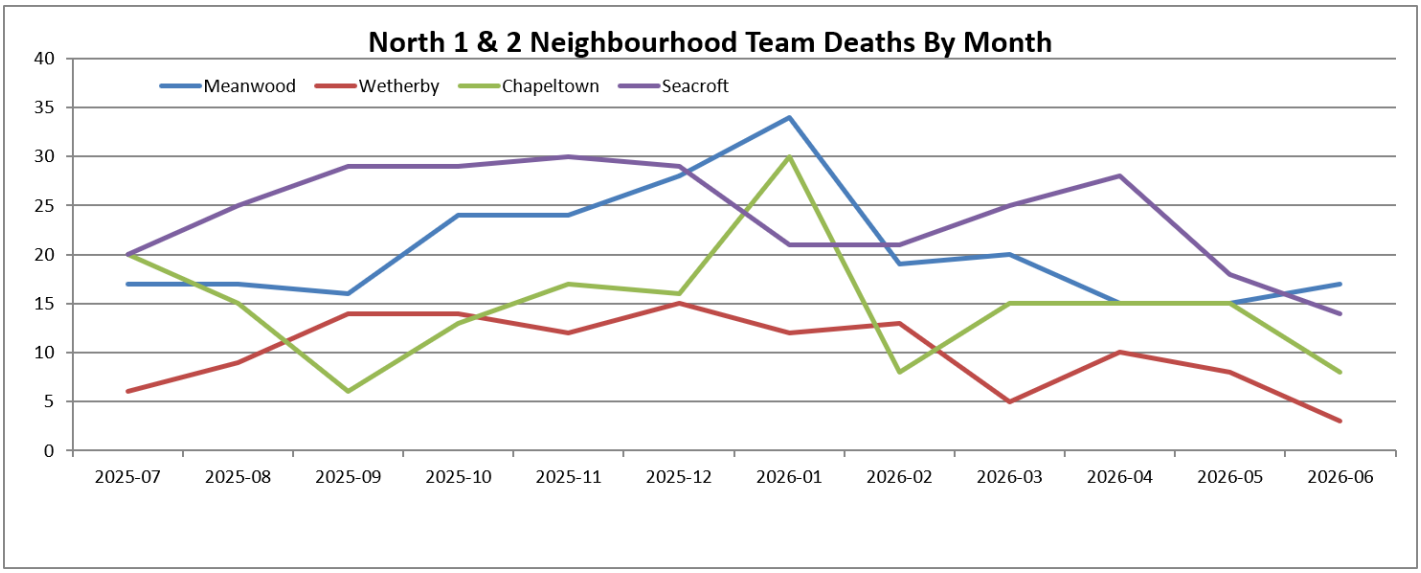
6. Recommendation

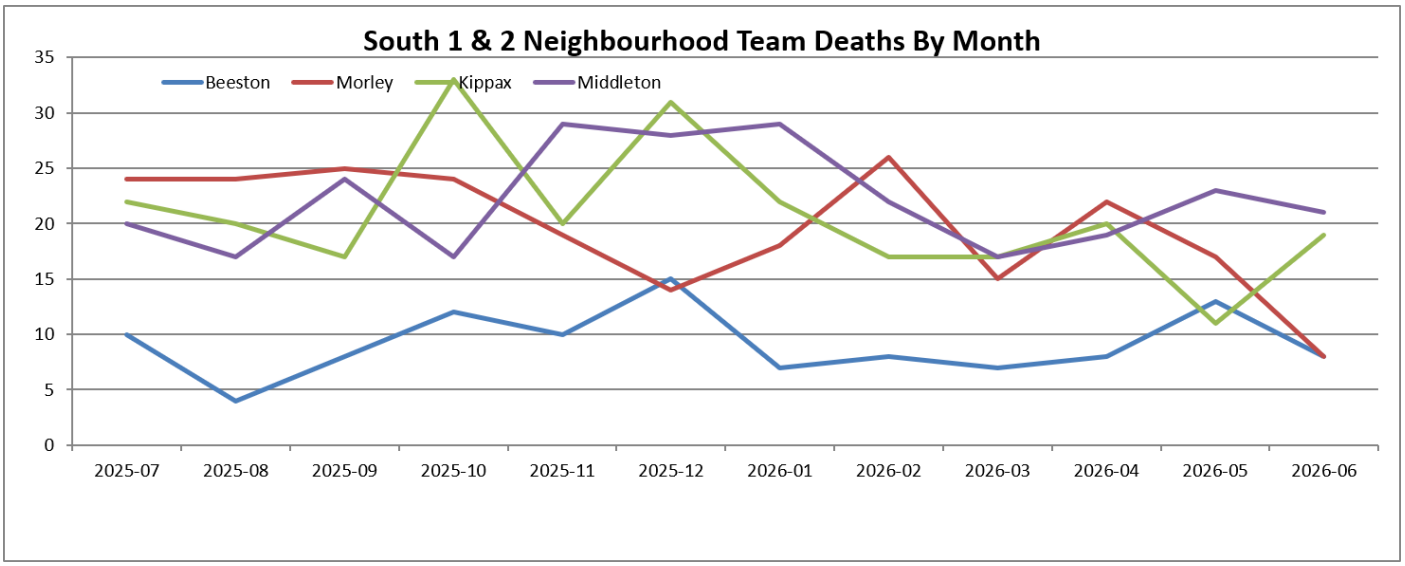
Quality Committee is requested to:

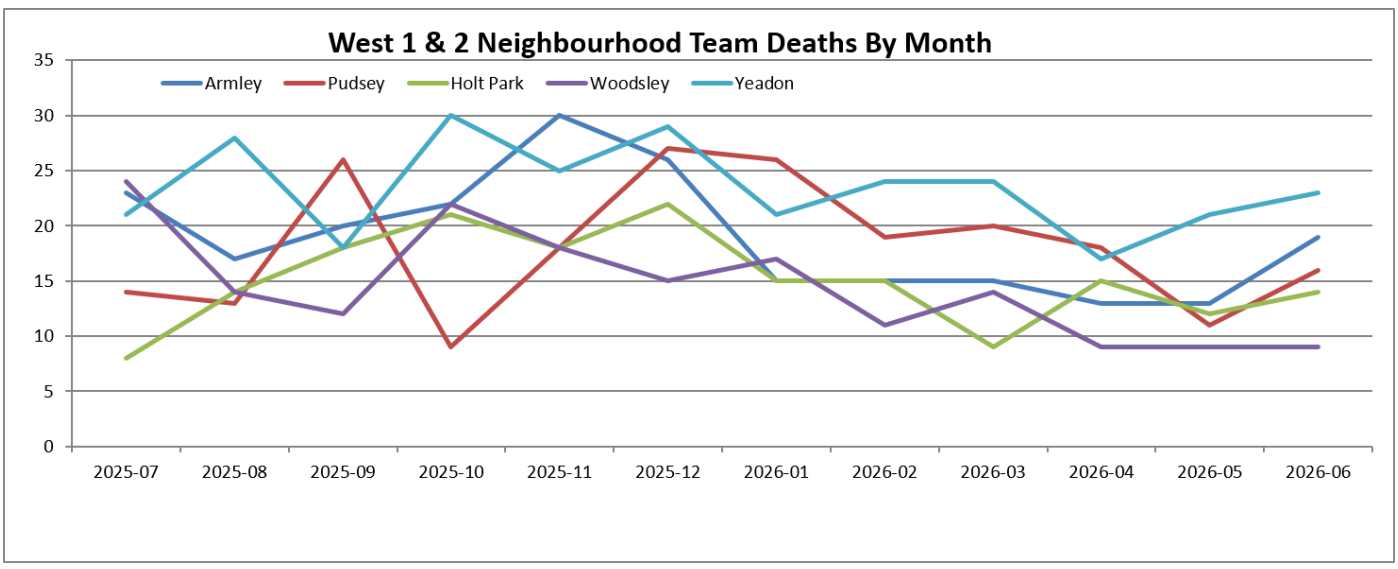
- Note and consider the mortality and Learning from Deaths information presented for Quarter 1 2026/27.
- Receive assurance regarding the ongoing development of mortality review processes and organisational learning arising from deaths.
- Approve the proposed extension to elements of the Learning from Deaths improvement plan timescales to support process alignment and implementation.

Appendix 1: Data Pack

Figures 2a, b, c, d. Neighbourhood and Specialist services surveillance







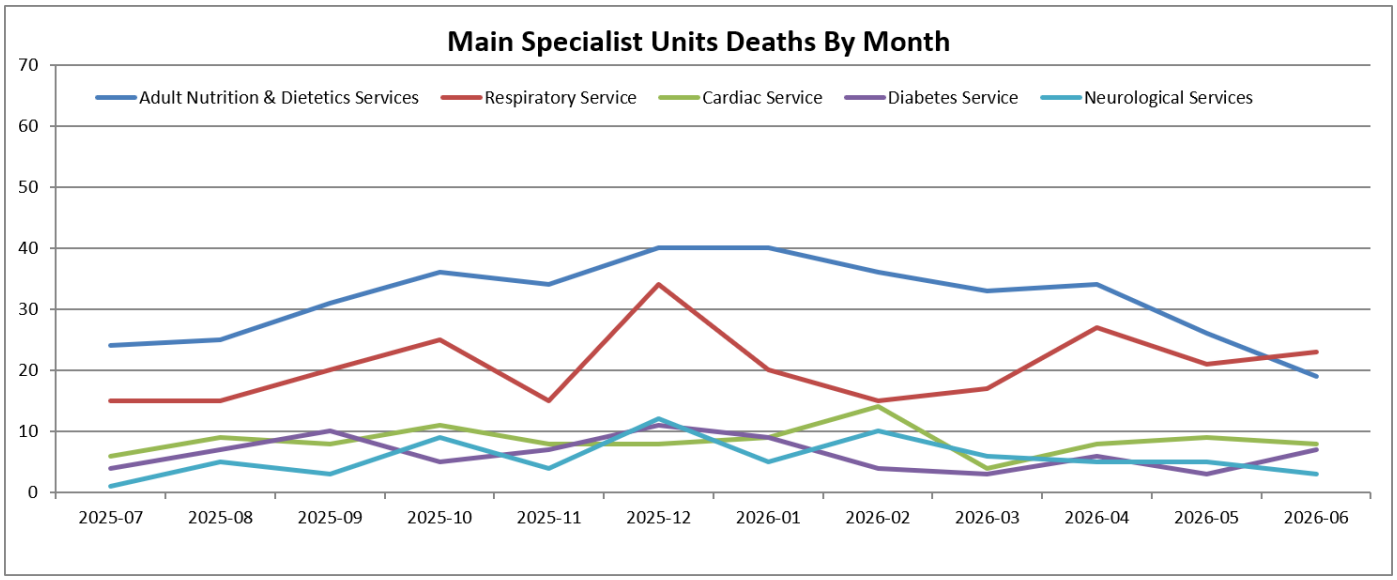


Figure 3. IMD deciles compared to age by Neighbourhood.

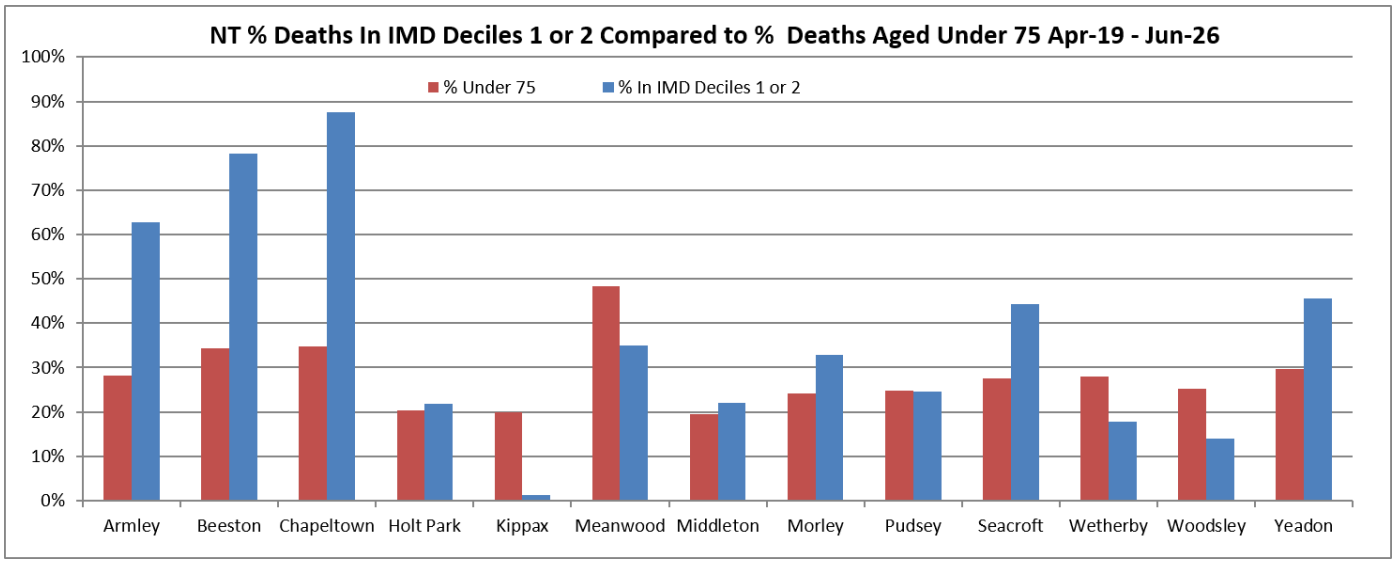
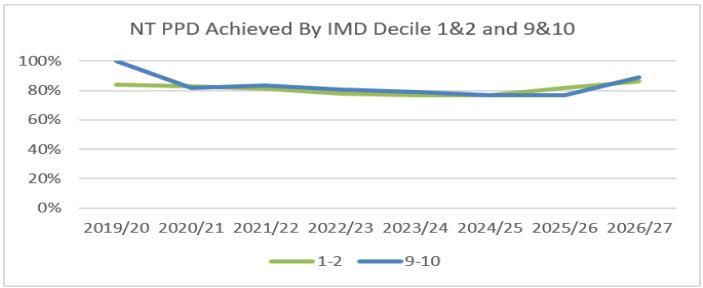
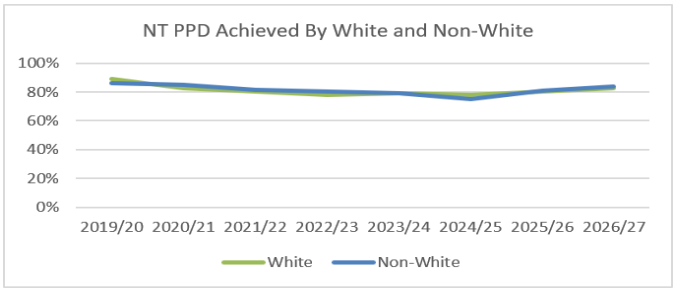


Figure 4. Preferred place of death





Appendix 2: Table 3 - Learning from Deaths Improvement Plan

Changes to implement	Priority	Timescale	Update	Status
Engagement event and workshop to map current process, identify gaps, redesign to ensure consistency (not withstanding special cases e.g. children), and develop assurance metrics.	Medium	30-Jun-26	23/04/2026 GJ Engagement event booked for 28th May, invites sent. 11/06/2026 GJ initial engagement session completed. Opportunities, challenges and recommendations circulated. SharePoint confirmed to hold mortality trackers for centralised visibility. Plan to update tracker to include local learning. Confirmed national metrics are: Number of deaths, number of deaths reviewed, number of deaths where LCH more likely than not to have contributed to the death, number of deaths where learning was identified. Need to further consider equity metrics and surveillance metrics. Consideration needed on how to align with Neighbourhood Model to ensure system learning shared.	Complete
Design TOR for a corporate mortality review group with suggestions such as leadership, membership, roles and responsibilities, data required, learning and evidence of learning, governance and reporting lines if agreed outcome from mapping exercise	Medium	31-Jul-26	11/06/2026 GJ has attended both Adult and Child Death mortality review meetings, plan to attend the LYPFT meeting on 03/07/2026. Has LYPFT ToR for their LIMM meeting. Meeting planned with LYPFT mortality lead for July when back from leave. 03/07/2026 GJ attended LYPFT LIMM meeting. Terminology challenges regarding what reviews are called. Overall similar process but more visibility of commissioning of SJRs. Similar issues in terms of delays from commissioning of SJR to presentation.	In progress
Ensure robust process for LeDer and SJRs are present within the mortality review meeting.	Medium	31-Jul-26		In progress
Agree parameters for review, who would review, where they would be reviewed, identify deaths for further review and assign them to the appropriate level, investigation including timescales, DOC, quality metrics.	Medium	31-Jul-26		In progress

Agenda item:	2025-26 (19) (Blue Box)

Title of report:	Safeguarding - combined Annual Report 2025/26

Meeting:	Trust Board Meeting Held in Public
Date:	23 July 2026

Presented by:	Heather McClelland Interim Executive Director of Nursing and Allied Health Professionals					
Prepared by:	Lynne Chambers, Head of Safeguarding					
Purpose: (Please tick ONE box only)	Assurance		Discussion		Approval	√

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

Previously considered by:	Quality Committee

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

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

Recommendation(s)	• To note its approval for publication by the Quality Committee

List of Appendices:	0

Safeguarding - combined Annual Report 2025/26

1 Introduction

- The Combined Safeguarding Annual Report is presented to the LCH Quality Committee and Trust Board to provide a comprehensive overview of safeguarding activity, including key achievements, challenges, and areas of risk. The report outlines progress made during the year and identifies the Trust's strategic priorities and ambitions for 2025/26, supporting Board assurance regarding the effectiveness of safeguarding systems and continuous improvement.

2 Current position/main body of the report

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

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

3 Impact

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

Quality

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

Resources

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

adult team have been on business continuity by staff being flexible and supporting each other across the whole team.

Risk and assurance

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

Equity

LCH actively works to ensure that all individuals, regardless of race, gender, socioeconomic status, or other characteristics, have equal access to opportunities, resources, and support. This commitment is reflected in LCH recruitment and hiring practices, where we strive to build a diverse workforce that mirrors the communities we serve. We provide ongoing training on unconscious bias and cultural competency to ensure that our staff are equipped to deliver services that respect and meet the unique needs of every individual. Additionally, we have established clear policies and procedures to address disparities and remove barriers to access, regularly reviewing and adjusting our practices to promote fairness and inclusion across all levels of our organisation. Through these efforts, we aim to create an environment where everyone feels valued, respected, and empowered to thrive."

- **4 Next steps**
- LCH remains committed to safeguarding, making strong progress in policy, training, and multi-agency collaboration. While challenges such as Prevent and Serious Youth Violence continue to demand attention, the Trust is focused on supporting staff, strengthening partnerships, and embedding safeguarding across all services to ensure safe, high-quality care.
-
- **5 Recommendations**
- Board is recommended to note the contents of this report and note its approval for publication by Quality Committee 14 July 2026.

Name of author/s:
Lynne Chambers
Wendy Brown
Helen Barwell
John Finney
Angela Dillon
Gemma Dalby
Julie Wilson

Safeguarding - combined Annual Report 2025/26

Agenda item:	2026-27 (20) (Blue Box)
Title of report:	Infection Prevention and Control Annual Report 2025-2026
Meeting:	Trust Board Meeting Held in Public
Date:	23 July 2027

Presented by:	Heather McClelland Interim Director of Nursing & Allied Health Professionals
Prepared by:	Liz Grogan Deputy DIPC and Head of IPC

Purpose of the report:		
This report provides: To inform the LCH Quality Committee of the achievements within Infection Prevention and Control during 2025-26 and provide assurance of the overall compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, in line with the 10 criterion.	Approval	
	Discussion	
	Assurance	☒

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

Summary of Key Issues:

- The Trust maintained strong IPC performance during 2025/26, with zero assigned cases of MRSA bacteraemia, Clostridioides difficile and E. coli bacteraemia, while continuing to identify and implement learning through the PSIRF process. Compliance with mandatory IPC training reached 90%, and frontline staff influenza vaccination uptake increased to 53%, a 5% improvement on the previous year.
- The Trust has continued to demonstrate compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance through its effective governance arrangements, surveillance programmes, staff training, and infection prevention activities.
- Key achievements included the continued development of the Partnership Cooperation Agreement with Leeds City Council, successful implementation of PSIRF, ongoing surveillance of healthcare-associated infections, and continued collaborative working across health and social

care partners. Progress was also made in relation to antimicrobial resistance, sustainability and sepsis prevention, while recognising the ongoing impact of health inequalities on infection prevention and health promotion outcomes.

Previously considered by:	Quality Committee 14 July 2026
Outcome of previous discussion/s:	

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

Is Health Equity Data included in the report (for patient care and/or workforce)?	Yes	☒	What does it tell us?	Data around HCAI is provided within the report for example MSSA and some of the activities we undertake within the service around system work and engagement with underrepresented communities, with specific emphasis on our upstream approach to support those living in the most deprived communities, having a greater risk of infection and increased usage of antibiotics.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	Note contents of the report

List of Appendices:	Appendix 1 – Infection Prevention and control Board Assurance Framework

Infection Prevention and Control Annual Report 2025-2026

1 Executive Summary

The report covers the period 1st April 2025 to March 31st, 2026, and provides information on:

- Compliance with the outlined criterion of the Health and Social care Act 2008.
- Healthcare Associated Infections (HCAI) statistics and surveillance.
- IPC activities undertaken within the organisation and collaboratively with partners across the healthcare economy inclusive of the cooperation partnership agreement and additional commissioned services.
- Description of the (IPC) arrangements including governance structure.
- Forthcoming IPC programme 2026/27.

2 Main body of the report

The following are key elements of the infection prevention activity and performance during the period of April 2025 to the end of March 2026.

- The Trust has had zero meticillin-resistant *Staphylococcus aureus* (MRSA) assigned bacteraemia cases during the year; however, learning has been identified through the Patient Safety Incident Response Framework (PSIRF) process.
- The Trust has had zero assigned *Clostridioides difficile* case during the year, however learning has been identified through the PSIRF process.
- The Trust has had zero assigned *Escherichia coli* (E. Coli) gram negative bacillus bacteraemia case during the year; however, learning has been identified through the PSIRF process.
- The Trust has achieved 90% of all staff members being up to date with statutory and mandatory Infection Prevention and Control training for level 1 and level 2.
- The Trust achieved 53% of front-line staff vaccinated against influenza, which is a 5% increase on the 24/25 figures.

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

3 Impact

• Quality

The Trust maintained zero assigned MRSA bacteraemia cases, zero assigned Clostridioides difficile cases, and zero assigned Escherichia coli (E. coli) bacteraemia cases during

2025/26. This demonstrates the continued effectiveness of infection prevention and control (IPC) arrangements and surveillance processes.

- Learning identified through the Patient Safety Incident Response Framework (PSIRF) has provided opportunities to strengthen practice, improve patient safety and support continuous quality improvement, despite no assigned cases being recorded.
-
- Achievement of 90% compliance with statutory and mandatory IPC training (Levels 1 and 2) provides assurance that staff have the knowledge and skills required to deliver safe care and reduce the risk of healthcare-associated infections (HCAIs).
- Influenza vaccination uptake amongst frontline staff increased to 53%, a 5% improvement on 2024/25, supporting workforce resilience and reducing the risk of transmission of seasonal infections within healthcare settings.
-
- Continued surveillance of HCAIs and work associated with antimicrobial resistance (AMR), sustainability and sepsis prevention has strengthened the Trust's approach to infection prevention and patient safety.
-
- **• Resources**
-
- The continued development of the Partnership Cooperation Agreement between Leeds Community Healthcare (LCH) and Leeds City Council (LCC) and the restructuring of the IPC Service has enabled more efficient use of specialist IPC resources across health and social care settings.
-
- Collaborative working with partner organisations across Leeds has supported the sharing of expertise, reduced duplication of activity and strengthened system-wide infection prevention arrangements.
-
- Maintaining high levels of staff training and vaccination uptake requires ongoing investment in workforce development and engagement; however, these activities contribute to reducing

the risk of outbreaks, staff sickness absence and preventable healthcare-associated infections, delivering longer-term efficiency and cost avoidance benefits.

- Continued focus on antimicrobial stewardship and infection prevention supports the reduction of avoidable treatment costs and contributes to sustainable healthcare delivery.

- **• Risk and Assurance**

- Although there were no assigned cases of MRSA, C. difficile or E. coli bacteraemia during the reporting period, the ongoing risk of healthcare-associated infections remains and requires continued vigilance.

- The implementation of PSIRF and collaborative reviews with provider organisations provide assurance that learning from incidents is identified, shared and translated into service improvements.

- Ongoing surveillance programmes, mandatory training compliance monitoring and partnership working across the health and care system provide assurance that infection prevention risks are being actively managed and mitigated.

- Emerging health inequalities across the population served by the Trust may increase risks associated with infection prevention, health promotion and access to care. These risks are being addressed through targeted partnership working and population health approaches.

- Continued work around antimicrobial resistance, sepsis prevention and system-wide IPC arrangements provides assurance that strategic infection prevention risks are being managed proactively.

- **• Equity**

- The Trust recognises that health inequalities continue to impact the population it serves, influencing individuals' ability to access health promotion, infection prevention advice and healthcare services.

- Collaborative working with Leeds City Council, adult social care and wider system partners supports a coordinated approach to addressing inequalities and improving access to infection prevention support across diverse communities.

- The continuation of surveillance, health promotion activities and targeted infection prevention initiatives helps ensure that vulnerable populations and those at greater risk of poor health outcomes are identified and supported appropriately.

- No specific adverse impacts on protected characteristic groups have been identified through the work outlined in this report; however, consideration of equality, diversity and inclusion remains embedded within IPC service planning and delivery.

- **4 Next steps**

The Trust will continue to strengthen its infection prevention and control arrangements during 2026/27 through a focus on prevention, learning, partnership working and reducing health inequalities.

Key priorities for the coming year include:

- Maintaining robust surveillance and monitoring of healthcare-associated infections (HCAIs), including MRSA bacteraemia, Clostridioides difficile and Escherichia coli

bacteraemia, to ensure early identification of risks and prompt intervention where required.
- Increasing compliance with mandatory IPC training beyond the current 90% level to ensure all staff remain competent and confident in delivering safe care.
- Continuing efforts to improve staff influenza vaccination uptake and support wider vaccination programmes, protecting both patients and the workforce from preventable infections.
- Further developing the Partnership Cooperation Agreement with Leeds City Council and strengthening collaborative working across health and social care to support a consistent approach to infection prevention across the Leeds system.
- Continuing to build on the excellent relationships established with system partners, recognising that the work of the Infection Prevention and Control Service is highly regarded across the health and care system.
- Continuing work to address antimicrobial resistance, sepsis prevention and sustainable healthcare practices, in line with national and local priorities.
- Supporting targeted health promotion and infection prevention initiatives that help address health inequalities and improve outcomes for vulnerable and underserved populations.
- Reviewing the effectiveness of the IPC service restructure to ensure resources are deployed efficiently and continue to meet the needs of the Trust and wider system partners.

Conclusion

The Trust has demonstrated strong infection prevention and control performance during 2025/26, achieving zero assigned cases of MRSA bacteraemia, *Clostridioides difficile* and *E. coli* bacteraemia, while maintaining high levels of staff training compliance and improving influenza vaccination uptake. The Trust has also continued to demonstrate compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance through effective governance, surveillance, training and assurance arrangements.

The continued use of PSIRF, strong partnership working and a commitment to learning and improvement provide assurance that infection prevention risks are being effectively managed. This approach aligns with the priorities identified in the Chief Medical Officer's Annual Report on Infections, which highlights the importance of infection prevention, vaccination, surveillance, antimicrobial resistance and maintaining resilience against emerging infectious disease threats.

The Infection Prevention and Control Service continues to be highly regarded by system partners, and the Partnership Cooperation Agreement with Leeds City Council continues to be positively reviewed, demonstrating the value of collaborative working across the Leeds health and care system. This collaborative approach supports the ambitions set out within the Government's health reform agenda and the NHS 10 Year Health Plan, particularly the shift from sickness to prevention, greater integration across health and social care, and the development of neighbourhood-based services focused on improving population health and reducing inequalities.

Focus during 2026/27 will be on sustaining these achievements, further strengthening partnership working and addressing emerging challenges, including health inequalities, antimicrobial resistance and workforce resilience, while continuing to contribute to the delivery of national priorities for prevention, community-based care and improved health outcomes.

5 Recommendations

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

Name of author: Liz Grogan Head of IPC and Deputy DIPC
Title: Infection Prevention and Control Annual Report 2025 - 2026
Date paper written: 30/06/2026

Leeds Community Healthcare NHS Trust

Infection Prevention and Control (IPC)

Annual Report

2025 – 2026

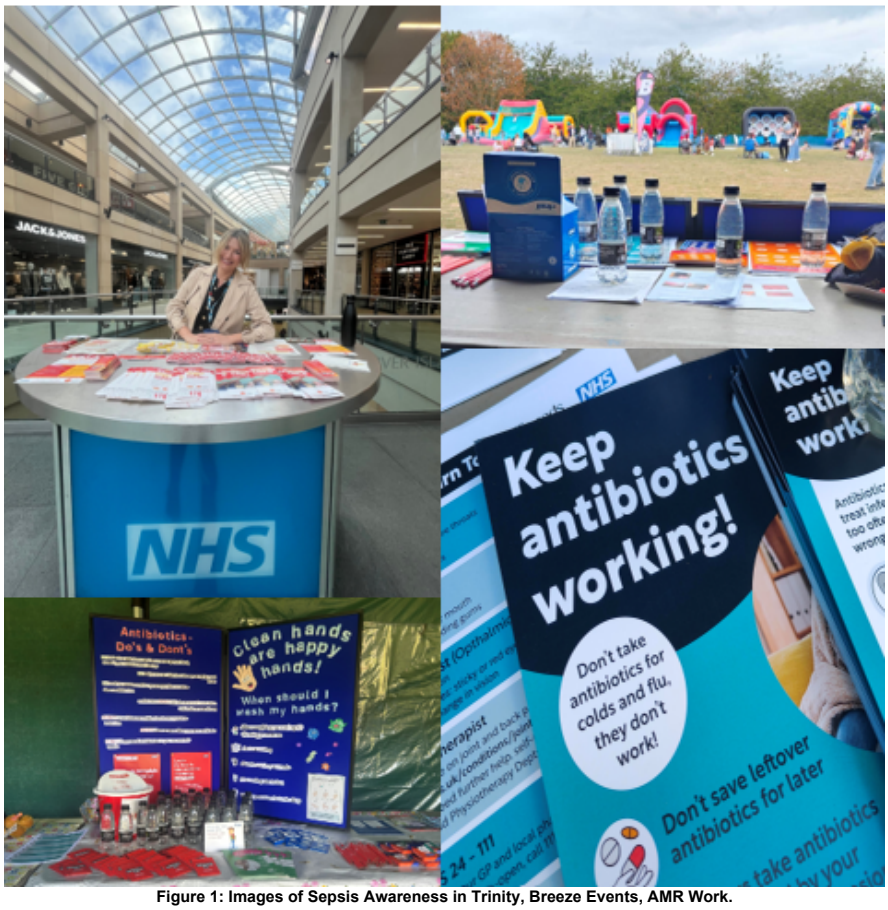


Figure 1: Images of Sepsis Awareness in Trinity, Breeze Events, AMR Work.

Report compiled by Liz Grogan Deputy Director of Infection Prevention and Control with contributions made by members of the IPC Team.

Introduction

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

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

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

Key Achievements 2025-2026

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

- Continuing compliance with the CQC criterion relating to Infection Prevention and Control (IPC) and Board Assurance Framework.
- Hugely successful collaborative working across the healthcare system and working towards the Partnership Cooperation Agreement with Leeds City Council.
- Continued funding capacity from Leeds City Council to deliver the Cooperation Partnership Agreement.
- Increased activity with the winter vaccination programme of work for influenza. We vaccinated 53% of frontline staff overall with a noted increase of 5% uptake from 2023/2024.
- Digitalisation of Fit Test App with Coreshare that has been started and is due to be finished 2026/2027.
- Collaborative work with West Yorkshire ICB for High Consequence Infectious Diseases.

Key Risks

- Major infection/outbreak/pandemic – this is a risk for any service. However, there were several outbreaks of infection this year throughout the healthcare economy including measles, and 'High Consequence Infectious Diseases' (HCID) such as MpX, and testing support for polio which were effectively managed and provides mitigation and assurance.
- Limited assurance around Water Safety, Ventilation and the Built Environment.
- The financial stability of the service is dependent on Local Authority funding, which remains outside direct organisational control. Ongoing fiscal pressures within the Council may lead to reductions or variability in funding, posing a risk to service continuity, workforce stability, and delivery against agreed outcomes within the cooperation agreement.

Key plans for 2025-2026

The IPC programme aims to continuously review and build on existing activity. This is driven by local needs, whilst incorporating and complying with the latest Department of Health (DH), UK Health Security Agency (UKHSA) and relevant strategy and/or regulation(s). Key priorities for 2025/26 are as follows:

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

Cooperation Agreement with Leeds City Council main deliverables 2025-2026:

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

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

Cooperation agreement priorities for 2025-2026:

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

1. Background

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

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

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

1.2 Infection Prevention and Control Board Assurance Framework (BAF)

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains the responsibility of the organisation and all registered care providers must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the 10 criteria outlined in the Act. The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format (Appendix 1).

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

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

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

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for Infection Prevention and Control. The DIPC has overall responsibility for the control of infection, and this role is undertaken by the Deputy Director of Nursing who feeds into the Executive Director of Nursing and AHPs for Trust Board reporting. Trust Board are provided with detailed updates on infection prevention and control and escalations as required.

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

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

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

Fig. 1: Governance Meetings

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

Performance

2.1 Surveillance of Healthcare Associated Infections (HCAIs)

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

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

2.2 Continuation of Patient Safety Incident Response Framework (PSIRF)

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

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

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

2.3 MRSA Blood Streat Infections (BSI)

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

During the 2025/26 reporting period, the team was notified of nine Community Onset Community Acquired (COCA) MRSA bacteraemia cases, five of which had LCH involvement. Of these, three patients with diabetes were receiving care from Neighbourhood Teams and Podiatry Services for the management of chronic leg ulcers in a background of diabetes, while two patients were receiving District Nursing support for urinary catheter care.

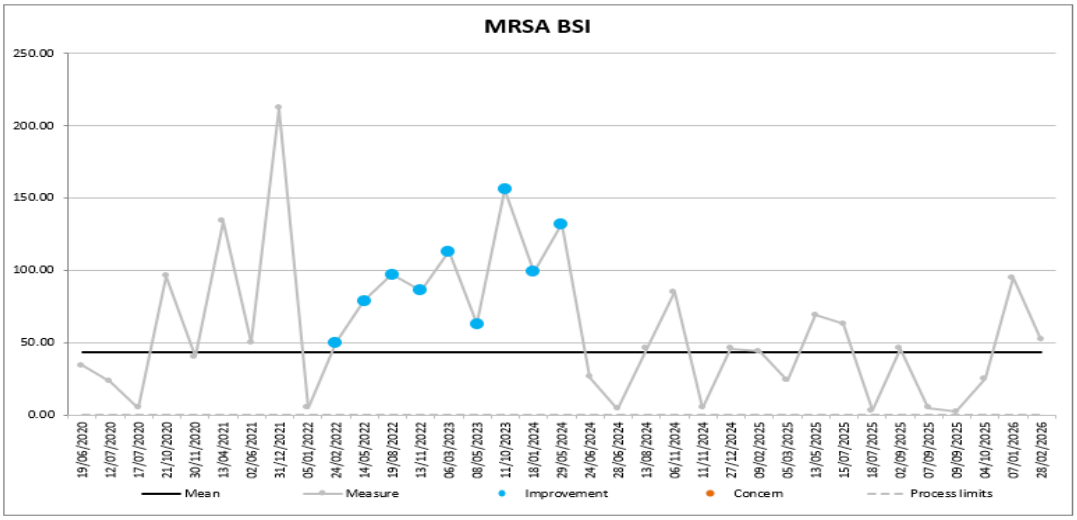


Fig. 2: T Chart of MRSA BSI cases from 2020 – 2026. (T charts plot the number of days between rare events.)

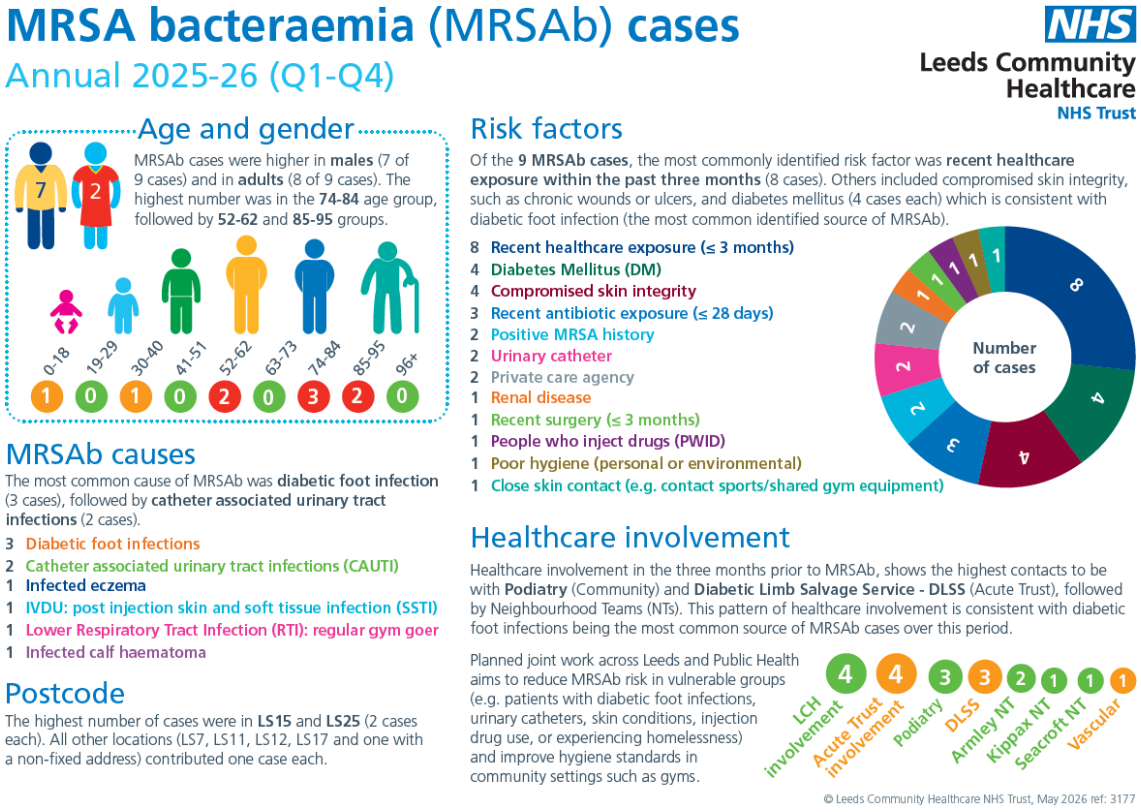


Fig. 3: MRSA Cases 2025-2026 Key Findings

There was no contributory learning specific to LCH services has been identified from the MRSA bacteraemia cases reviewed during the 2025/26 reporting period. However, the reviews identified several non-causal learning points and opportunities for service improvement. The actions undertaken as response to these findings are summarised below:

- Development of a pathway to support the timely use of prophylactic antibiotics following traumatic catheterisation in community settings
- Delivery of targeted training to Forward Leeds support workers, focusing on harm reduction and safer injecting practices
- Initiation of a review of diabetic patient pathways, enhancing collaboration with community and acute Trust services, including IPC and DLSUs.

- Review of processes for communicating significant IPC-related results to primary care, with the aim of improving clarity, timeliness and consistency.
- Review of the Lower Limb Deterioration Framework to strengthen early identification and management. This work was already underway following learning identified from other non-MRSA bacteraemia-related cases.
- Development of a complexity assessment checklist to support holistic patient care and improve the identification and management of patients with complex needs. This work was already underway as part of broader service improvement initiatives.
- Development of a tiered IPC action plan to improve hand hygiene audit compliance and submission rates, with support and escalation aligned to performance levels (detailed information is included in the Business Units Annual Report).
- Commencement of the review of the Community MRSA Policy, to provide clearer guidance on patient eligibility and appropriate decolonisation regimens in community settings, supported by user-friendly flowcharts.
- Development of a patient decolonisation leaflet to support patient understanding and adherence (Fig. 5).

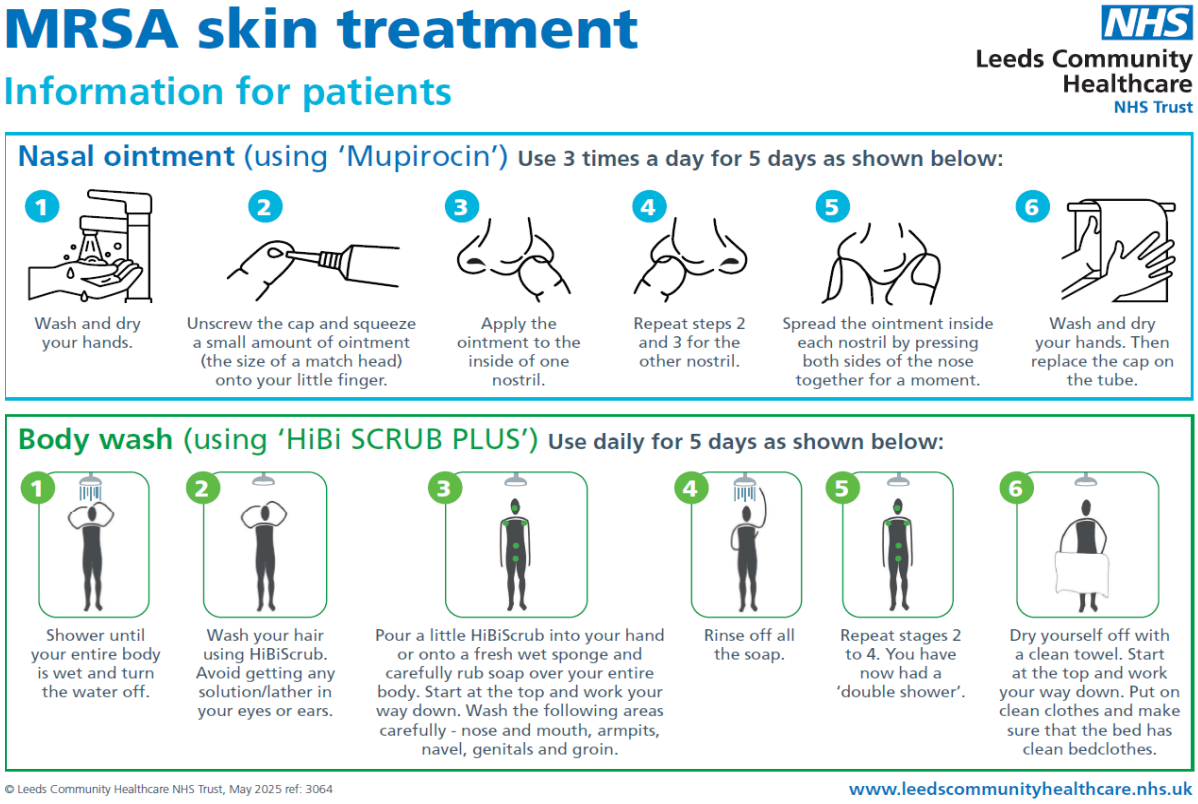


Fig. 4: MRSA Skin Treatment Leaflet

2.3 Clostridioides difficile (CDI)

Due to commencing a new investigation tool, all community-apportioned CDI cases identified as Community Onset, Community Associated (COCA) or Community Onset, Indeterminate Associated (COIA), will undergo the Root cause Analysis (RCA) process. This will ensure a clearer, more detailed picture of CDI in Leeds and better identify areas of learning and action. IPC team continues to provide all patients, who have been sampled by their GP, with a CDI information leaflet and identifying card to share their status with health care professionals. A Patient safety incident investigation (PSII) is undertaken where the episode of infection is identified as part of an outbreak, when the patient is identified within an LCH inpatient area, or when CDI is a contributing factor (1a, b, c) in the death of the patient.

There were 86 community-apportioned CDI cases during the reporting period. This represents an increase of 26 cases compared to 2024/25, which recorded the lowest number of community-apportioned CDI cases since 2015.

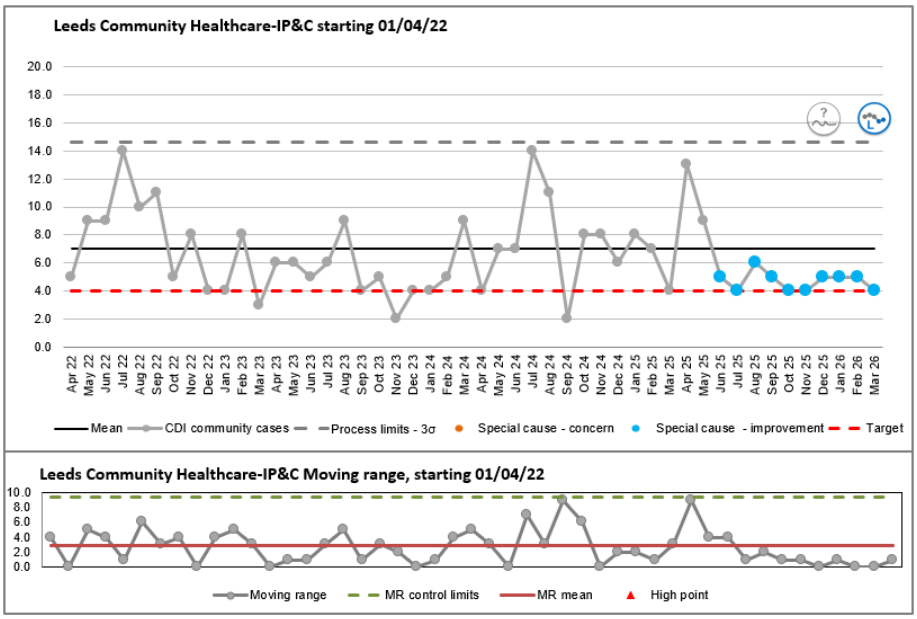


Fig. 5: SPC chart of C. diff cases per month 2022– 2025

During the 2025/26 reporting year, community Clostridioides difficile infection (CDI) toxin activity remained low overall, with monthly case numbers fluctuating at a modest level and no sustained increases observed. Case numbers ranged from low single figures to small peaks, with comparatively higher activity noted at the beginning and end of the financial year. Mid-year months demonstrated particularly low incidence, indicating a stable pattern of community CDI with reduced volatility across the year.

Case classification throughout 2025/26 continued to be predominantly healthcare-associated with community onset, particularly HOHA and COCA categories, reflecting the ongoing influence of prior healthcare exposure on community presentations. Purely community-associated (COIA) cases remained consistently low, and the near absence of “unknown” classifications reflects good surveillance quality and accurate attribution. No outbreaks or periods of increased incidence were identified, providing reassurance regarding transmission control and environmental management.

Known risk factors, including recent hospitalisation, antibiotic exposure, and proton pump inhibitor use, continued to be present among a proportion of cases, though without driving an increase in overall incidence. Relapsing infections were uncommon and sporadic, and care home residency was infrequently recorded. Taken together, the 2025/26 data indicate that current infection prevention and control measures, antimicrobial stewardship, and medicines optimisation approaches are effective, supporting ongoing control of community CDI and maintaining a stable risk profile across the year.

2.4 Gram Negative Blood Stream Infections (GNBSI)

All COCA E. coli BSI cases are subject to some information gathering (likely source, geographical location, age, community care involvement). Any E. coli BSI cases where a patient has died and E. coli is listed as either 1a or 1b on their death certificate, and the

patient is known to either LCH services or a resident of a care home, undergo further investigation.

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

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

Fig. 6: GNBSI Cases 2024/25

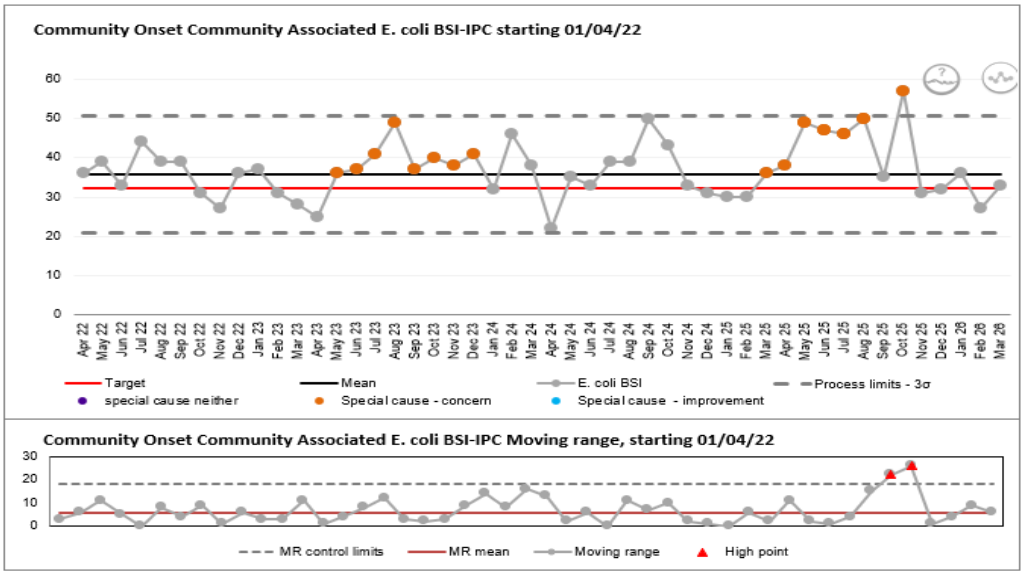


Fig. 7 SPC chart of E. coli cases per month 2022– 2026

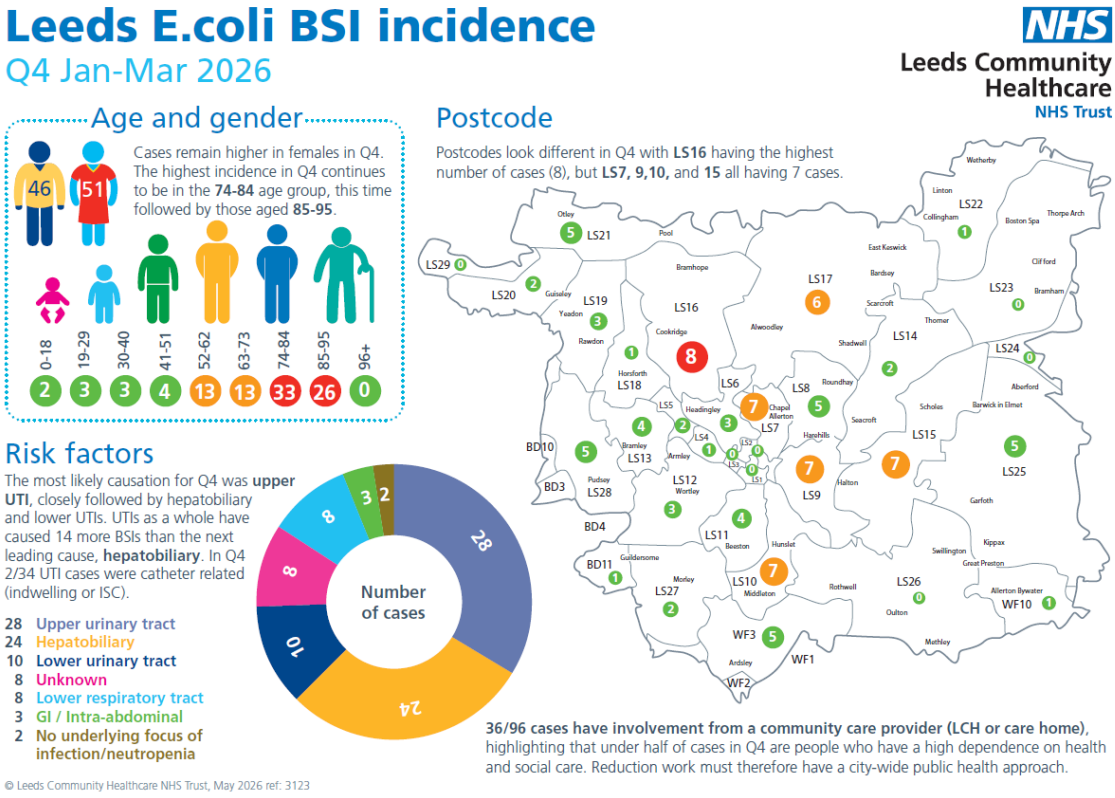


Fig.8: E.coli Key Findings 2025-2026

Pareto analysis for the 2025 – 26 year shows that UTI's are the most likely causation of E. coli BSI. When comparing UTI's as a whole, UTI's are responsible for 227 cases which is over twice as many as the next leading likely causation – hepatobiliary infection which has seen 92 cases. When compared to the previous year (2024 – 25) the number of cases with an unknown causation has fallen significantly from 88 cases to 39. This shows higher quality information is documented by both microbiology colleagues and the discharging wards.

2.5 Discussions and Actions of HCAI activity

- During Quarter 3, staffing shortages within the Patient Safety Team, alongside an increase in MRSA bacteraemia cases, necessitated a reduction in support for reviews without LCH involvement and led to delays and cancellations of MRSA review meetings.
- Reduced availability of meeting chairs due to sickness and wider organisational pressures, combined with the redeployment of Quality Leads, limited patient safety oversight and the effective dissemination of learning across Business Units.
- Although capacity was partially strengthened through the appointment of a new Patient Safety Team member in February 2026, uncertainties remain regarding administrative support and consistent Quality Lead attendance at PSII meetings.
- Reviews identified notable variability in the quality and timeliness of PSII timelines submitted by some services, indicating a need to reinforce understanding of PSIRF requirements.
- Targeted feedback was provided, and staff were signposted to Health Services Safety Investigations Body (HSSIB) training to improve the standard of investigation documentation and processes.

- Engagement with GP services was generally positive; however, attendance at key 25- and 45-day review meetings requires further reinforcement to ensure effective multidisciplinary engagement and timely progression of investigations.
- The introduction of T-chart methodology for MRSA bacteraemia reporting has enhanced the ability to monitor trends by measuring days between events, recognising the relative rarity of such incidents.
- A comprehensive MRSA reduction plan has been developed for implementation in the forthcoming financial year, focusing on pathway collaboration, upstream prevention in high-risk groups, community risk reduction, aseptic technique assurance, and a Trust-wide hand hygiene campaign.
- A review of the Community MRSA Policy is under consideration, with a risk assessment to determine whether updates are required or whether alignment with the forthcoming LYPFT merger would be more appropriate.
- Key infection prevention priorities include the establishment of a multidisciplinary PVL task group, the implementation of a new CDI data collection tool, and ongoing work to strengthen laboratory-to-IPC communication and cross-boundary reporting processes.

2.6 Leeds Health Care Record / PPM+

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

Each result was processed by adding a high priority alert/reminder on SystmOne. An IPC information task was sent to any LCH services currently involved with the patient, identified by any services with an open referral. The result was flagged up to the patient's GP by either a task on SystmOne, or a telephone call to those using a different healthcare record system, requesting that the patient be reviewed in light of the result. If the patient was a resident in a care home or nursing home the facility was contacted to inform of the result and offered appropriate infection control advice. GPs were signposted to the MRSA decolonisation guidance, available at Leeds Health Pathways.

The impact of Primary Care Collective Action has included some referrals to primary care being redirected or not accepted, which may affect pathway flow and service capacity across the system. As a service we have been working with Leeds Teaching Hospitals (LTHT) IPC team to identify a different process, ensuring that the patient remains at the centre of care delivery and that decolonisation and patient safety is not compromised.

2.7 Communicable Disease Control (CDC)

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

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

There were 266 reports of suspected food poisoning which were reported electronically, via the Food Standards Agency (FSA), or LCC self-service reporting systems, slight increase compared to last year's figure of 259. All suspected food poisoning reports are reviewed each day by the CDC nurse to detect any potential food poisoning outbreaks, and cases are responded to accordingly. Of the 266 reports of illness, 39 required follow up action from the CDC nurses which may have been by email, telephone contact and referral to Environmental Health Officers where necessary.

The overall number of positive isolates was slightly lower compared to 2024-2025. The table below incorporates the confirmed positive isolates identified via faecal testing at local laboratories and UKHSA Colindale Central Surveillance Centre.

Organsim	Number of cases 2023-24	Number of cases 2024-25	Number of cases 2025-26
E.coli (STEC)	18	16	41
Hepatitis A	5	7	10
Cholera	1	3	0
Typhoid/Paratyphoid	10	12	13
Cryptosporidia	87	59	70
Shigella	29	28	24
Salmonella	105	113	99
Campylobacter	781	866	746
Listeria	2	0	1
Giardia	73	69	85
Yersinia	2	4	4
Cyclospora	0	0	1
TOTAL	1113	1177	1094

Fig. 9: Organisms identified through Notification of Infectious Disease Reporting 2023-2026

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

2.8 Significant outbreaks with IPC response

Internal to LCH

During 2025-26 there have been 5 outbreaks involving LCH services reported to IPC, this is a reduction of 67% from the previous year. All five outbreaks involved services that fall within the adult business unit. Out of the five outbreaks, 2 were gastrointestinal disease and 3 acute respiratory infections.

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

External to LCH

During 2025-2026 the IPCT responded to outbreaks for measles and MpX across the Leeds system, working collaboratively with UKHSA and LCC. In addition to these the team supported with polio screening for families medically repatriated from Gaza. These infections required subject matter expertise, with proactive and timely responses to vaccination,

contact tracing and relevant control measures to reduce the impact and containment of the infections. For each of these specific pathogens we received outstanding feedback from regional and national colleagues in relation to our response.

2.9 Incident Reporting – Datix

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

The scope of this report includes the number of reported incidents arising due to healthcare associated infection (HCAI); however, the detail of these cases is not explored further as this falls within a separate reporting arrangement.
The information contained in this report is obtained from the LCH Datix® system. Any data from non-LCH incidents has been excluded. All incidents referenced were reported during the 2025/26 period.

There were 39 incidents were reported during the reporting period. This is a decrease on the total reported (47) in 2025/26.

Incident type	Q1	Q2	Q3	Q4	Total
Total Sharps Injuries (breakdown below)	7	8	2	4	21
Sharps with no harm	2	0	0	2	4
Sharps with harm	5	8	2	2	17
Infection control related incident*	1	7	3	4	15
Environmental	2	0	1	0	3
Total IPC related Datix reports	10	15	6	8	39

Fig.10: Distribution of incidents reported in 2025/26 by quarter (table).

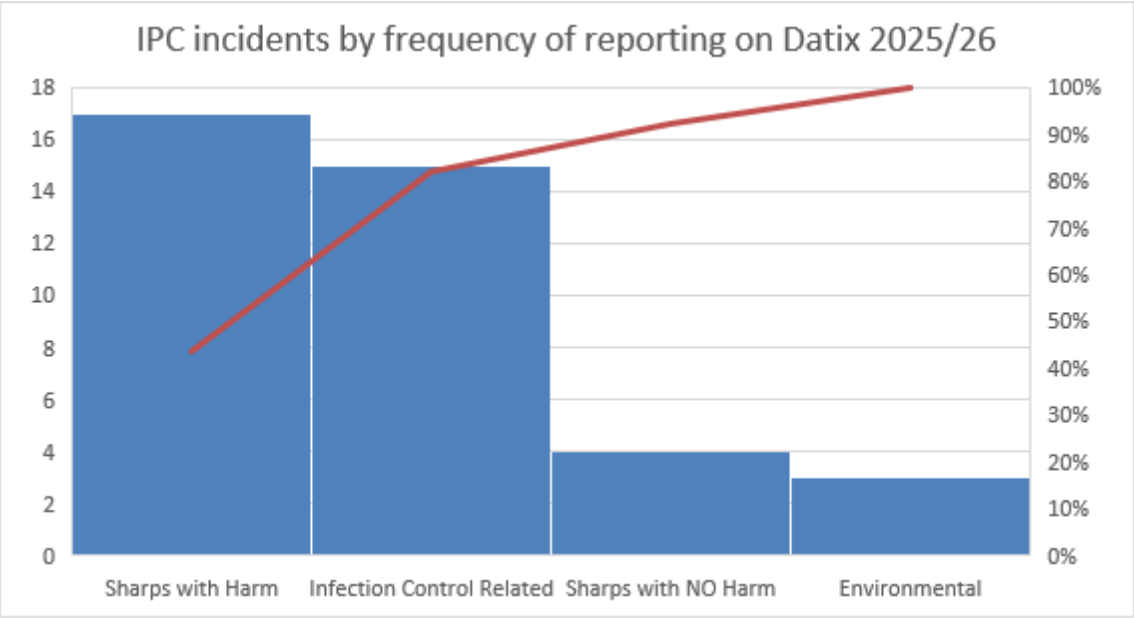


Fig 11. Pareto chart demonstrating the most frequently reported categories 2025-26.

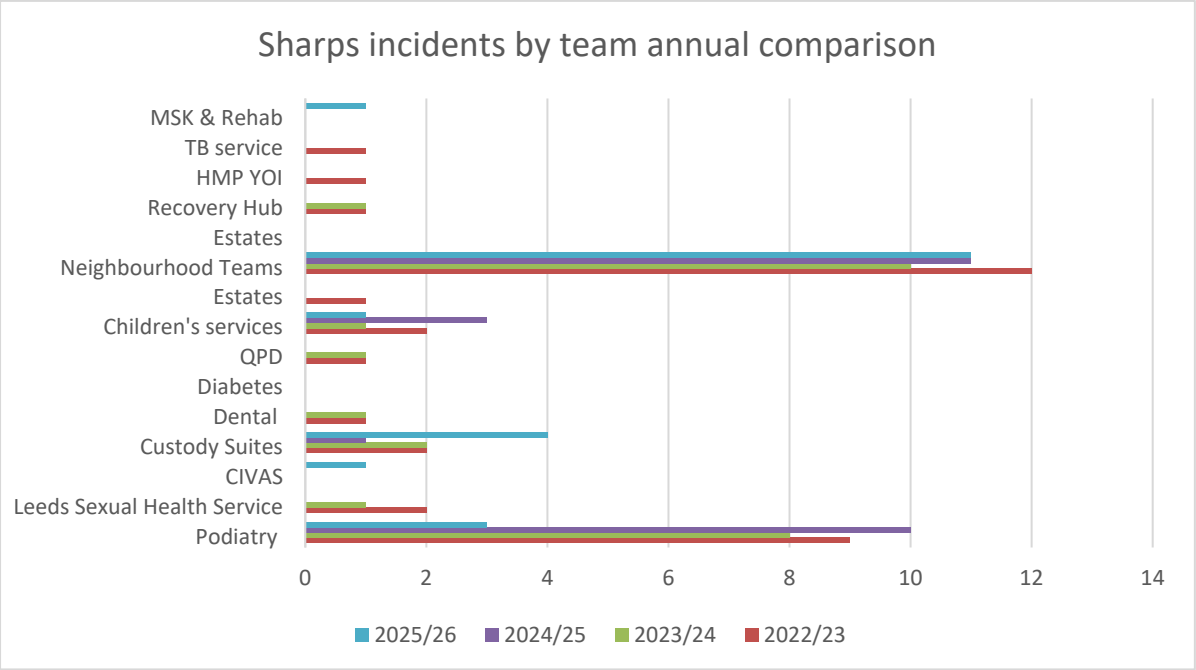


Fig. 12: Annual comparison of sharps incidents reported by team 2023-2026

Reporting of incidents is an important aspect of a positive safety culture. Although this report details a small reduction in sharps incidents overall, there was a slight increase in sharps incidents resulting in harm during the reporting period. No harm incidents present important learning opportunities, and therefore when conducting incident reduction work, those both with and without injury will still be targeted as the team works towards reducing all incidents. Sharps injuries remain the highest reported IPC incidents annually on Datix and the theme of insulin administration persists, particularly relating to safety devices not being in use for patient's own medications (e.g., insulin pens). All staff reporting sharps incidents are contacted by the IPC team and offered advice and support, ensuring that the policy for the management of needlestick injuries is followed.

Completion of Datix incident forms has slightly improved when compared to the previous year, 2024/25. However, actions to prevent recurrence are still rarely added to Datix by the handler, potentially missing important learning opportunities.

The podiatry team has been a high reporter of no harm sharps incidents in previous years relating to single use blades being returned to central reprocessing rather than being disposed of at the point of care. Following a hierarchial task analysis process and resulting changes to the standard operating procedure there has been only one such incident. Incidents will continue to be monitored closely to understand if this intervention has resulted in the necessary improvements.

Environmental incidents continue to be a low reported category. The IPC team works closely with Estates and Health and Safety colleagues where needed, and a working group to develop supportive guidance for staff working in hazardous environments has IPC representation.

Healthcare associated infection related incidents are investigated in line with national requirements, and local procedure as defined in the LCH Patient Safety Incident Reporting Plan (PSIRP). Findings of these reviews are contained in a separate report.

2.10 Headstart

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

This reporting period 34 referrals have been received, compared to 51 2024/2025. As the graph demonstrates the referral numbers fluctuate, this can be due to a number of factors, however it is not uncommon for referrals to include family groups of 3 or more siblings hence one family making up 10% or more of the referrals for the entire reporting period.

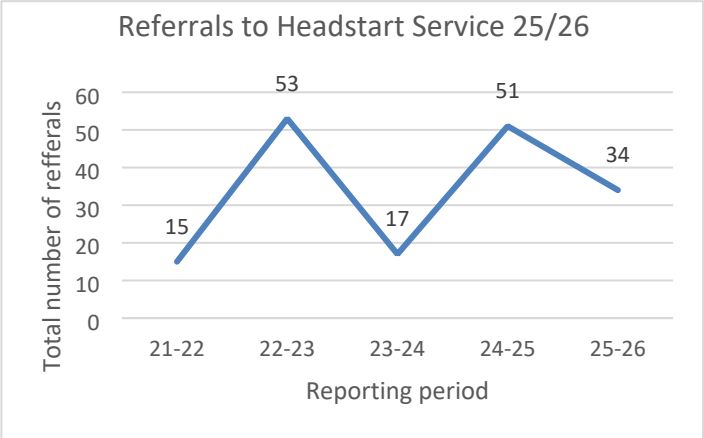


Fig. 13: Head start referral annual comparison 2021-26

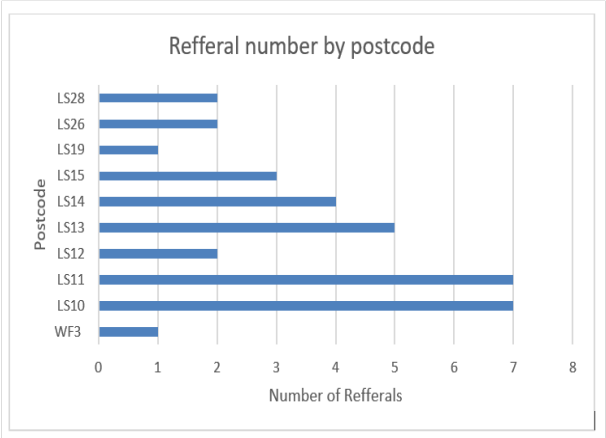
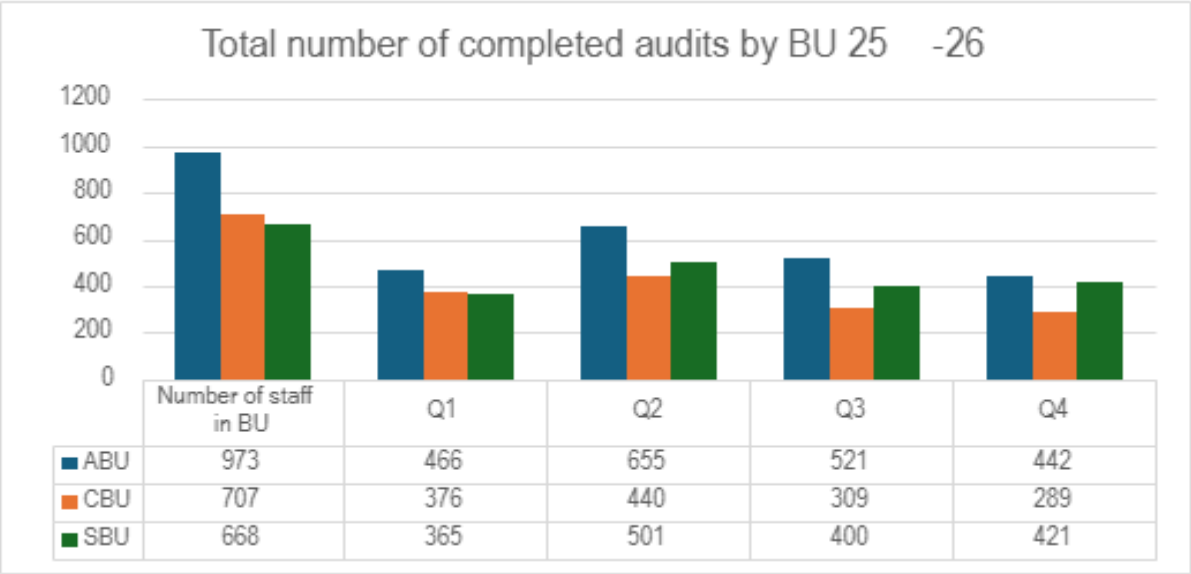


Fig 14: Head start referrals from postcodes 2025-2026

2.11 Hand Hygiene Audits

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

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



	Number of staff in BU	Q1	Q2	Q3	Q4
ABU	973	466	655	521	442
CBU	707	376	440	309	289
SBU	668	365	501	400	421

Fig.15: Hand hygiene audit returns for each business unit 2024-2025

A dedicated page for everything hand hygiene has been set up on the LCH Intranet. This includes access to the audit tool, learning posters which are shared each quarter with the answers to questions from the tool, FAQ's, easy access to associated policies, approved products list, training videos and external resources.

Analytics show staff are viewing the resources here. In the 11 months since the page was developed it has been continually updated, and has received 2479 views, an average of 225 visits per months.

One of the main focuses of the IPC Team has been to prevent inappropriate glove use across all business units by pushing consistent messages about risk assessing when gloves are required.

Fig. 16: Training poster on glove usage

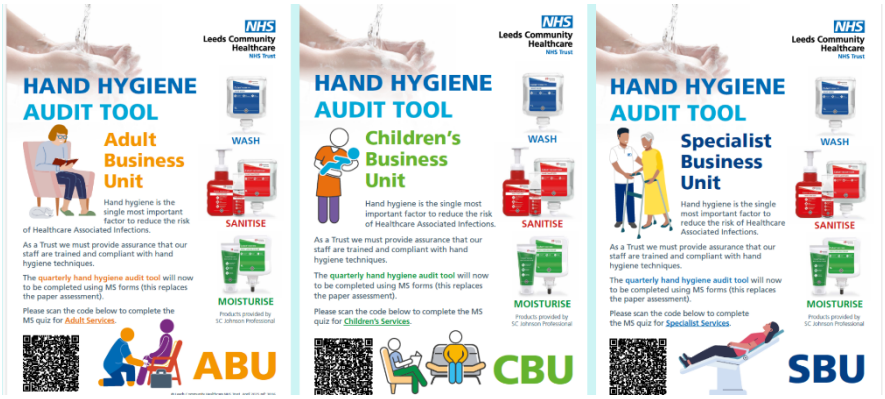


Fig.17: Hand hygiene audit tool as displayed on the Oak

2.12 Mattress audits

Mattress audits are completed quarterly at Hannah House and Wharfdale – Heather and Bilberry Wards, during 2025 – 2026. These have been completed and identified actions implemented.

2.13 Documentation audit for Wharfedale Hospital – Heather & Bilberry wards

Wharfedale Hospital relies on IPC information being included in the referral form from the transferring agency prior to accepting a patient transfer. This information is critical to enable nursing staff to conduct a risk assessment and make informed decisions on bed allocation, including the requirement for side rooms. The audit was designed to evaluate whether IPC information is consistently received from transferring agencies, its accuracy and timeliness, and to identify any delays in its provision.

This reporting period Wharfedale has completed four sample record reviews: one in November, one in December, and two in January 2026. All sampled records related to patients transferred from Leeds Teaching Hospitals NHS Trust (LTHT), and each was found to contain the correct inter-healthcare transfer form with the required IPC information included.

IPC has requested that, for the next financial year, Wharfedale increase the sample size to a minimum of ten records to strengthen assurance.

2.14 Dental water line testing

Dental water line testing is performed twice a year by the dental teams and are reported to the IPC team. Results demonstrate good compliance; all dental chairs passed first time.

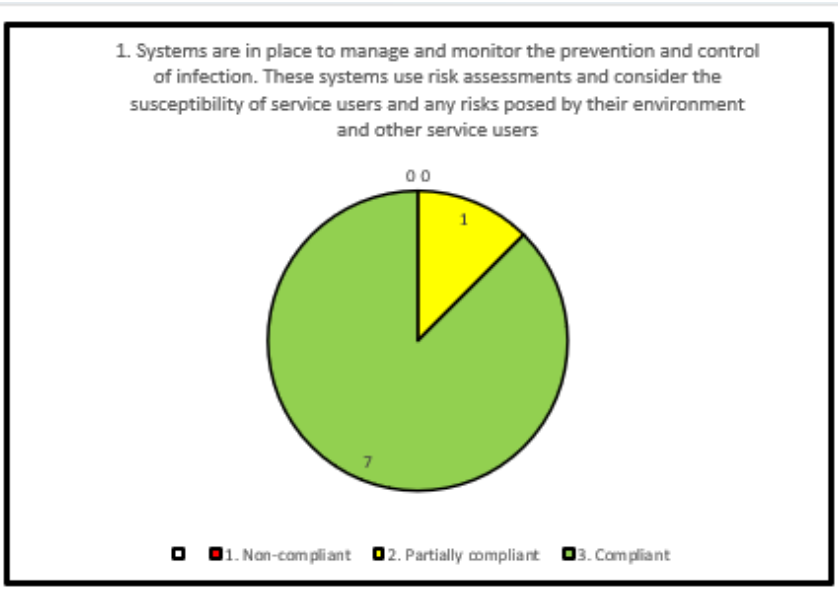


Fig. 18: BAF compliance to Criterion 1

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

3.1 Implementation of the National Cleaning Standards

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

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

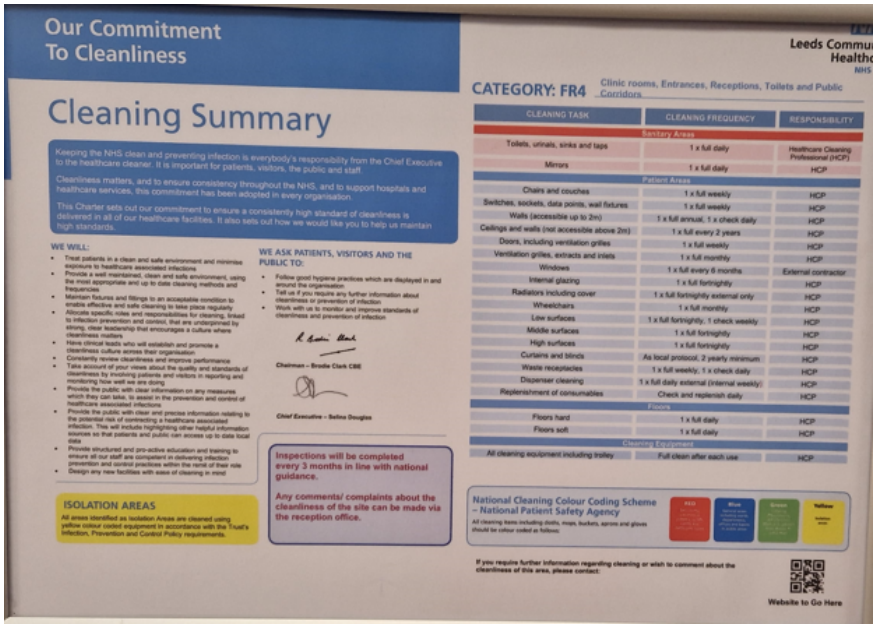


Fig. 19 and 20 examples of scores on the doors for the National Cleaning Standards

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

Site	FR category	Audit frequency	Target (%)	No of rooms audited	Target calculation	Max score	Actual score	% score	Stars
All sites	FR3	2 monthly	90	5	450	78	75	0.96	
	FR4	3 monthly	85	87	7395	1260	1122	0.89	
	FR6	12 monthly	75	65	4875	819	716	0.87	
	FR Blended		81						
	Total			**157**	**12720**	**2157**	**1913**	**0.89**	**5 star**

Fig. 21: Cleaning standard scores

3.2 Environmental Audits

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

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

3.3 Audit activity – LCH premises

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

During the report period the total average compliance score for health centres (owned, LIFT, leased and others) was 93% from 28 observations, with a range of 82% to 97%. Of the 28 health centres audited only one scored below the 85% pass score which was Woodhouse HC with 82%. A follow-up audit is scheduled for early May 2026.

- 26 Health Centres
- David Beevers Day Unit - Dental Suite
- St George's Centre for Musculoskeletal (MSK) and Children's Outpatients
- Leeds Assisted Living Centre
- Leeds Sexual Health Service (Beeston)
- Hannah House Respite Unit for children with complex health needs
- Wetherby Young Offenders Institute (WYOI) and Adel Beck Secure Children's Home (HMPs)
- 12 Police custody suites in South, East and West Yorkshire
- 4 Specialist inclusion learning centre (SILC) schools.
- 3 Recovery hubs
- 1 MSK unit: Wharfedale Hospital
- Wharfedale Hospital – 2 in patient areas

Each of the 9 audit categories scored 85% or above during the 2025-2026 period - a slight improvement on last year when the cleaning scored slightly less.

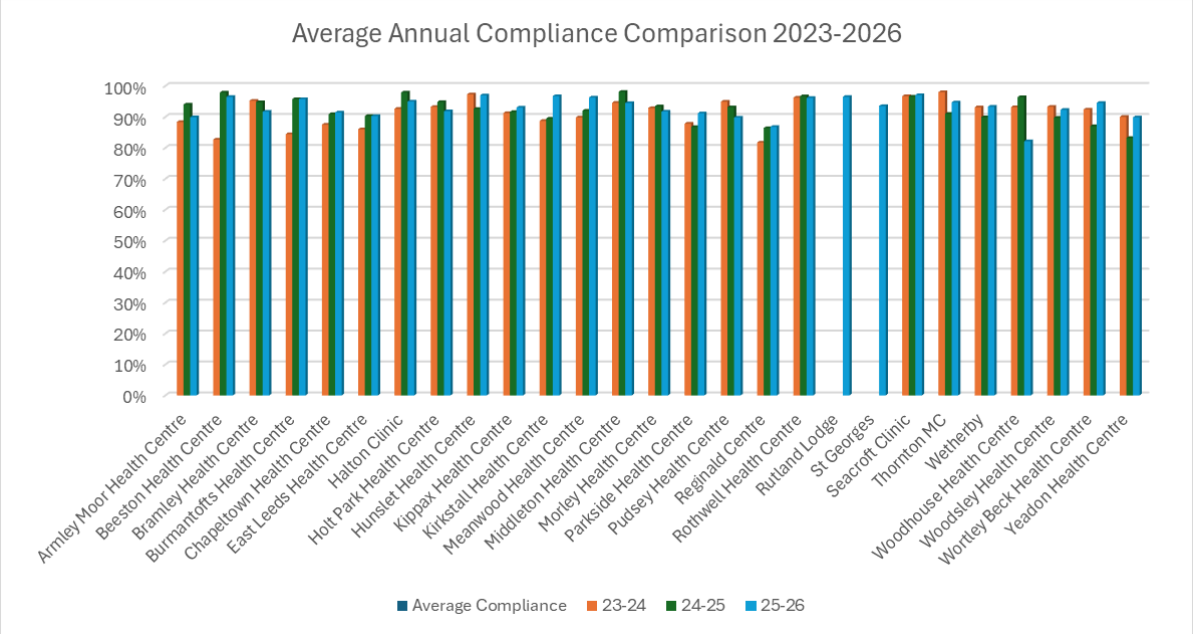
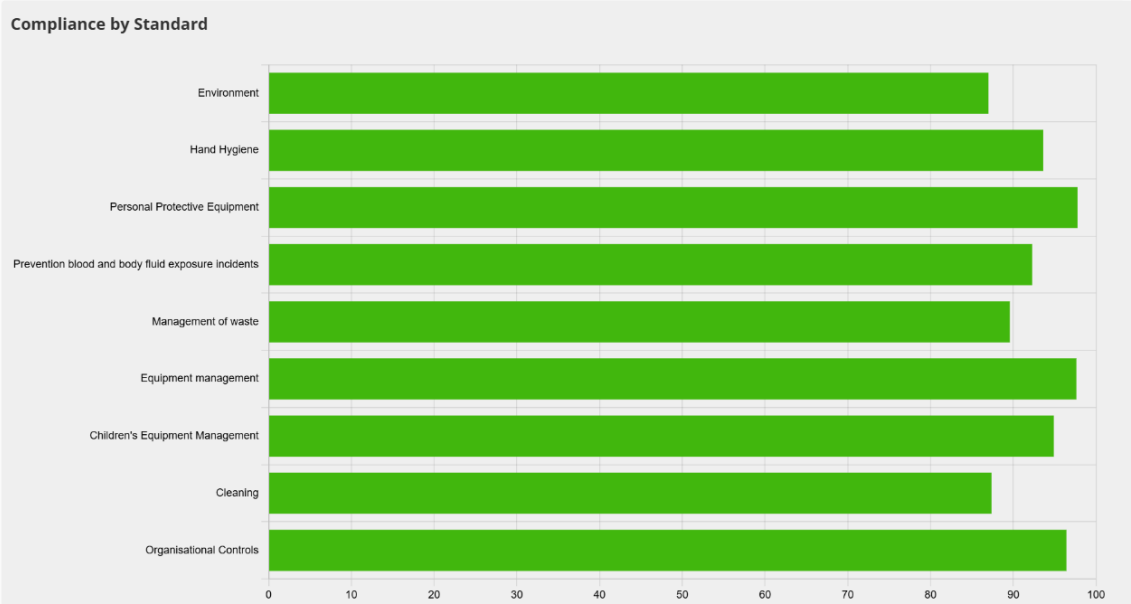


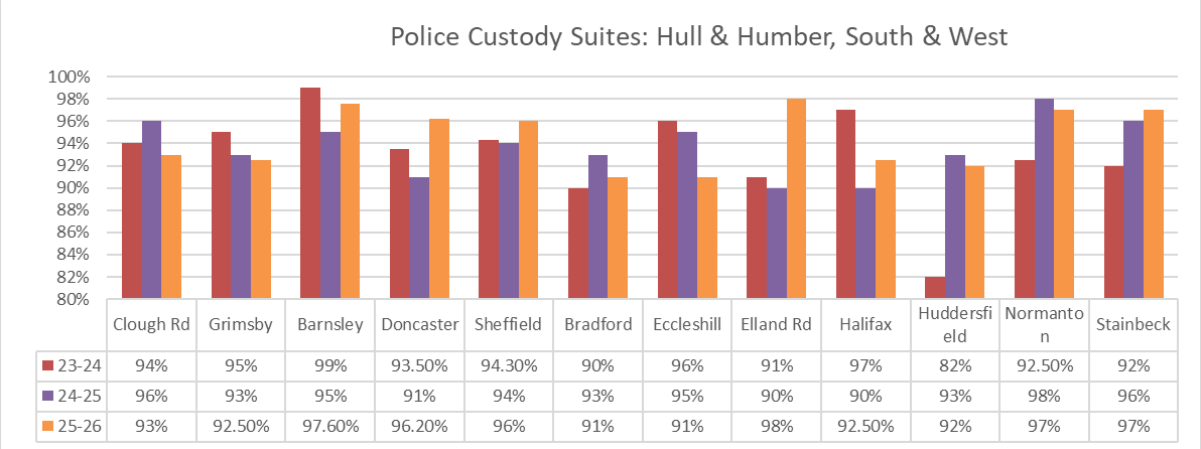
Fig 22: Average compliance comparison across all health centres 2022-2025



Compliance	Compliance by Standard
87.0%	Environment
93.6%	Hand Hygiene
97.8%	Personal Protective Equipment
92.3%	Prevention blood and body fluid exposure incidents
89.6%	Management of waste
97.6%	Equipment management
94.9%	Children's Equipment Management
87.4%	Cleaning
96.4%	Organisational Controls

Fig. 23: Overall compliance to the different standards. Fig.20: most common issues identified

Police Custody Suites: There are 12 Police custody sites situated across Humberside, South and West Yorkshire where LCH have a health provision contract. LCH staff work within the police custody suite buildings alongside non healthcare staff, which can present challenges in maintaining adequate IPC practice.



	Clough Rd	Grimsby	Barnsley	Doncaster	Sheffield	Bradford	Eccleshill	Elland Rd	Halifax	Huddersfield	Normanton	Stainbeck
23-24	94%	95%	99%	93.50%	94.30%	90%	96%	91%	97%	82%	92.50%	92%
24-25	96%	93%	95%	91%	94%	93%	95%	90%	90%	93%	98%	96%
25-26	93%	92.50%	97.60%	96.20%	96%	91%	91%	98%	92.50%	92%	97%	97%

Fig. 24: Average compliance comparison across all police custody suites.

Sexual Health Services: LSH are based at Beeston Hill health centre and have clinic space leased at Gateway West, which is beneficial for provision of a city centre presence.

Beeston Hill Sexual Health service when audited identified themes on clutter/storage, cleaning and sharp bin safety. The teams were working to address these.
Gateway West had posed several IPC concerns including non-compliant hand hygiene sinks. Mitigations had been recommended and the use of alternative rooms with compliant sinks were being explored. IPC worked closely with colleagues in LSH when the site was identified for refurbishment providing IPC support and advice. Due to the refurbishment Gateway West has not been audited during this period. The new unit is now open, fully refurbished with compliant sinks and an improved overall environment.

Secure Sites: Adel Beck continues to have a good standard of compliance and cleanliness. It is obvious that LCH clinical staff take ownership and pride of IPC within their environment. Aldine House a new 12 bedded secure unit in Sheffield was onboarded with an initial audit compliance of 95%. Wetherby Young Offenders maintained their compliance of 87%. A continued improvement remains with staff engagement and cleaning standards. The Environmental standards will remain challenging.

3.4 Integrated Wound Clinic Audits

Across Leeds Community Healthcare, Integrated Wound Clinics (IWC) are delivered at multiple sites throughout the city. As these locations are not consistently included within the annual IPC environmental audit programme, IPC teams undertake annual visits to these sites to provide assurance. These visits ensure compliance with the Health and Social Care Act and confirm that appropriate IPC standards are being maintained.

During the 2025–26 period, the IPC team conducted seven environmental audits of IWC sites. Of these, three audits were undertaken within GP practices and four within community-based hubs, reflecting the expanded scope of audit activity undertaken this year.

All IWC sites achieved compliance scores exceeding 85%, demonstrating a high level of adherence to IPC and environmental standards. However, some community-based hubs, which incorporate elements of social prescribing, did not fully meet standard IPC requirements. These settings, by nature, differ from clinical environments and therefore posed unique challenges. Specific issues were identified during the audits, and mitigation measures were implemented to reduce associated risks.

ABU Wharfedale: The IPC audit for Wharfedale was completed in March 2026. The two wards, Bilberry and Heather, were audited jointly and achieved an overall compliance score of 93.9%.
Key areas identified for improvement include decluttering the sluice room by removing inappropriate or broken equipment, ensuring that high-level dusting is undertaken and incorporated into a regular cleaning schedule, and improving storage practices to prevent contamination of PPE.
As the Wharfedale Recovery Hub is located within a Leeds Teaching Hospitals Trust building, actions arising from the audit are being jointly addressed in collaboration with the Trust's Estates team.

CBU Hannah House: The Hannah House audit was completed along with colleagues from Hannah House, Health and Safety and Estates. The audit tool was adapted early last year and following a successful pilot was used for this reporting period audit. The tool used acknowledges the bed base and is more detailed for the environment presented, rather than using the generic LCH premise audit tool, which is designed for Health Centre Audits. This has made the comparison of previous percentage scores unreliable, however has produced a detailed qualitative report on the estate. The score of 79.2% reflects the aging building and need for upgrade in some areas.

3.5 Patient Led Assessment of Care Environment (PLACE)

This report provides an overview of the results of the 2025 programme of Patient Led Assessments (PLACE) of Care Environments. The assessment process was undertaken at Hannah House and Wharfedale Recovery Hub (WRH) Heather and Billberry Units during October and November 2025. The Trust's results have been submitted to the Department of Health.

Results for 2025/26:

Ward Type: The Ward Assessment - Acute and Community Hospitals

Ward Name	Cleanliness	Food	Privacy	Condition, Appearance & Maintenance	Dementia	Disability	First Impression	Final Impression		Comments
Acute 1	100.00%		88.89%	100.00%		100.00%	Confident	Confident	⇨	We did not see documentation relating to frequency & completion of cleaning tasks

Fig. 25 PLACE Scores for Hannah House

Ward Type: Food

Ward Name	Cleanliness	Food	Privacy	Condition, Appearance & Maintenance	Dementia	Disability
Billberry		98.72%			100.00%	100.00%

Ward Type: The Ward Assessment - Acute and Community Hospitals

Ward Name	Cleanliness	Food	Privacy	Condition, Appearance & Maintenance	Dementia	Disability	First Impression	Final Impression		Comments
Billberry	100.00%		90.00%	100.00%	76.00%	85.71%	Confident	Confident	⇨	
Heather	100.00%		90.00%	100.00%	76.00%	85.71%	Confident	Confident	⇨	

Fig. 26 PLACE Scores for Wharfdale

3.6 Waste, water and ventilation management

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

Under the Terms of Reference, a six-monthly Water Safety Group meets which is chaired by the Senior Estates Manager. The aim of the group is to provide the framework to ensure that the Trust complies with current legislation and best practice guidelines for control of water quality and water systems across the Trust. A water engineer/specialist is contracted by LCH to provide subject matter expertise.

3.7 Central Sterile Services Department (CSSD)

Leeds Community Healthcare NHS Trust has a framework agreement in place with *Synergy Health (UK) Limited T/A STERIS Instrument Reprocessing*. Steris are audited twice per year, one is performed by a member of the Internal Quality team at Steris, the second is external performed by the British Standards Institution (BSI).

The Assurance visit took place on the 29th May 2025, to Steris at Tameside. Members of dental, podiatry and IPC attended. The process was observed; however no formal audit tool is in place to capture assurance. Work is ongoing to ascertain the formal contractual arrangements between LCH and Steris. Contractual meetings were taking place prior to the covid pandemic but these have not restarted. We do have a certificate of accreditation that the company meet the correct ISO standard STERIS Certificate ISO 13485:2016 which is current.

An assurance report was provided to NHS England in February 2026, regarding the Trust's oversight of externally delivered surgical instrument decontamination services, in alignment with HTM 01-01 and HTM 01-06.

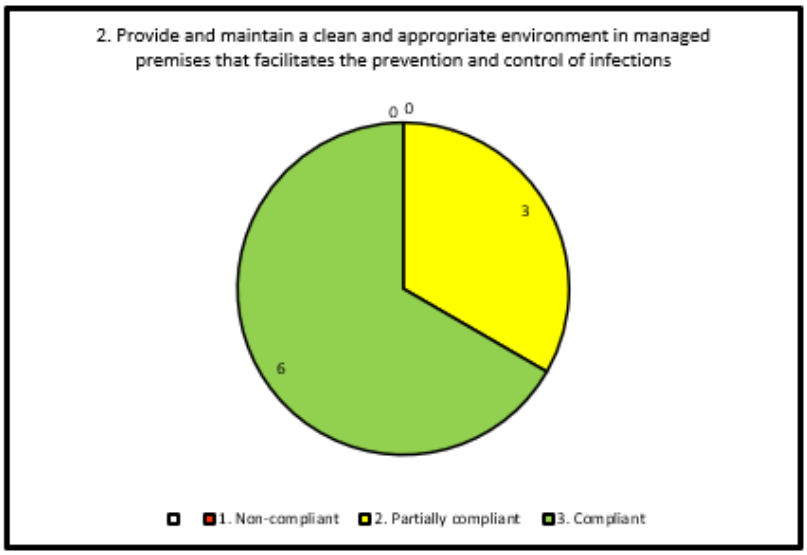


Fig. 27: BAF compliance to Criterion 2.

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

4.1 Antimicrobial Resistance

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

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

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

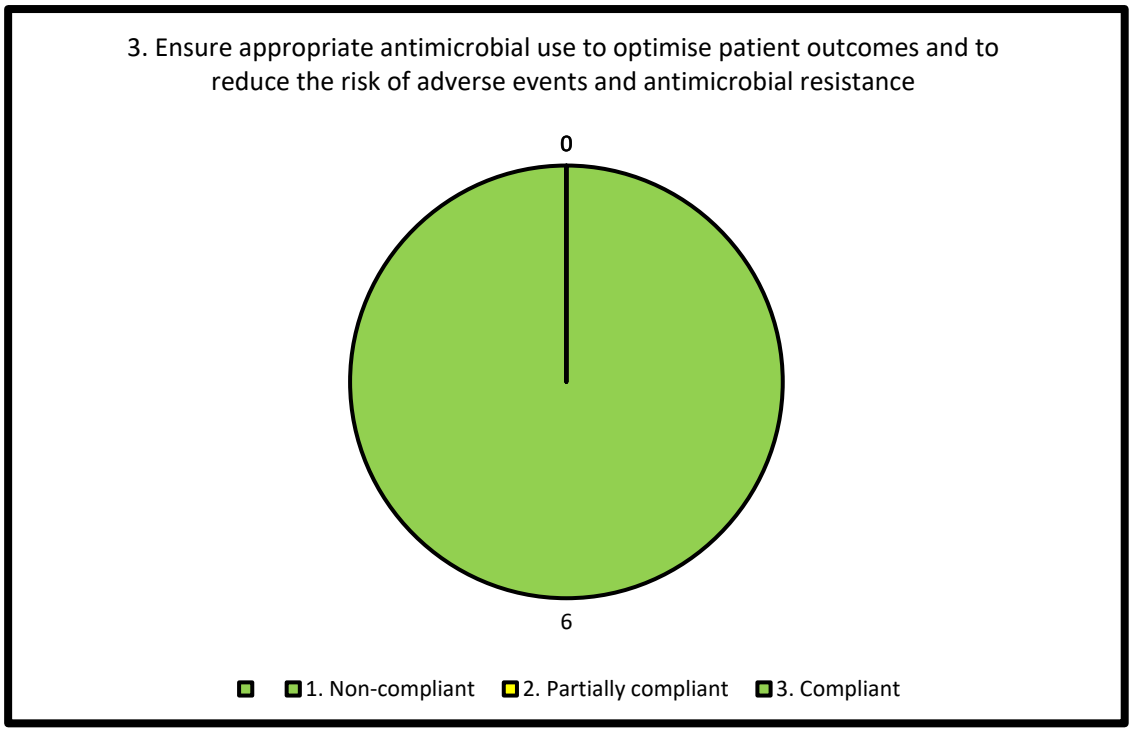


Fig. 28: BAF compliance to Criterion 3.

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

5.1 Conferences and awareness campaigns

Hand Hygiene Campaign May 2025

During the week commencing 5th May 2025, the team actively promoted World Hand Hygiene Day. IPC engaged with a range of teams across the business units to reinforce key messages on appropriate glove use, effective handwashing techniques, and the correct use of hand hygiene products. Multiple sites and teams were visited as part of this initiative.

IPC Week October 2025

Cold Weather, Hot Topics – Winter IPC Strategies was held on 16th October 2025 at Tenant's Hall in Middleton. The team held two half day study events for LCH staff with a focus on promoting winter wellness and preventing outbreaks ahead of the winter months via the following presentations:

- Sharps awareness and needlestick injury prevention
- Outbreaks and the chain of infection
- Managing diarrhoea in the community
- The importance of hand hygiene
- Vaccination
- Deteriorating patient

The event was well received and feedback was positive; however, attendance was low and those present on the day told us that a full day event was likely to attract more attendees; this is feedback that we are using in the planning for the May conference on World Hand Hygiene Day.

Fig. 29: Winter IPC Strategies – IPC Week 2025

Breeze Summer Event

The IPC team attended 5 Breeze events with Leeds City Council, Health Protection Team colleagues over the summer. Engagement with members of the public (adults & children) on a range of IPC related topics occurred. The focus of the events was to speak with families about Antimicrobial Resistance (AMR) and appropriate use of antibiotics. Events attended, were in high use & high prescribing areas of the city. We had conversations regarding AMR and collected 45 Seriously Resistant pledges – which is a commitment by healthcare practitioners to actively reduce, monitor, and manage the most dangerous antibiotic-resistant infections.

Fig. 30: Summer Breeze Event 2025

5.2 IPC Oak Web Page

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

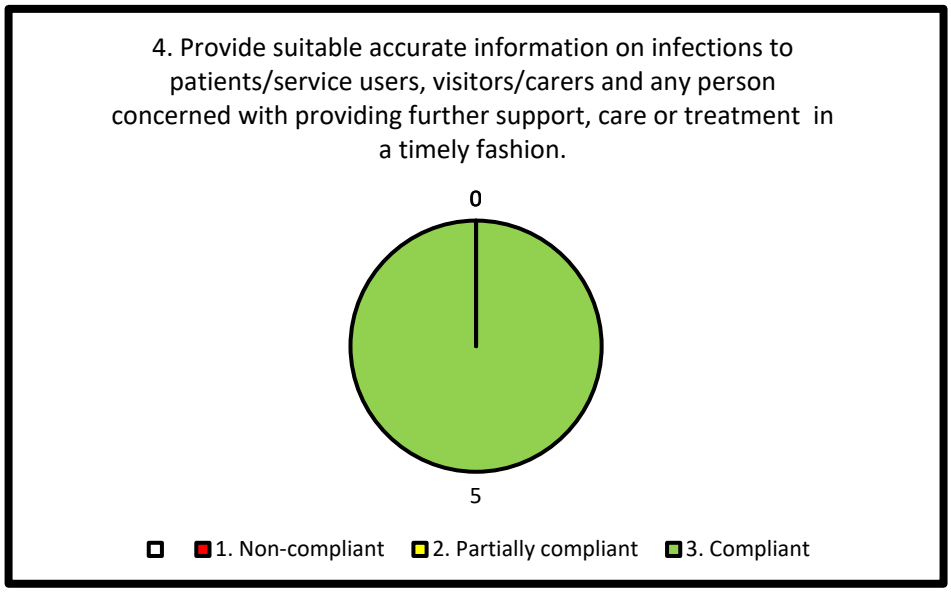


Fig 31: BAF compliance to criterion 4

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

6.1 Outbreak management and surveillance software

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

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

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

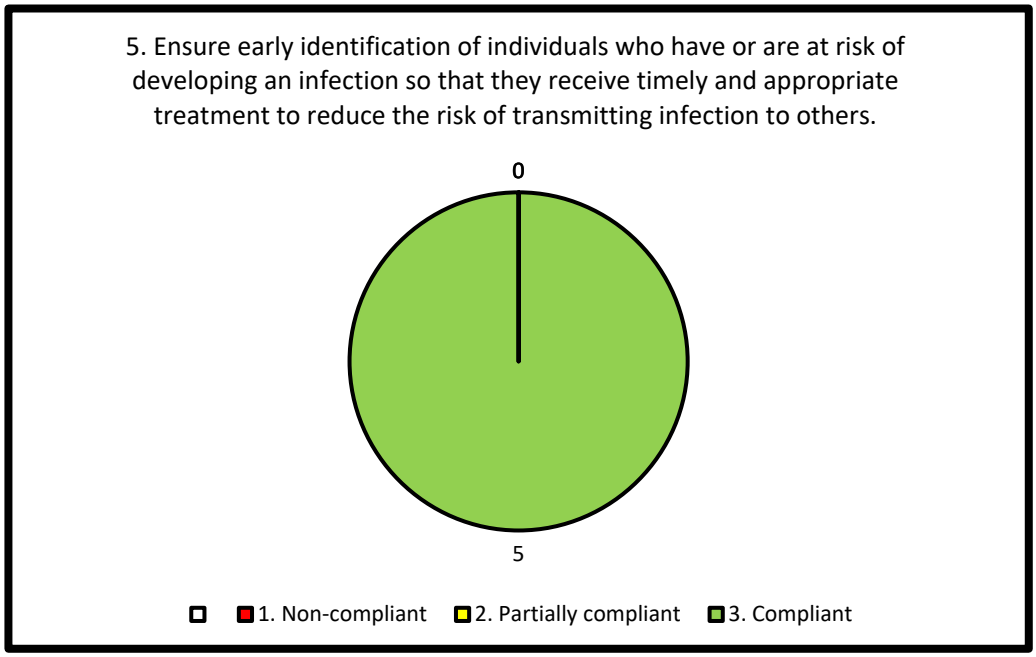


Fig. 32: BAF compliance to Criterion 5.

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

7.1 Statutory and Mandatory Training

The Health and Social Care Act (2008) identifies the importance of effective education and training for all staff members. The continued development and implementation of an effective mandatory training programme remain central to the LCH Infection Prevention strategy. All internal mandatory training is via E learning on ESR. All sessions meet the statutory and mandatory requirements of learning outcomes for Infection Prevention and Control levels 1 and 2 in the UK Core Skills Training Framework.

Training compliance for Level 2 averaged **90%** at year end, reflecting a slight improvement compared with the 2024–2025 reporting period. Compliance with Level 1 training reached **92%**, representing a marginal decrease from the previous financial year.

	Q1 L2	Q1 L1	Q2 L2	Q2 L1	Q3 L2	Q3 L1	Q4 L2	Q4 L1
ABU	79.3%	96.7%	81.6%	100%	83.2%	92.5%	84.8%	86%
CBU	89.5%	91.7%	91.6%	91.7%	91.8%	90.9%	92%	100%
SBU	92.0%	86.3%	92.6%	86.7%	92.8%	89%	92.7%	89%

Fig. 33: IPC Mandatory Training uptake per business unit 2025/26

7.2 Student placements

The IPCT supported 13 learners throughout the year, 7 from Leeds Beckett, 6 from University of Leeds. First, second and third-year undergraduate nursing students, were supported on placement with the majority spending 2 weeks with the team. This year the team welcomed 2 child branch first year students, due to reduced capacity within the 0-19 PHINS Team allocation this offer was made and successfully executed – 2 three-week placements were accommodated.

The team have 92.1% positive feedback, which is an decrease from 96% in 2024/25. Behaviour and Values are well evaluated at 100% and the comments made by students demonstrate the positive experience they have. The placement is evaluated positively at 92.1%. The team now only accept second and third year students, this is following evaluation of first year students. First year students have shared that the placement has been difficult to contextualise, and as a first placement, or having limited healthcare exposure is difficult to put understanding into the learning received. The higher education audit completed in summer 2025 received good feedback and no action planning has been required.

We received excellent feedback as exampled below:

''My mentor was really supportive and arranged opportunities with different team members''

''They always made time to talk to me all the time about different questions I may have''

''This placement was the most positive experience I have had so far whilst studying for my nursing degree. I learnt about what the LCH infection team do and how they practice. The staff are absolute lovely and welcoming. They got me involved in all sorts of projects such as vaccinations, quality improvement, staff resource creation for the wider trust, audit processes in a wide range of areas like care homes, police station holding cells and a young offenders institute. I also got the opportunity to help teach people in other care settings about infection control and best practices. I was able to work with the LTHT infection team and the CIVAS team.''

''Every single staff member on this team is absolutely wonderful, they made me feel included since day 1 and got me involved in a wide range of activities and projects. Made me really feel like I was part of the team!''

''Nothing to improve this placement, I just wish I was able to spend more time with them as I really enjoyed this placement.''

7.3 IPC Team Development - Education and team building

- Team members attended the Queens Nursing Institute Aspiring Leader Programme.
- The team has had engagement with the Infection Prevention Society (IPS) for continuous professional development and the 'Institution Membership' was purchased, to support education, learning and networking.
- A member

7.4 Fit Testing

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

During the reporting period, the IPC Team have completed 95 Fit Tests for LCH staff, compared to 89 in 24/25. There are currently 211 staff members in LCH with an up-to-date Fit Test (completed within 2 years). All quantitative fit testing is currently undertaken by the IPC team. Members of some teams in the Trust such as Leeds Sexual Health Service, Neighbourhood Nights and Wharfedale have equipment and training to carry out qualitative fit testing for staff in their locality. The IPC team remains responsible for holding the records for staff fit tested in this way.

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

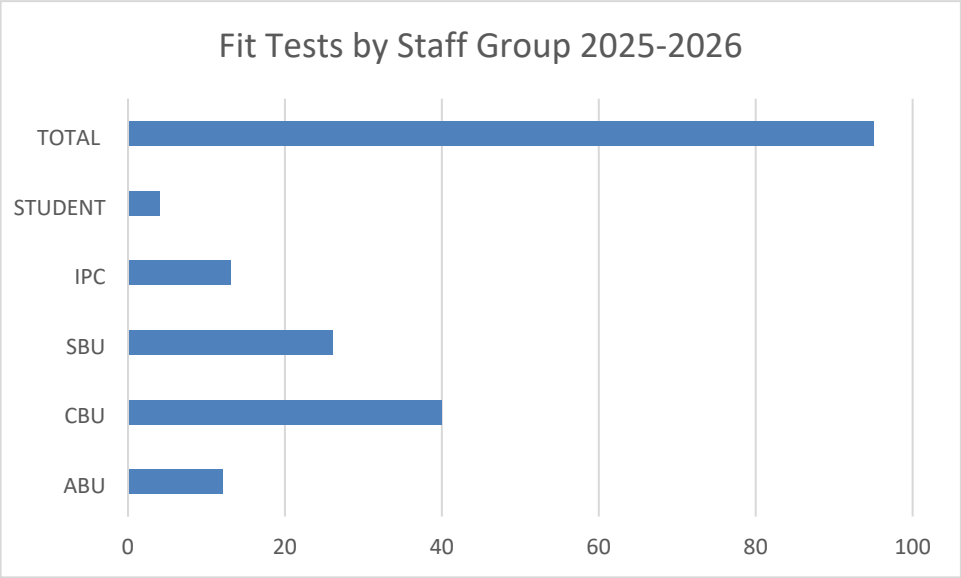


Fig 34: The total number of staff who were newly fit tested in 25/26.

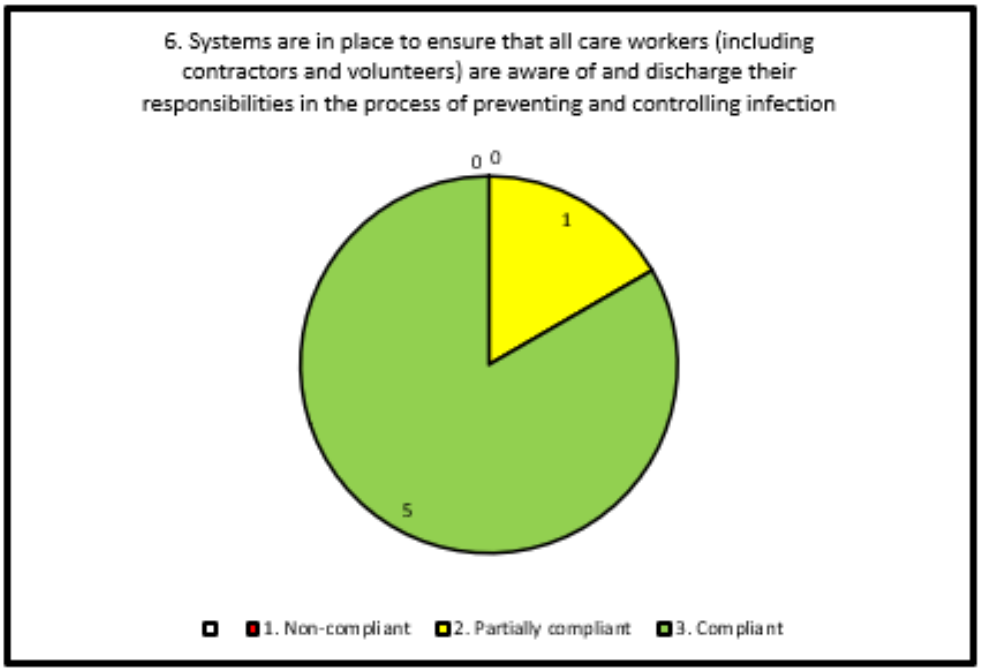


Fig.35: BAF compliance to Criterion 6

Criterion 7	Provide or secure adequate isolation precautions and facilities

8.1 Isolation Facilities

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

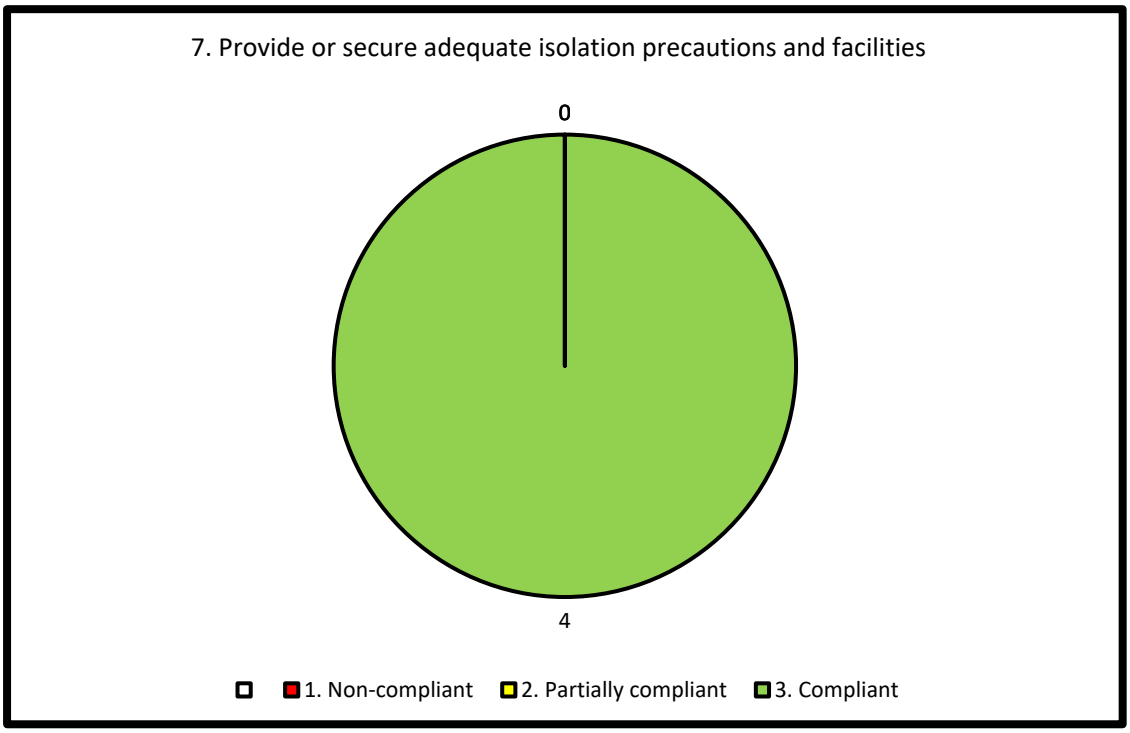


Fig. 36: BAF compliance to Criterion 7.

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

9.1 Microbiology Provision

LCH has a dedicated contracted microbiology service with Leeds Teaching Hospitals NHS Trust, which provides a 24/7 service with UKAS (United Kingdom Accreditation Service) accreditation. A microbiology consultant is available 7 days a week with core contracted hours via Leeds Integrated Care Board (ICB) to provide specific support and advice. The service provides support with IPC Patient Safety Investigations as well as policy and guideline updates. All results for specific organisms such as MRSA, CDI, E. coli, influenza etc, are reported via PPM+ which is then accessed by the IPC Team and reiterated to clinicians on measures required via the SystmOne electronic patient record.

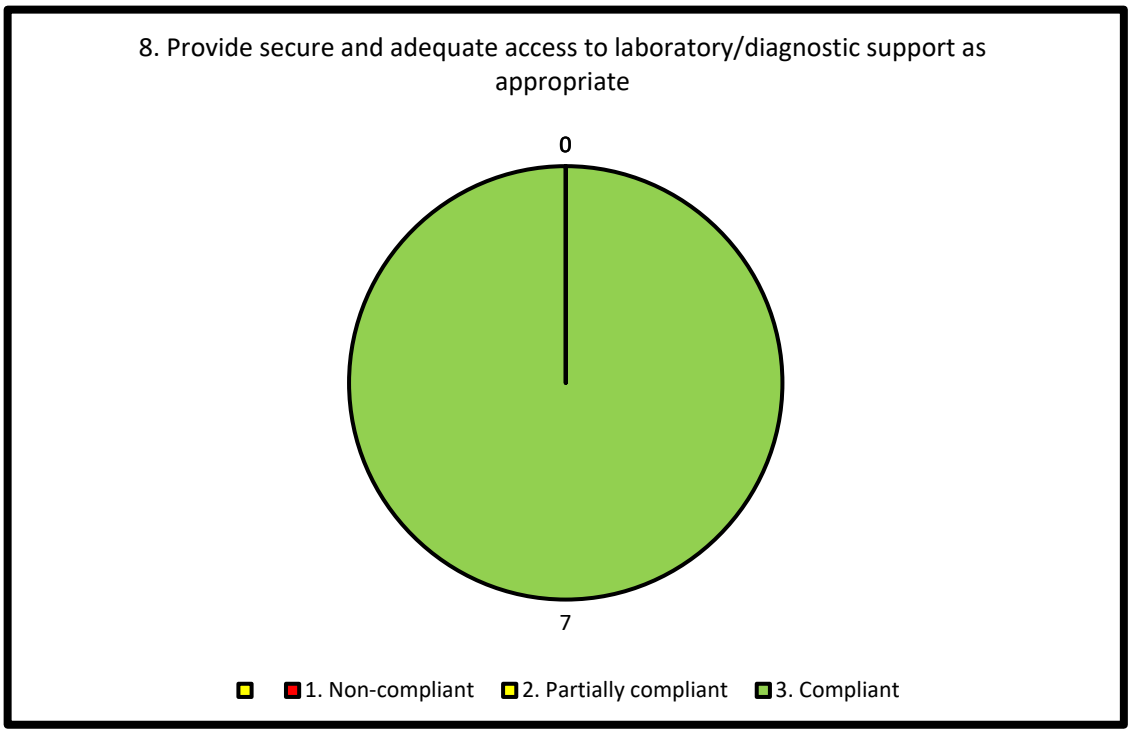


Fig. 37: BAF compliance to Criterion 8.

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

10.1 Policies and guidelines

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

- Aseptic Non touch Technique (ANTT) Policy
- Clostridium Difficile
- Diagnostic & screening Procedures including safe sampling, handling and transportation of specimen's policy
- Food Safety
- Guidelines for the management of Headlice
- Guidelines for the management of Animals in the community in-patient health care premises
- Guidelines for the management of Scabies
- Guidelines for the management of Toys in the community
- Healthcare waste
- Infection Prevention and Control overarching policy
- Isolation policy and procedures for LCH trust in patient areas
- Linen and Laundry Management Policy
- Local Decontamination of reusable medical equipment
- Management of communicable disease outbreak within the community setting
- Management of Patients with Meticillin Resistant staphylococcus Aureus (MRSA) in the community and social care settings
- Prevention and control measures for specific infections in the community
- Prevention and management of multi-resistant bacteria (Including Carbapenemase producing Enterobacteriaceae (CPE) Glycopeptide Resistant & extended spectrum Beta-lactamase
- Respiratory Virus Policy
- Standard Precautions Policy (includes hand hygiene, PPE & management of spills within the community
- Transmissible Spongiform encephalopathy: Prevention of cross infection incidents policy
- Management of the Deteriorating Patient Policy

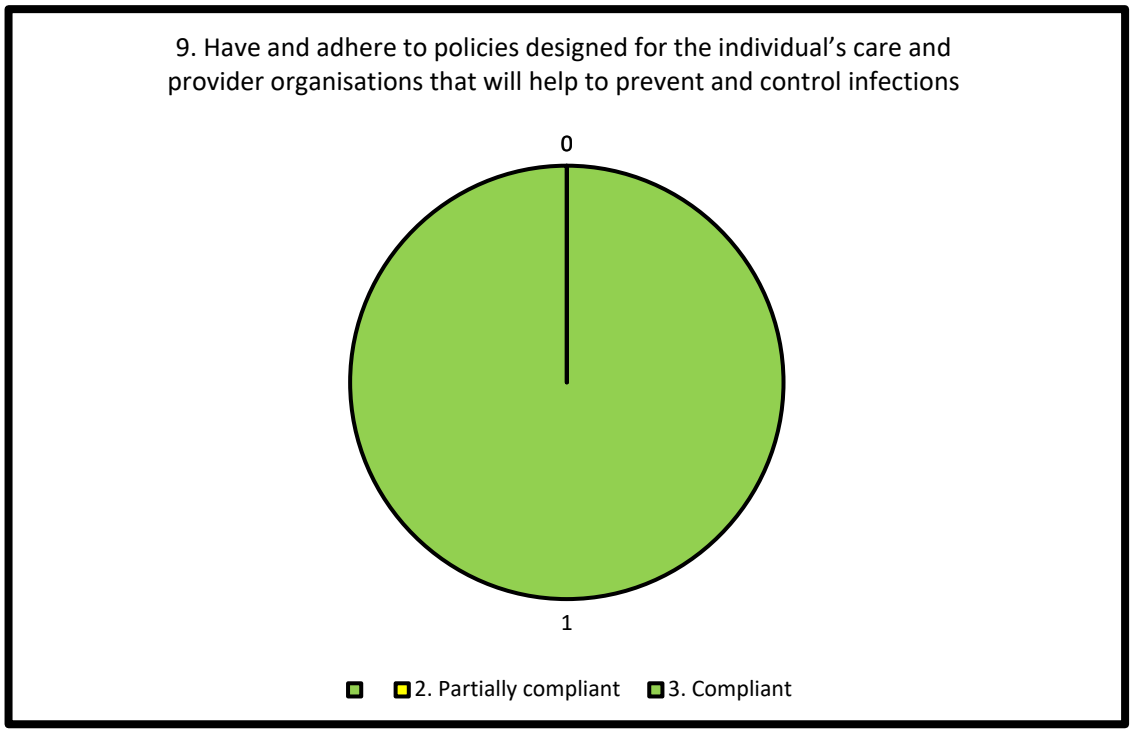


Fig. 38: BAF compliance to Criterion 9.

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

11.1 Staff health

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

11.2 Seasonal Staff Winter Vaccination Campaign – Influenza 2025/2026

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

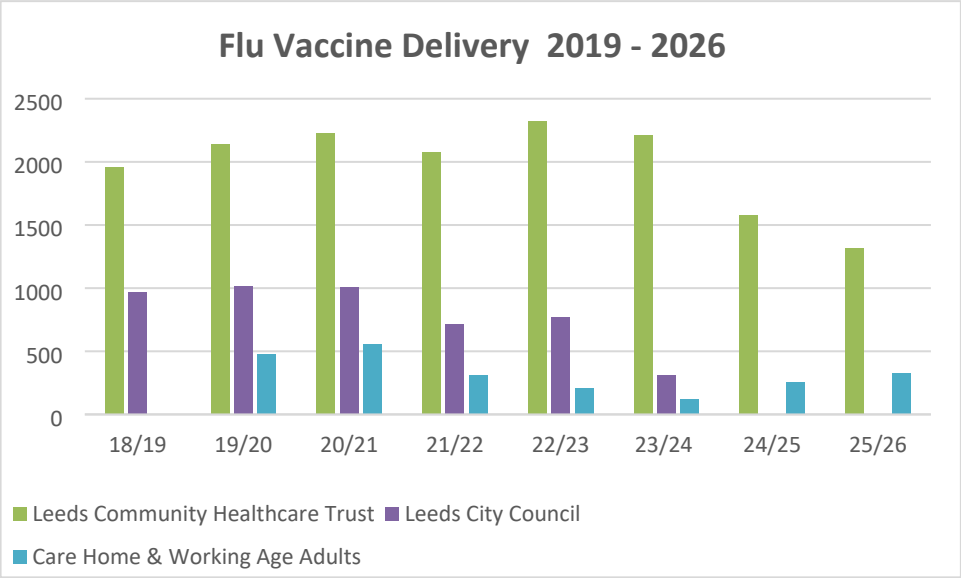


Fig. 39: Influenza Vaccines administered 2019-26.

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

1,317 of 3,602 eligible LCH staff were recorded as having received the flu vaccine. This figure includes staff who self-reported vaccinations obtained outside the organisation, such as through their GP or a local pharmacy. Although the absolute number of vaccinated staff was lower than in the previous year, overall uptake increased to 53%, compared with 48% in the 2024/25 season.

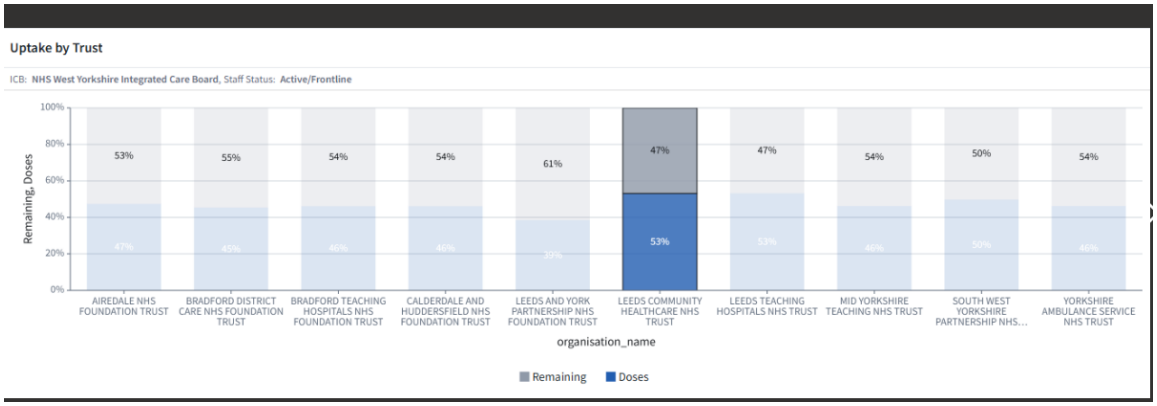


Fig. 40: NEY Autumn Covid and Influenza Campaign per trust (frontline workers)

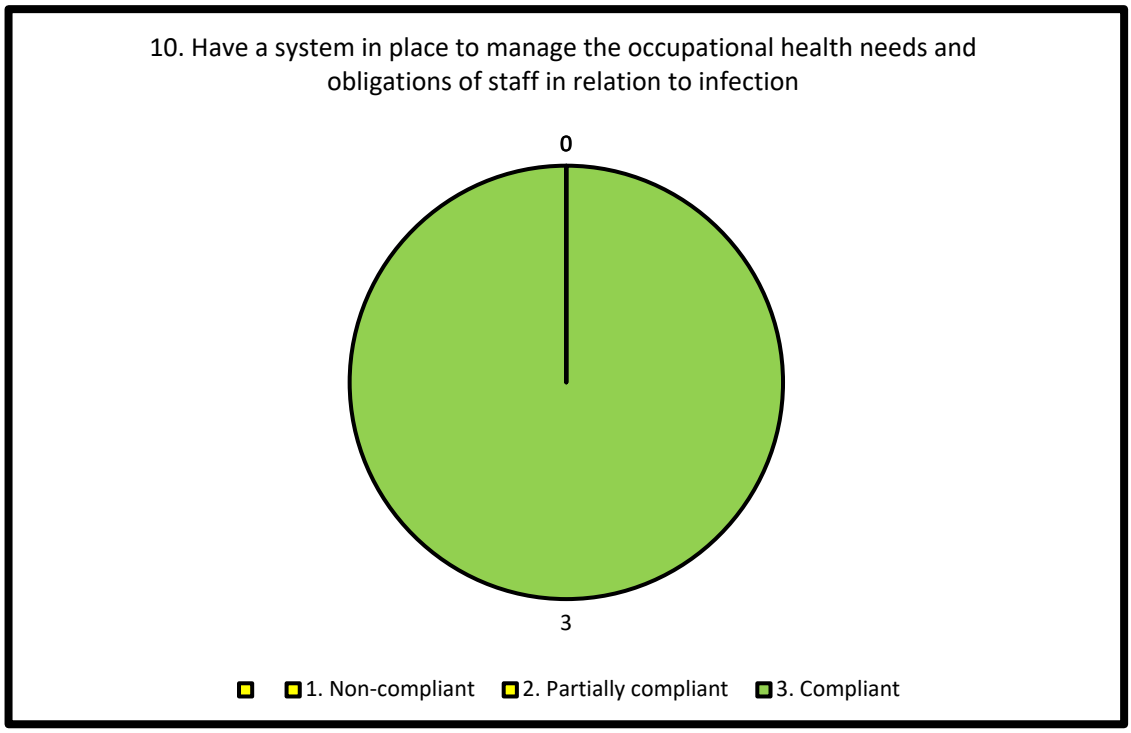


Fig. 41: BAF compliance to Criterion 10.

12. IPC team structure and celebrations

- There are currently 16 members of the IPC team which equate to 14.2 WTE, which includes adult, children, and learning disability nurses.
- The team has continued to work at an enhanced capacity with an uplift in funding from Leeds City Council in line with the cooperation partnership agreement.
- The IPC team had a Quality Walk in July 2025; where we were awarded Outstanding overall. This is a huge achievement for the team, growing from the Good awarded in the previous year. This highlights not only the great work the team are doing but also how the team are able to support each other within the different work streams.

- In June 2025 Rachael Ainley IPCN was highly commended for her significant contribution to the development and implementation of the new digital Hand Hygiene tool, which was successfully rolled out across all Leeds Community Healthcare (LCH) services during the year.
- In August 2025 Leanne Parker was awarded the title of Queens Nurse, it recognises nurses who go above and beyond in their role and make a positive impact on their patients and services in the community.

- In November 2025 Liz Grogan Head of IPC and Deputy DIPC was awarded the Silver Chief Nursing Officer (CNO) Award for her outstanding contribution to social care by Deborah Sturdy, Chief Nurse for Adult Social Care NHS England. This prestigious recognition celebrates individuals who go above and beyond in their work, making a lasting impact on the lives of those they support.
- In January 2026 Dave Hall, was awarded a Cavell Star Award in recognition of his exceptional contributions to patient care. The Cavell Star Award honours those who go above and beyond for patients and colleagues, and Dave is a truly deserving recipient.

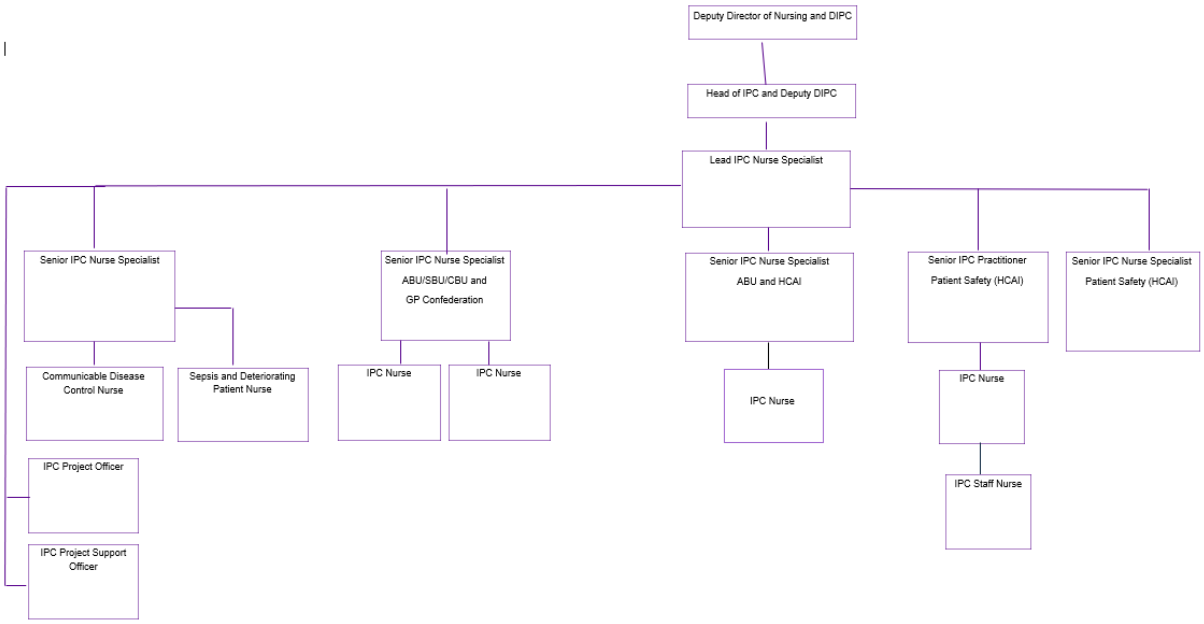


Fig. 42: IPC staffing structure

13. Challenges and forward plan 2026/2027

Challenges for 2026-27 will include:

- Achievement of the HCAI objectives with specific emphasis on the gram-negative agenda and CDI.
- LCH Cost improvement and the Quality and Value programme and the trust integration programme with Leeds and York Partnership Trust.
- The uncertainty around potential high consequence infectious diseases including new and emerging infections and pandemic preparedness.

Forward Plan 2026 - 2027

- Link in and combine our work with the recommendations in the Chief Medical Officers Annual Report for Infectious Diseases with particular emphasis on expanding our focus on older adults infection prevention and cross cutting our priorities around health inequalities.
- Continue to focus our attentions around the collaborative citywide HCAI Improvement Group including CDI's MRSA BSI and GNBSI's.

- Outcome measurement of the services we provide, outlining the impact to the system.
- Align fit testing to the newly devised Core Share App – Fit Test Hub and promote shared organisational responsibility.
- Building on pandemic preparedness for future potential outbreaks of novel viruses and to work with the LCH Emergency Planning Officer to update emergency planning resilience, look to develop a joint plan with LYPFT.
- Embed work around antimicrobial resistance, building on collaborative work with the West Yorkshire ICB incorporating core principles around data, education and sustainability and the impact on climate change, in line with the UKHSA National Action Plan.
- Education and development of IPC team and implementation of the core competencies from the Infection Prevention Society (IPS).
- A focus around Quality Improvement to be implemented by IPC in relation to auditing, hand hygiene compliance, fit testing and HCAI Surveillance.
- Continue to build engagement with the ICS for West Yorkshire for IPC for the HCID Contract that LCH has in place with the ICB.

Cooperation agreement priorities for 2026/27

- **Zero tolerance to preventable HCAIs**
  Across LCH services and the wider community healthcare system, including strengthened surveillance (HCAIs – particular focus on MRSA, GNBSI *E. coli*), community engagement, and alignment with UKHSA/CDC work on *E. coli* (including STEC).
- **Strengthen prevention and management of key infections**
  Focus on UTIs, sepsis, and antimicrobial resistance (AMR), supported by robust surveillance and early intervention.
- **Enhance care home quality and infection prevention support**
  Maintain an effective IPC offer, develop surveillance dashboards, identify outbreak trends, and support improvements in care for older people.
- **Develop education, training, and workforce capability**
  Expand HCAI training to the wider public health workforce, re-establish preventative education programmes, and share key resources (e.g. I-Spy) to support system-wide learning.
- **Provide IPC leadership in system planning and preparedness**
  Lead on outbreak preparedness, pandemic planning, and whole-system coordination.
- **Strengthen outbreak management and response**
  - Provide expert leadership in managing infectious disease outbreaks, including gastro-infectious diseases. Review of Communicable Disease Control arrangements
- **Promote inclusive and person-centred IPC services**
  Progress towards becoming a Dementia Friendly Service and ensure IPC approaches are accessible and responsive to population needs.

14. Conclusion

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

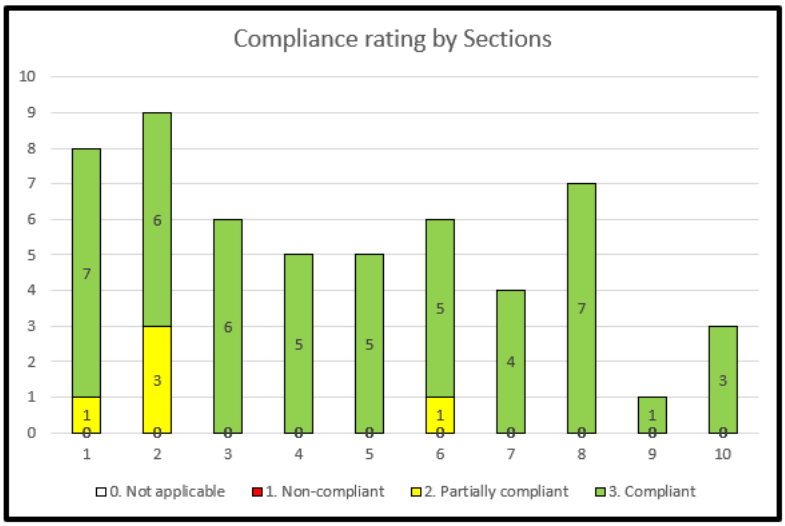


Fig.43: Overall compliance with the Health and Social care Act (2008)

It is evident that 2025-2026 has continued to be a very successful year for the Infection Prevention and Control team within LCH. The team have delivered successfully on the sixth fiscal year of the enhanced 'Partnership Cooperation Agreement' with Leeds City Council, which has now seen a permanent uplift in funding from public health monies.

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

15. Recommendation

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

16. References

- Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)
- NHS England » National infection prevention and control
- Chief Medical Officer's Annual Report 2024 – Health in Cities

Appendix 1: IPC Board Assurance Framework

IPC BAF QC March 2026 V1.0.docx

Key line of enquiry (partial compliance)	Risk of partial compliance	Mitigation / current actions
1.6 Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Gaps have been identified in staff compliance with the Standard Precautions Policy, specifically regarding hand hygiene and adherence to “bare below the elbows” requirements.	A newly developed IPC audit tool has been implemented across LCH to enable consistent monitoring of compliance and early identification of non-adherence. IPC education and training are overseen by the IPCC and HSG, with strengthened hand hygiene messaging embedded throughout mandatory training. The staff induction programme includes comprehensive hand hygiene training, supported by regular refresher sessions and access to e-learning modules. A preferred product list ensures staff carry required equipment when undertaking domiciliary visits, enabling compliance in all care settings. Access to hand hygiene supplies when in clinic and in patient areas. Additional mitigation includes increased visibility of IPC champions across services, and targeted support for teams with low audit scores. Feedback loops have been established to ensure learning from audits is shared at team meetings, and managers are required to monitor and address non-compliance promptly through supervision and performance management
2.1 There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	We continue to not have full assurance from external partners regarding cleaning activities at certain sites, for example Leeds City Council at St George’s Centre and the Ministry of Justice at Wetherby Young Offenders Institute.	A combined short-life working group with Estates and Facilities continues to operate to address and monitor assurance gaps relating to external cleaning providers. This group reviews issues escalated from IPC Environmental and Cleaning Audits, identifies areas of concern, and agrees actions with the relevant partner organisations. Ongoing assurance, risks, and unresolved issues continue to be formally escalated to the IPCC. Strengthened communication pathways, routine review meetings, and shared action plans aim to improve transparency, responsiveness, and overall confidence in external partners’ cleaning performance.
2.4 "There is monitoring and reporting of water and	When a positive water sample is identified, there must be a clearly	A risk assessment has been completed to identify gaps and associated risks arising from the policy being out of date. The Water

ventilation safety, this must include a water and ventilation safety group and plan. 2.4.1 Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. 2.4.2 Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01."	defined and consistently applied escalation and management process. Although a water safety expert and Estates lead are actively involved, the current level of assurance remains insufficient. The Water Safety Policy is now overdue for review and requires updating to reflect current risks, responsibilities, and operational processes. In addition, there is currently no formalised plan for the management of ventilation systems. This gap was highlighted at IPCC (9 July 2025) and has been escalated by the DIPC via the AAA to Quality Committee.	Safety Group continues to meet on a six-monthly basis to review monitoring results, risks, and areas requiring escalation. However, a dedicated Ventilation Group is now required to develop a Trust-wide plan, covering air conditioning units and ventilation systems across LCH premises and those managed by third-party organisations. The group would provide oversight of compliance, ensure appropriate governance structures are in place, and develop clear operational pathways for responding to ventilation concerns. These requirements will be incorporated into the forthcoming policy review, with regular reporting and escalation through established IPC governance routes.
2.5 There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	There is a risk that we are not fully informed of planned maintenance activities undertaken by external partners. This lack of visibility may impact compliance with HTM requirements within the Built Environment and could affect the safe and consistent provision of services.	A formal process for sharing and reviewing planned maintenance activity is now in place for all LCH-managed premises and is included as a standing agenda item at IPCG to ensure ongoing oversight. IPC audit findings are routinely shared with Estates and Facilities, enabling timely action and increased transparency. Areas identified as non-compliant are subject to targeted follow-up, with re-audits scheduled every three months to monitor improvement and provide assurance. Strengthened communication pathways between IPC, Estates and Facilities, and external partners support earlier identification of risks and ensure that any emerging issues are escalated through established governance routes.
6.5 That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	A rolling training programme is in place to support staff requiring FFP3 fit testing. However, there is a risk of inaccuracy within the current fit-testing records because the data is stored on a locally held Excel spreadsheet. This format makes it difficult	Fit-testing records are currently maintained by IPC on a local Excel database; however, this limits visibility and does not provide individual staff or service teams with clear ownership of their compliance status. In March 2025, an app-based solution was identified by the Workforce & Innovation (WFI) team, and a scoping exercise with Corshare is underway to support development.

	to maintain accurate, real-time information—particularly when staff leave, change roles, or are on long-term absence. Although this meets HSE compliance requirements, NHS England recommended during the COVID-19 pandemic that organisations store fit-testing data within a formal system such as ESR to ensure workforce-wide visibility and ownership.	The development of the app has been complex, requiring multiple iterations and integration considerations across systems. Despite this, a rollout across LCH is planned for **Q2 of 2026/2027**, which will allow all clinical frontline staff to be uploaded onto the system and undertake a digital risk assessment to determine their requirement for FFP3 fit testing. In parallel, considerations are being given to how the solution could interface with, or be adopted by, **LYPFT**, ensuring future alignment and reducing duplication where staff work across both organisations. The new digital system aims to significantly improve the accuracy, accessibility, and governance of fit-testing data, bringing LCH in line with NHS England's recommended approach. This is on the risk register.
6.6 If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	There is a risk that staff may not be receiving regular updates, refresher training, or competency checks to ensure that clinical practice remains aligned with the current evidence base. Limited assurance around clinical competencies increases the risk of avoidable HCAIs, particularly in areas requiring high-precision skills such as aseptic technique, taking observations as well as the insertion and maintenance of catheters. Without a reliable system for verifying that staff remain competent in these core clinical skills, there is a concern that unsafe variation in practice may occur, potentially compromising patient safety.	Staff currently self-declare their competencies and work autonomously within their professional codes of practice. Bespoke training is available from specialist teams such as CUCS, CVAS and IPC to support key clinical skills, including aseptic technique. LCH is undertaking further scoping work to develop a digital app to record staff competencies and identify additional training needs, for example recognising the deteriorating patient and escalation of soft signs. This development is included on the risk register.

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

Agenda item:	2026-27 (21) (Blue Box)
Title of report:	**Guardian For Safe Working Hours - Quarterly Report**
Meeting:	Trust Board
Date:	23/07/2026

Presented by:	Ruth Burnett, Medical Director
Prepared by:	Ruth Burnett, Medical Director

Purpose of the report:		
This report provides: Provides board with an update around national changes terms and conditions for resident doctors, Exception reporting reforms and local implementation. Quarter 3 and 4 update	Approval	
	Discussion	
	Assurance	X

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

Summary of Key Issues:

- Dr Baljit Karda's appointment as the guardian of safe working from June 2026.
- Introduction of the new exception reporting system, with GOSWH and the People's Directorate rolling out an MS Forms process from 4 February 2026 to replace email based reporting.
- Implementation of the NHS England 10 point action plan, with GOSWH progressing key improvements to resident doctor working lives and appointing appropriate board level leads.

Previously considered by:	GoSWH Quarter 2 report presented Jan 2026
Outcome of previous discussion/s:	n/a

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

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

Recommendation(s)	• Board is recommended to note the appointment of Dr Baljit Karda as the new Guardian of safe working from June 2026. • Board is recommended to note the introduction of the new MS Forms exception reporting system since 4th February 2026. • Board is recommended to endorse the implementation of the NHS England 10-Point Plan.

List of Appendices:	Nil

Gurdian of Safe working hours report

- **1 Executive Summary**

Dr Baljit Karda has been appointed as the Guardian of Safe Working from June 2026. A new exception reporting system has been introduced, with the Guardian of Safe Working Hours and the People's Directorate implementing an MS Forms–based process from 4 February 2026 to replace the previous email-based system. In addition, the NHS England 10-point action plan is being implemented, with the Guardian of Safe Working Hours supporting key improvements to resident doctors' working lives and ensuring appropriate board-level leadership is in place.

- **2 Main body of the report**

The role of Guardian of Safe Working Hours (GOSWH) was introduced as part of the 2016 Resident Doctor's contract. The role of the GOSWH is to independently assure the confidence of Resident doctors that their concerns will be addressed and require improvements in working hours and rotas.

Purpose of Guardian of Safe Working Hours report
To provide assurance that doctors and dentists in training within LCH NHS Trust are safely rostered and that their working hours are consistent with the Resident Doctors Contract 2016 Terms & Conditions of Service (TCS).

To report on any identified issues affecting trainee doctors and dentists in Leeds Community Healthcare NHS Trust, including morale, training and working hours.

- **3 Impact**

This report has been informed by discussions with JNC, HR business partner BMA IRO and guidance received from NHS employers and Health Education England.

- **Quality**

Exception reports
No exception reports were filed during this quarter.

Fines
No fines levied by the GOSWH during this quarter

- **Resources**

Rota gaps and CAMHS ST rota
The CAMHS ST non-resident on-call rota consists of a 1:5 rota, and gaps on this rota are covered by locums, typically doctors who have worked on the rota in the past or doctors currently working for LCH who are willing to do extra shifts. The current CAMHS ST on call rota is checked by senior CAMHS admin staff with experience in managing CAMHS consultant rota to double check the Locum shifts picked up by Junior doctors.

Rota Gaps (number of night shifts needing cover)		Jan 2026		Feb 2026		Mar 2026		April 2026	
		CT	ST	CT	ST	CT	ST	CT	ST
	Gaps		18		25		20		26
	Internal Cover		5		7		3		5
	External cover		13		18		17		21
	Unfilled		0		0		0		0

- **Risk and assurance**

Appointment of LNC Resident Doctors' Representative
From June 2026, Dr Baljit Karda has been appointed as the Guardian of Safe Working. She has been supported in her transition into this role by the Guardian of Safe Working Hours, the Medical Director, the BMA Industrial Relations Officer, and the previous resident doctor representative. There was a gap in the role between April 2026 and June 2026, which was covered by Dr Nallapeta, Medical Director and Head of Medical Education.

Feedback from Junior doctors
Most recent Resident Doctors Forum (RDF) was held on MS teams on 26/03/2026.

The RD Forum welcomed the appointment and expressed support for Dr Karda as she begins her new role as the GoSWH from June 2026.

Members discussed progress on the exception reporting reforms and GoSWH encouraged Resident doctors to complete the test exception reporting.

CAMHS NROC rota monitoring was discussed and plans made to monitor to gather data.

Exception reporting Reforms
Exception reporting reforms for doctors and dentists on the 2016 Terms and Conditions of Service in England set out significant updates to be implemented by February 2026. At LCH, a Microsoft Forms system has been created for exception reporting. The form has been implemented from 4 February 2026.

Resident doctors have been informed of the change, with communications shared through the People's Directorate, direct email updates, and the RD Forum for test exception reporting. The uptake for test reporting remains to be poor despite all efforts.

- **Equity**

NHSE 10 Point Plan to improve resident doctors' working lives
Trust Medical Education—working with the Medical Directorate, DME and GOSW is delivering NHS England's 10-Point Plan, published in August 2025, to improve resident doctors' working lives.

As part of this programme, the trust is to appoint two named leads at board level: a senior leader responsible for resident-doctor issues and a peer representative who is a resident doctor, both of whom will report directly to the board; currently, these roles are felt to be appropriately fulfilled by the Medical Directorate and the LNC Resident Doctor representative.

4 Next steps

GoSWH will continue to work collaboratively with key stakeholders across the trust to ensure effective and timely implementation of the 10 point plan.

5 Recommendations

The Board is recommended to:

- Board is recommended to note the appointment of Dr Baljit Karda as the new Guardian of safe working from June 2026.
- Board is recommended to note the introduction of the new MS Forms exception reporting system launching on 4 February 2026.
- Board is recommended to endorse the implementation of the NHS England 10-Point Plan.

Name of author Nagashree Nallapeta
Title Guardian of Safe Working Hours
Date paper written 01/06/2026

Agenda item:	2026-27 (21) (Blue Box)
Title of report:	**Guardian For Safe Working Hours - Annual Report**
Meeting:	Trust Board
Date:	23/07/2026

Presented by:	Ruth Burnett, Medical Director
Prepared by:	Ruth Burnett, Medical Director

Purpose of the report:		
This report provides: Provides board with an Annual update around working conditions and changes affecting resident doctors in the trust. Covering period: 01/05/2025-30/04/2026	Approval	
	Discussion	
	Assurance	X

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

Summary of Key Issues:

- Introduction of the new exception reporting system, with GOSWH and the People's Directorate rolling out an MS Forms process from 4 February 2026 to replace email based reporting.
- Implementation of the NHS England 10 point action plan, with GOSWH progressing key improvements to resident doctor working lives and appointing appropriate board level leads.
- Dr Salma Elhag's appointment as LNC Resident Doctors' Representative and peer representative from Jan 2026.
- Dr Nallapeta Stepping down as GoSWH in April 2026 and Dr Baljit Karda's appointment as the guardian of safe working from June 2026.
- CAMHS NROC monitoring remains a concern due to low RD engagement, with the Medical Director offering to liaise with the CAMHS team to identify any additional support needed.

Previously considered by:	GoSWH Annual report presented June 2025
Outcome of previous discussion/s:	n/a

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

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

Recommendation(s)	• Receive this assurance regarding Resident Doctor working patterns and conditions within the Trust. • The board is recommended to note the implementation of the NHS England 10-Point Plan, including the appointment of the Medical Director and the LNC Resident Doctor representative as the trust's named leads for resident-doctor issues. • Board is recommended to note the introduction of the new MS Forms exception reporting system since 4th February 2026. • Board is recommended to note the appointment of Dr Salma Elhag as the LNC Resident Doctors' Representative from January 2026 and Dr Karda's appointment as the new GoSWH from June 2026.

List of Appendices:	Nil

Gurdian of Safe working hours report

1 Executive Summary

This report covers the period from May 2025 to May 2026.

A new exception reporting system has been introduced to modernise and streamline the way resident doctors raise concerns about safe working. The Guardian of Safe Working Hours, in partnership with the People's Directorate, implemented an MS Forms–based reporting process from 4 February 2026, replacing the previous email-based system. This change is expected to improve accessibility, standardisation, and oversight of exception reporting, enabling more timely identification and resolution of issues affecting working conditions.
Progress has also been made in implementing the NHS England 10-point action plan, with focused efforts on improving the working lives of resident doctors. The Guardian of Safe Working Hours has played a key role in advancing these priorities, including supporting initiatives around rest facilities, rota design, and wellbeing, while ensuring appropriate board-level leadership and accountability are in place to sustain these improvements.

In terms of representation, Dr Salma Elhag was appointed in January 2026 as the Local Negotiating Committee Resident Doctors' Representative and peer representative. This has strengthened the voice of resident doctors within organisational processes, supporting effective engagement, advocacy, and communication between resident doctors and senior leadership.

There has also been a transition in the Guardian of Safe Working role. Dr Nallapeta stepped down in April 2026, with interim cover provided at a senior level, followed by the appointment of Dr Baljit Karda in June 2026. Support has been provided to ensure a smooth handover and continuity in the oversight of safe working practices.

Monitoring of the CAMHS non-resident on-call rota remains an area of concern, largely due to low engagement from resident doctors in exception reporting. This limits the ability to fully assess and address potential issues. The Medical Director has offered to work directly with the CAMHS team to explore barriers to engagement and identify any additional support required to strengthen monitoring and improve working conditions in this area.

2 Main body of the report

The role of Guardian of Safe Working Hours (GOSWH) was introduced as part of the 2016 Resident Doctor's contract. The role of the GOSWH is to independently assure the confidence of Resident doctors that their concerns will be addressed and require improvements in working hours and rotas.

Purpose of Guardian of Safe Working Hours report
To provide assurance that doctors and dentists in training within LCH NHS Trust are safely rostered and that their working hours are consistent with the Resident Doctors Contract 2016 Terms & Conditions of Service (TCS).

To report on any identified issues affecting trainee doctors and dentists in Leeds Community Healthcare NHS Trust, including morale, training and working hours.

➢ **3 Impact**

This report has been informed by discussions with JNC, HR business partner BMA IRO and guidance received from NHS employers and Health Education England.

- **Quality**

Exception reports

No exception reports were filed during this quarter.

Fines

No fines levied by the GOSWH during this quarter

- **Resources**

Number of doctors / dentists in training (total): 21

Number of doctors / dentists in training employed by LCH 11

Resident Doctors within LCH
(Quarter 1- year 2025 to Quarter 4 -year 2026)

Department	Grade	Status	Quarter 1	Quarter 2	Quarter 3	Quarter 4
			2025	2025	2026	2026
Adults		LCH contract	0	0	0	0
Foundation year 1	FY1	Honorary contract	2	2	2	2
CAMHS	ST	LCH contract	2	3	4	4
	ST	Honorary contract	0	0	0	0
	CT	Honorary contract	2	3	3	3
Community Paediatrics	ST Level 1	Honorary contract	2	4	5	5
	ST Level 2 Grid trainee	LCH contract	5	4	3	3
Sexual Health	ST	LCH contract	0	2	2	2
GP	GPSTR	LCH contract	3	2	3	3
Obstetrics/ community gynae		Honorary contract	0	0	0	0
Dental Services		Honorary contract	0	0	1	1
Total			16	20	22	22

Rota gaps and CAMHS ST rota
The CAMHS ST non-resident on-call rota consists of a 1:5 rota, and gaps on this rota are covered by locums, typically doctors who have worked on the rota in the past or doctors currently working for LCH who are willing to do extra shifts. The current CAMHS ST on call rota is checked by senior CAMHS admin staff with experience in managing CAMHS consultant rota to double check the Locum shifts picked up by Junior doctors.

Rota Gaps (number of night shifts needing cover)		Jan 2026		Feb 2026		Mar 2026		April 2026	
		CT	ST	CT	ST	CT	ST	CT	ST
	Gaps		18		25		20		26
	Internal Cover		5		7		3		5
	External cover		13		18		17		21
	Unfilled		0		0		0		0

- **Risk and assurance**

Appointment of GoSWH
From June 2026, Dr Baljit Karda has been appointed as the Guardian of Safe Working. She has been supported in her transition into this role by the Guardian of Safe Working Hours, the Medical Director, the BMA Industrial Relations Officer, and the previous resident doctor representative. There was a gap in the role between April 2026 and June 2026, which was covered by Dr Nallapeta, Medical Director and Head of Medical Education.

Working Hours and work schedule review
For CAMHS non-resident on-call , a compliant rota is in place. Work schedule has been drawn up based on the work conducted during on call and incorporating the required rest periods and breaks as per the Resident doctors contract.

GSWH has requested HRBS the need for a robust monitoring system with every cohort of resident doctors who join the trust.

Educational Opportunities
No exception reports submitted relating to educational opportunities.

GoSWH recognises that Exception reporting is not used to regularly to capture the missed educational opportunities and that this may lead to underreporting and a lack of visibility of training-related issues affecting resident doctors. To address this, the Resident Doctors' Forum is being used regularly as an alternative platform to raise and discuss these concerns, and additional support and structure have been provided through the Local Negotiating Committee Resident Doctors'

Representative to help strengthen engagement and encourage more consistent reporting going forward.

Rota Gaps
The CAMHS ST non resident on call rota consists of a 1:5 rota, and gaps on this rota are covered by locums, typically doctors who have worked on the rota in the past or doctors currently working for LCH who are willing to do extra shifts. The current CAMHS ST on call rota is checked by senior CAMHS admin staff with experience in managing CAMHS consultant rota to double check the Locum shifts picked up by Resident doctors.

Feedback from Junior doctors
Most recent Resident Doctors Forum (RDF) was held on MS teams on 26/03/2026.

The RD Forum welcomed the appointment and expressed support for Dr Karda as she begins her new role as the GoSWH from June 2026.

Members discussed progress on the exception reporting reforms and GoSWH encouraged Resident doctors to complete the test exception reporting.

CAMHS NROC rota monitoring was discussed and plans made to monitor to gather data.

Exception reporting Reforms
Exception reporting reforms for doctors and dentists on the 2016 Terms and Conditions of Service in England set out significant updates to be implemented by February 2026. At LCH, a Microsoft Forms system has been created for exception reporting. The form has been implemented from 4 February 2026.

Resident doctors have been informed of the change, with communications shared through the People's Directorate, direct email updates, and the RD Forum for test exception reporting. The uptake for test reporting remains to be poor despite all efforts.

Engagement with Resident doctors and Resident doctor forum meetings
The Virtual Resident Doctor's Forum (JDF) was held in July 2025, October 2025, January 2026 and March 2026.

Resident doctors have found the JDF platform a useful platform to voice their feedback around HR issues, training opportunities. Attendance continues to be an issue despite the virtual nature of the meeting. Ideas and suggestions have been included to improve engagement with resident doctors.

- **Equity**

NHSE 10 Point Plan to improve resident doctors' working lives
Trust Medical Education—working with the Medical Directorate, DME and GOSW is delivering NHS England's 10-Point Plan, published in August 2025, to improve resident doctors' working lives.

As part of this programme, the trust is to appoint two named leads at board level: a senior leader responsible for resident-doctor issues and a peer representative who is a resident doctor, both of whom will report directly to the board; currently, these

roles are felt to be appropriately fulfilled by the Medical Directorate and the LNC Resident Doctor representative.

4 Next steps

GoSWH will continue to work collaboratively with key stakeholders across the trust to ensure effective and timely implementation of the 10 point plan.

5 Recommendations

The Board is recommended to:

- Receive this assurance regarding Resident Doctor working patterns and conditions within the Trust.
- The board is recommended to note the implementation of the NHS England 10-Point Plan, including the appointment of the Medical Director and the LNC Resident Doctor representative as the trust's named leads for resident-doctor issues.
- Board is recommended to note the introduction of the new MS Forms exception reporting system since 4th February 2026.
- Board is recommended to note the appointment of Dr Salma Elhag as the LNC Resident Doctors' Representative from January 2026 and Dr Karda's appointment as the new GoSWH from June 2026.

Name of author Nagashree Nallapeta
Title Guardian of Safe Working Hours
Date paper written 01/06/2026

Leeds Community Healthcare NHS Trust

Agenda item:	2026-27 (22) Blue Box
Title of report:	Annual Sustainability Report 2025/26
Meeting:	Trust Board Meeting Held in Public
Date:	23 July2026

Presented by:	Andrea Osborne, Executive Director of Finance and Resource
Prepared by:	Diane Allison, Head of Facilities Management and Safety

Purpose of the report:		
This report provides an update on the progress made with the Trust's Green Plan during 2025/26.	Approval	
	Discussion	
	Assurance	x

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

Summary of Key Issues:

This report:

- Gives updates on the four main emitting areas: procurement, estates, travel, and waste.
- Provides the overall emission trend for those four areas.
- Indicates areas of focus that will help reduce emissions over the next year and beyond.
- Identifies risks and issues including limited capital resource and no dedicated resource for sustainability or travel and transport.
- Further staff engagement with the Green Plan has been paused due to the resource issue.

A review of previously collated carbon emissions data for 2025/26, and some data for 2024/25 has been undertaken to ensure accuracy of recording, using the most recent conversion factors calculations.

Partial assurance is provided, given the current resourcing situation described in the report.

Previously considered by:	Business Committee (May 2026) People and Culture Committee (June 2026)
Outcome of previous discussion/s:	The People and Culture Committee would like to see more estates data and analysis when the newly installed Building Management Systems can be interrogated. It was explained that they would need to be in place for some months to provide useful data. The Committee expressed concern that the current carbon emissions trajectory may not be sufficient to achieve net zero by 2040. The Committee heard about plans for LYPFT to provide sustainability support when their team expands and Jenny Allen (DoW) offered to liaise with her equivalent at LYPFT to move this along, which she subsequently did.

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

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

Recommendation(s)	Please note the Green Plan achievements throughout 2025/26, as well as the risks and issues highlighted.

List of Appendices:	None

LCH sustainability

NHS
Leeds Community Healthcare
NHS Trust

Sustainability Report

2025/26

1. Introduction

This report provides a comprehensive overview of the progression made with sustainability over the past 12 months as the Trust strives towards its commitment of Net Zero by 2040. The report describes our current carbon profile and evaluates our status against our new Green Plan. It highlights the positive changes made over the past 12 months but also explore the challenges. Finally, this report includes climate adaptability work as consensus across the NHS both nationally and regionally is that there is a need to prepare and improve resilience to deliver our services in extreme weather events.

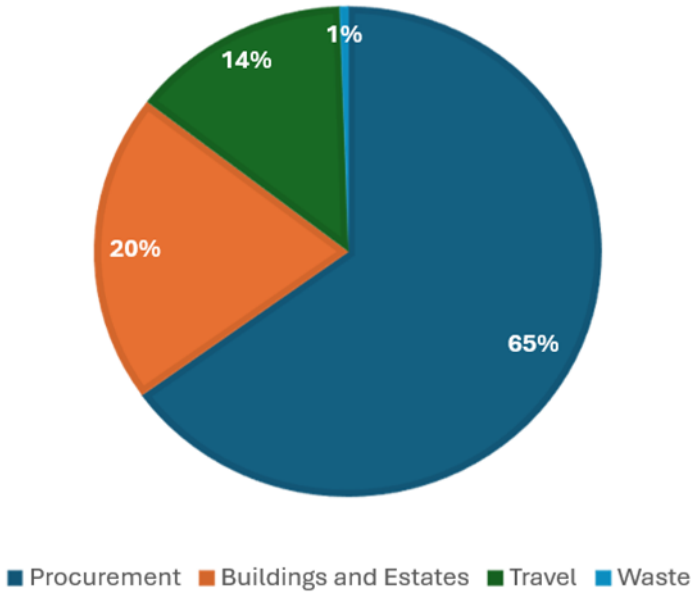
2. Background

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 approved at the Trust Board meeting on 10 July 2025. The Green Plan then had a ‘soft launch’ however there is currently no sustainability lead in the Trust to encourage staff engagement or to identify or support any new green initiatives.

3. Carbon Emissions in the main emitting areas

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: Buildings & Estates, Travel, Procurement, and Waste. Efforts are primarily focused on stabilising emissions in these areas, followed by specific projects to facilitate decline.

Fig 1. Pie chart: current emission split between the four main emissions areas.



3.1 Carbon data

A review of previously collated carbon emissions data for 2025/26, and some data for 2024/25 has been undertaken to ensure accuracy of recording, using the most recent conversion factors calculations.

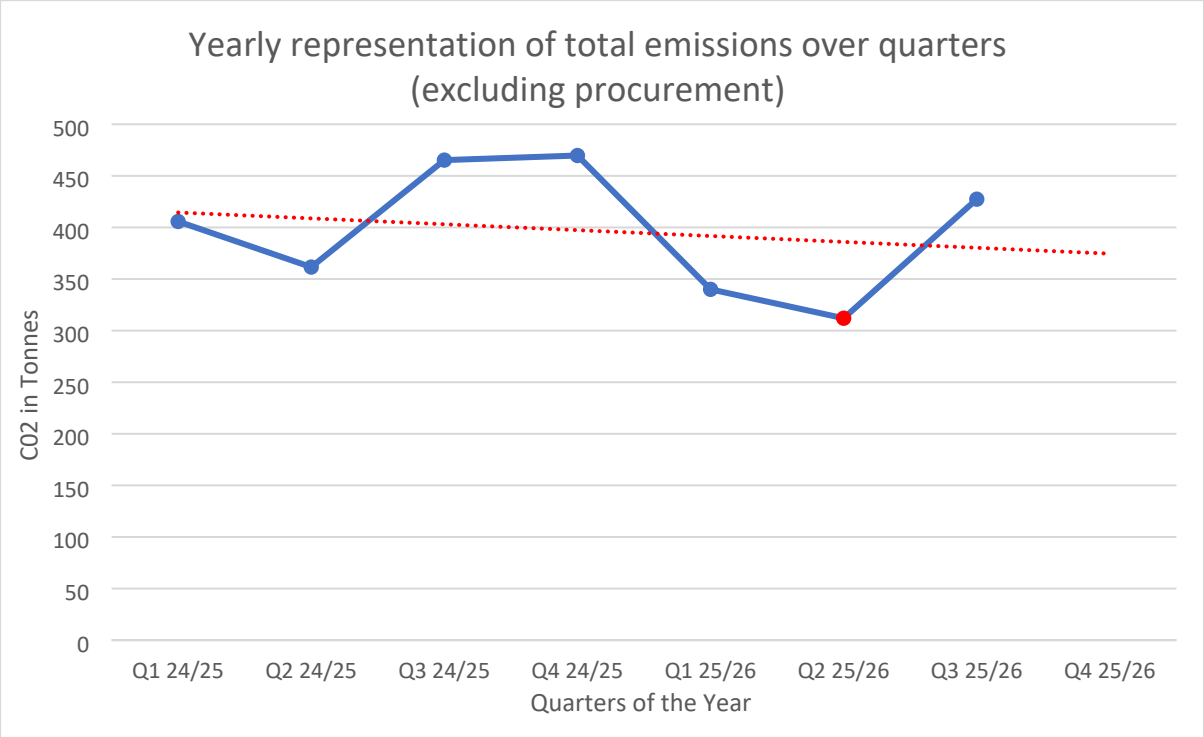
The metrics we have used to assess our carbon footprint are described below:

Emissions area	Method of calculation
Travel data calculation	The Trust's travel profile comprises mainly of a 'grey fleet', meaning the Trust does not own a fleet of vehicles which it then lets staff use (e.g. pool cars). Staff own or lease the cars that they use for work and claim for mileage expenses. This model presents challenges when transitioning to net zero as the Trust does not have direct control over all the vehicles that are used across the organisation. The Trust does influence the types of leased cars provided through the salary sacrifice scheme. At present carbon emissions for travel are calculated using staff mileage claims (mileage claims exclude commuting to and from home).
Procurement data calculation	Procurement is currently the highest emitter of the 4 areas of carbon. This is partly due to the current calculation for procurement being based on spend, which is not an accurate way of identifying and calculating emissions however there is no more accurate way of doing so at

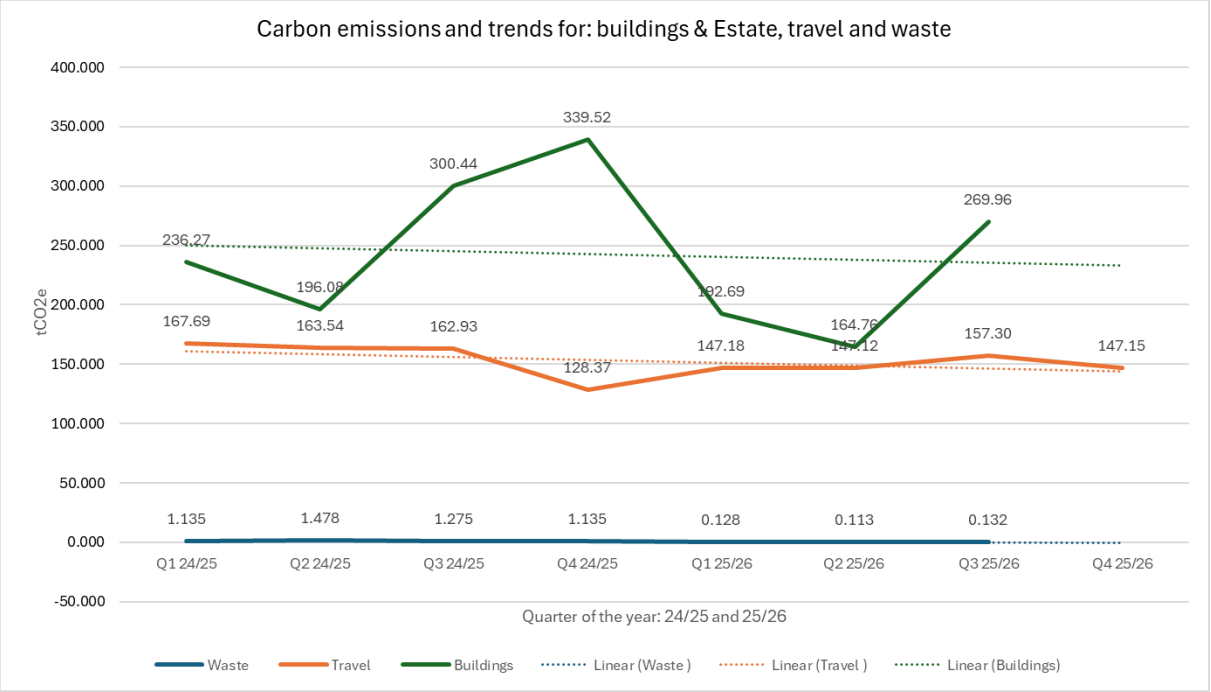
	present. Procurement carbon emission figures are not shown in the following charts due to this.
Buildings and Estate data calculation	This is the utilities (gas, water, electricity) that the Trust consumes / uses per quarter. As our billing process via EDF is accounted for differently across each site, some data is estimated where actual figures have not been received by the reporting deadline. This can occasionally result in discrepancies within the electricity data. This will improve once smart meters are in use across all sites.
Waste data calculation	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 CO_2e factors to measure our tonnage of CO_2 emissions.

3.2 Emissions per quarter 2024/25 to 2025/26.

The Trust's carbon emissions are showing a gentle decline over time. The reasons for the improving situation are described in sections 3.3 to 3.6, along with our ambitions for further improvement.



The emissions decline is consistent in Buildings & Estate, Travel and Waste.



3.3 Buildings and Estate

Achievements in 2025/26:

- A boiler replacement scheme has commenced across our owned sites with two health centres now having more energy efficient boilers installed during 2025/26.
- £161,834 funding was awarded by Greener NHS for an LED lighting upgrade across four health centres (Chapeltown, 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 Trust's owned estate (12 sites). A BMS is a computer-based control platform that centralises the monitoring and management of a building's mechanical and electrical systems, such as heating, lighting, and security. It optimises energy efficiency and reduces operational costs. Energy consumption is reduced by controlling equipment to run only when needed.

Future:

We will develop business plans for the delivery of measures outlined in the Heat Decarbonisation Plans. This will ensure we prepare well in advance for any funding opportunities or prioritising projects through capital spend including investment in fabric and fenestration of buildings, lighting and heating. Some of this will overlap with that for work underway as part of the regular maintenance and upkeep of the estate. Better use of roofs and adjacent ground space will support a shift to on-site renewable energy and heat generation across the owned estate.

There is to be a reassessment of the five-year capital plan to identify if any sustainability projects remain unfunded or at risk.

The Trust has begun work with regional bodies, such as the Northeast and Yorkshire Net Zero Hub, to create a timeline and overall estates decarbonisation strategy. This work will be used to help the estate and sustainability teams to create a plan for phasing out fossil-fuel primary heating by 2032.

The (draft) 2026/28 Strategic Estates Plan includes an aspiration for a phased, fabric-first sustainability programme will reduce carbon, improve energy efficiency and prepare sites for low-carbon technologies. This ensures alignment with NHS Net Zero standards and the Trust's sustainability commitments. The (draft) Strategic Estates Plan acknowledges the challenges for our aging estate, which will require substantial fabric improvements. An Estates Sustainability 'roadmap' is being developed to document specific measures and monitor progress against this aspect of the (draft) 2026/28 Strategic Estates Plan.

3.4 Travel

Achievements in 2025/26:

We have 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. This has also reduced costs.

Staff held a walking challenge at head office during Summer 2025 to encourage staff to walk more during their commute.

The Trust was shortlisted for the 2025 National Staff Benefit awards for making electric vehicles more affordable through our salary sacrifice and business lease schemes.

Carbon emissions from staff mileage claims continue to be calculated and monitored. Salary sacrifice car schemes continue to provide greater accessibility to electric or hybrid vehicles.

Future:

A draft travel and transport plan is now partially developed which outlines the Trust's strategy to reach travel CO2 net zero.

There is no dedicated travel and transport role within the Trust, which continues to hamper progress with this section of the Green Plan.

3.5 Procurement

Achievements in 2025/26:

The Procurement Team have completed the evaluation of the top 20 suppliers for LCH & LYPFT, trying to increase the utilisation of suppliers completing the Evergreen questionnaire. For relevant Procurements they request that Suppliers provide their carbon reduction plans in line with rule changes on PPN016.

The establishment of the LCH and LYPFT Sustainability Procurement Group to align ambitions and projects with our main provider / procurement partner, LYPFT.

The newly formed Clinical Procurement Group will have a focus on sustainable products.
Monitoring of office paper supplies has seen a 14% reduction in paper during 2025.

Future:

The Material Management System that was to be a pilot project in 2025 did not go ahead due to news of the impending merger. It will remain our ambition to pursue this project within the new Trust.

We will continue to procure from Crown Commercial Service under the guidance of the NHS England where it has been assured the companies use renewable sources of energy.

We will embed sustainability as an integral part of the decision-making process for selected products on the Trust catalogue.

3.6 Waste

Achievements in 2025/26:

Several initiatives continue to improve waste segregation and compliance with NHS England's required 20-20-60 clinical waste split, which requires:

- 20% Incineration (Yellow Bag): High-temperature treatment for highly infectious waste.
- 20% Alternative Treatment (Orange Bag): Infectious waste treated through autoclaving or alternative methods.
- 60% Offensive Waste (Yellow & Black "Tiger" Striped Bags): Non-hazardous waste, including PPE, hygiene waste, and continence products, that is not infectious but requires disposal.

To move towards achieving this, there has been a sustained focus on clinical waste segregation to ensure waste is disposed of in the least carbon emitting way. Increasing our tiger bag waste stream, has resulted in better waste treatment and less unnecessary specialist treatment of waste. None of our waste now goes to landfill. Waste-to-energy (WtE) technologies convert our non-recyclable waste into

electricity or heat, which significantly reduces our greenhouse gas emissions compared to landfilling.

The Trust reduced general waste from 55 tonnes in 2024/25 to 45 tonnes in 2025/26 and increased recycling from 12 tonnes to 14.8 tonnes. Since we implemented Simpler Recycling in early 2025, we have generated 1.2 tonnes of food waste.

Workplace recycling in England changed on 31 March 2025. All workplaces in England must now separate their waste before it is collected, including any waste produced by employees, customers and visitors. 2025 saw the successful implementation of these 'Simpler Recycling' regulations and the Trust introduced food and glass waste streams, on top of its existing dry recyclable materials waste stream, general (residual) waste stream, and clinical waste streams.

There has been collaboration with third-party landlords to improve onsite waste facilities to sustain best practice and lawful disposal of waste.
Waste disposal process and the waste site were inspected by the Trust's Waste Manager in 2025 to obtain assurance of compliant waste practices. The Trust's Waste Manager also produced a Sustainable Waste Strategy to progress the waste management priorities set out in the Trusts 2025/28 Green Plan. The strategy concentrates on waste reduction and improved waste disposal.

Future:

Further awareness and education to all staff regarding appropriate use each waste stream. New waste streams such as food waste are being monitored as occasionally food packaging is being placed in food caddies.

Work closely with procurement to evaluate products being purchased by the Trust. From a waste perspective this includes:

- Longevity of the product
- Packaging

4. Green Plan future additional areas of focus / opportunities

5.1 Digital emissions

The Informatics Department has an IT Recycling & Asset Disposal agreement with a provider who is accredited as "zero % to landfill", so everything collected by them is guaranteed to be reused either in its entirety via their many routes into schools, charities etc or broken down into different components, materials etc and used in remanufacturing.

In early 2026 we started our staff awareness campaign to alert everyone to the impact of our Digital carbon footprint and the Trust took part in the Digital Clean-up Day on 21 March. Staff and patients were encouraged to delete old emails, unsubscribe from websites that generate unneeded emails, clean up their digital files, delete unwanted photos etc.

5.2 Medicines/ prescribing emissions

The Trust started improving its medicines/ prescribing carbon footprint in June 2020 by transitioning to electronic prescribing from paper, along with encouraging staff to use digital versions of the 'BNF' resource rather than purchasing paper copies. The British National Formulary (BNF) contains key information on the selection, prescribing, dispensing and administration of medicines. The BNF is updated twice annually which means a lot of paper copies were previously procured.

Data for prescribing in February 2026 shows that for services where electronic prescribing is in place, every prescription was issued electronically via Electronic Transfer of Prescriptions. This totalled 2,757 items issued using the electronic prescribing system. As well as making a difference to the environment, it makes a positive difference for patients and staff.

According to NHS England's document 'Delivering a 'Net Zero' National Health Service', medicines account for 25% of emissions within the NHS. A small number of medicines account for a large portion of the emissions, and there is already a significant national focus on two such groups – anaesthetic gases (2% of emissions) and inhalers (3% of emissions) – where emissions occur at the 'point of use'.

Opportunities in the Trust exist to improve our own carbon emissions in this area by:

- the transition to high quality, lower-carbon respiratory care and promotion of return and recycle used and unwanted inhalers
- Structured medicines reviews to improve prescribing which will reduce medicines waste.

5. Climate adaptability

Achievements in 2025/26

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.

The Trust will describe its compliance with the Task Force on Climate-related Financial Disclosures (TCFD) framework requirements in the Trust's annual report and accounts 2025/26.

Future

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. The Trust's draft 2025/28 Strategic Estates Plan and consequently to be devised Estates Sustainability Road Map will provide direction and progress monitoring for the ways in which the Trust will adapt its estate in preparation and response to 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.

6. Governance

The Sustainability and Climate Adaptability Steering Group, which was established in late 2025, oversees the implementation of the Green Plan and monitors its progress. The Group, which is chaired by the Executive Director of Finance and Resources, has met twice during 2025/26 and provides a report to the Business Committee following each meeting.

7. Risks and issues

Risk / issue	Mitigation / Action
Issue: The Trust's sustainability manager left in December 2025.	Mitigation: The Head of Facilities Management and Safety is caretaking the essentials of the vacant role, with some professional support from the sustainability manager at LYPFT. The 'Must Do's of the vacant post are being met to ensure the Trust is compliant with its responsibilities for calculating and reporting carbon emissions.

	Action: LYPFT is in the process of recruiting a band 5 sustainability officer to support its sustainability manager. When in post, LYPFT will then offer a sustainability service via a service level agreement to LCH, whilst merger / integration work is underway.
Risk: Limited capital assigned to the Trust in 2026/27 may impact on sustainability projects.	Mitigation: the Trust will prioritise estates projects that will support our net zero ambition. Action: the Trust will develop business plans to opportunistically apply for any sustainability funding that becomes available.
Issue: The Trust does not have a dedicated travel and transport role.	Mitigation: Salary sacrifice car schemes continue to provide greater accessibility to electric or hybrid vehicles. Carbon emissions from staff mileage claims continue to be calculated and monitored. Action: roles and responsibilities will be reviewed as part of the LYPFT/LCH merger.

8. Recommendations

The Committee should note the 2025/26 achievements, as well as the risks and issues highlighted.

Agenda item:	2026- 27 (23) (Blue Box)
Title of report:	Emergency Preparedness, Resilience & Response EPRR Annual Report
Meeting:	Trust Board
Date:	23rd July, 2026

Presented by:	Sam Prince
Prepared by:	Rebecca Todd, Emergency Planning Manager

Purpose of the report:		

• To provide an overview of the workplan\activities of Emergency Planning over the year May 2025 – 2026
• To highlight the outcome from the NHSE EPRR Annual EPRR Core Standards Assurance Audit - 2024\25
• To update on the recommendations from two Internal Audit reviews in regard to:
  ○ The effectiveness of the Trust's Business Continuity Management System
  ○ Trust preparedness for the annual EPRR Core Standards Assurance Audit 2025\2026
• Section 4 of the Report also highlights the work to be undertaken in 2026/27 to continue to improve our compliance rating against the NHSE EPRR Core Standards.
	Approval	

	Discussion	
	Assurance	√

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

Summary of Key Issues:
• In December 2025 the Trust achieved a rating of partial compliance against the NHSE annual EPRR Core Standards assurance process. • During 2025\2026 EPRR has undergone x2 reviews by Internal Audit. • Action Plans have been developed to address gaps and respond to the recommendations from both reports • The Trust has increased the number of exercises undertaken over the last year in response to Internal Audit recommendations.

Previously considered by:	Trust Business Committee – 19/05/2026
Outcome of previous discussion/s:	Report accepted

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

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

Recommendation(s)	For Trust Board awareness and approval.

List of Appendices:	Appendix 1 – Emergency Planning Annual Report – May 2026 Appendix 2 – LCH EPRR Exercise Timetable 2024-2026

Emergency Preparedness, Resilience and Recovery (EPRR) Annual Report – 2025-26

1. Executive Summary

This report covers the period 1 April 2025-31 March 2026. In addition to an overview on the self-assessment compliance assessment, the report details the activities of the organisation in relation to Emergency Preparedness, Resilience and Response (EPRR). Section 4 of this report details the work to be undertaken in 2026/27 to continue to improve our compliance rating.

2. Annual NHSE EPRR Core Standards compliance

In October 2025, the Trust's compliance against the nationally-set Core Standards was assessed 'Partial compliance', demonstrating an improvement on the non-compliant rating of the previous two years. The Trust has demonstrated considerable improvement in many of the key areas of the core standards and the 2024\25 EPRR workplan focused on the areas of non-compliance to address the outstanding core standards.

Of the 58 Core standards relevant to Community Trusts, LCH was able to declare 50 fully and 8 partially compliant standards. The Trust will be required to review all core standards again ahead of the October 2026 submission.

Current position:

The 2024\25 submission saw a significant increase in the number of standards that are fully compliant. Only fully compliant standards are counted in the new scoring system. The Trust attained 50 fully compliant standards out of 58 which equates to 86% (see table below).

Despite the considerable number of fully compliant standards, this still only secures a rating of "Partial" compliance (86%). To achieve a rating of "Substantially" compliant, the Trust needs to be compliant against a minimum of 52 standards (90%).

The Trust will declare partial compliance against the national EPRR Core Standards in the Trust annual report.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	9	2	0

Command and control	2	2	0	0
Training and exercising	4	2	2	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	9	1	0
Hazmat/CBRN	10	8	2	0
CBRN Support to acute Trusts	0	0	0	0
Total	58	50	8	0

- Throughout the year the majority of the Trust's **Emergency Plans and Policies** have been reviewed and updated in line with the latest NHSE guidance and they are now approved by Trust Board.

- Progress has been made in a number of areas, particularly **Business Continuity** following the recommendations of the Internal Audit Review in summer 2025.

- The **Trust EPRR Learning and Exercising Group** meets regularly with good attendance and engagement. The Group is now being Chaired by the Executive Director of Operations in her role as Accountable Emergency Officer.

- The Trust **Incident Response Communications Pack** has been refreshed in line with the requirements of the Core Standards and now dovetails with the updated WY Resilience Forum Communications documentation.

- The **LCH Outbreak Policy** has been updated by the Trust Infection Prevention and Control Team (IPC) and has now been approved.

- **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.

3. Quality/Risk

An Internal Audit (IA) review was scheduled to take place ahead of the EPRR Core Standards Submission date in October 2025, however the visit was deferred to December 25\January 26. IA undertook an evidence audit of a sample of the core standards including those that were non-compliant assessing the gaps in evidence in terms of the actual risk to the Trust. The outcomes included valuable feedback and recommendations to highlight specific areas of focus if we are to maintain our partial compliance status or move up to a further improved rating of "Substantial" in our 2026 submission.

4. Improvements for 2026/27

A number of the remaining non-compliant standards require significant resources or a different approach to ensure the Trust can achieve "Full" compliance.

- The Trust is awaiting a **Chemical, Biological, Radiological and Nuclear (CBRN) audit** to be carried out by Yorkshire Ambulance Service (YAS). We have been assured by YAS that this should take place within the next 12 months.

- The Trust **Lockdown Plan** was live tested on 6th May 2026 and the outcomes from the debrief are awaited. The exercise ran well; however, a number of areas have been identified for further work.

  EPRR worked closely with the Trust Security Team and Estates to deliver the exercise and the recently installed tannoy system and the new electronic access system were both tested as an integral part of the exercise.

Both above plans share similar challenges regarding access to Trust buildings and a reliance on Front of House\ Reception staff for an initial response.

- The Trust's **New and Emerging Pandemic Plan** is to be developed and EPRR will work closely with the Trust IPC team to move this forward.

  Between September and November 2025, the Trust took part in a National Pandemic Exercise - Pegasus, a phased exercise to test pandemic response and 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.

  Learning from the exercise is being released through a series of themed modules and key points of learning will be incorporated into the Trust plan and shared with the Learning and Exercising Group.

  West Yorkshire Resilience Forum and the WY ICB is also developing plans therefore it is important to ensure full alignment.

  The citywide Pandemic Planning Group is being reconvened by Leeds City Council (LCC) Public Health and will provide a local forum to support the development of citywide Pandemic Plans.

- EPRR **incident response training for managers** currently forms a large part of the workplan going forwards. NHSE North East and Yorkshire (NHS NEY) have outlined requirements for senior managers within all NHS organisations to understand their roles and responsibilities when managing incidents/business continuity events. Additionally, there is a requirement to maintain a training portfolio to evidence attendance on mandatory EPRR training

  Following the Manchester Arena Inquiry NHS NEY updated the annual compliance requirements to specify that all staff with a command role in incident management must maintain continual professional development (CPD), keeping personal development portfolios (PDPs) in accordance with the NHS England Core Standards for EPRR. Additionally, there is a requirement to seek out opportunities to gain hands on experience of chairing strategic or tactical response meetings either through exercises or live incidents in order to evidence strategy setting and working alongside colleagues such as Loggists and EPRR.

Progress has been made regarding strategic commander training with all 2nd on-call managers currently in date with their Principles of Health Command (PHC) Strategic training. Work is also underway to ensure all 1st on-call managers are compliant with the PHC Tactical training. NHS NEY require the Trust to have a process\framework in place to ensure that all relevant managers can self-assess themselves against the competencies and experience required to carry out this role as outlined in the recently updated Minimum Occupational Standards (MOS) and the National Occupational Standards (NOS) for EPRR.

- The Trust is required to seek **assurance from commissioned providers/ suppliers** in the form of Business Continuity Plans. This has been highlighted through recent exercises at both local and national level. The Trust will now be working more closely with Supplies as the LCH and LYPFT teams are coming together. A joint exercise will take place in 2026/27to explore the challenges in this area.

- The Trust is currently partially compliant in regard to a number of the Chemical, Biological, Radiological and Nuclear (CBRN) standards, however we are awaiting an audit by the CBRN Lead from Yorkshire Ambulance Service. Once this audit has been completed the Trust will progress the actions required to achieve compliance in line with the NHSE Core Standards.

As can be seen, these issues are complex and require a Trust-wide approach. This work will be raised within the usual business planning arrangements to ensure that there are sufficient resources committed to carry out the work.

5. **Exercising:**
    - All 3 Trust Business Units have tested their Business Continuity Plans during the last 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.

    - The Trust has also recently taken part in a National Power Outage exercise led by NHSE Ex Klaus Australis. LCH formed an Incident Co-ordination Group to work through the scenarios which were very acute and ambulance focused. The exercise did however raise concern as to the severity of any such incident and the challenges around communication. The Trust is intending to follow up on a local level.

    - Other recent exercises include; fuel disruption, civil unrest and the Trust Lockdown exercise. The Trust cyber incident support plan test is to take place on Tuesday 12th May shortly to be followed by a Cyber Security and Remote Working exercise to take place on 19th June.

6. **Meetings**

- The Emergency Planning Manager regularly participates in the Y&H 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). The Trust will also be represented at the Leeds System Pandemic Preparedness Group in the coming months

- The Emergency Planning Manager has played a key role in the LCH Industrial Action Planning Group and WY ICB-led Industrial Action Briefing Group meetings working alongside the Trust Medical Director to identify risk, agree mitigating actions and complete and return situation reports (Sitreps).

  The Trust Learning and Exercising Group, chaired by the Trust 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.

7. Training

- The Trust 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 strategic level EPRR training in line with NHSE requirements. The Trust is also focusing on the development of Training portfolios for strategic and tactical commanders which includes Principles of Health Command (Strategic and Tactical), JESIP and Legal Awareness training.

- EPRR and relevant Trust colleagues have 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 Winter Resilience (Nov 2025) in addition to the launch of the UKHSA Adverse Weather and Health Plan.

8. **Event Management**

- The Trust has developed plans and communications for several large events with the potential to impact service delivery during the year. These include the Rob Burrow Leeds 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.

9. Next steps

- This year the ICB is taking a different approach to the preparation of the Core Standards submission. The standards have been broken down into sections and Trusts are being asked to submit their evidence through the year as opposed to a final upload at the end of October. This will allow the ICB to review evidence and feedback comments in advance of the October 31st deadline.

- The LCH and LYPFT AEOs are now meeting jointly with the EPRR teams on a regular basis to plan for the upcoming merger in April 2027. It is recognised that a number of key documents and arrangements will need to be in place at the time of the merger to enable a full and co-ordinated response should an incident occur over this time or shortly after. Both teams are working together to develop the LCH\LYPFT Merger EPRR Core Standard Categorisation document, which outlines the main priorities which will be fed into into the Transition Group by the AEOs to provide ongoing assurance.

➢ **Recommendations:**

Business Committee to accept this annual report as assurance that the Trust is on track with the EPRR workplan and in preparation for the NHSE EPRR Core Standard Assurance Audit 2025\26 and the future merger with LYPFT in April 2027.

Rebecca Todd
Emergency Planning Manager
05\05\2026

NHS
Leeds Community Healthcare
NHS Trust

Leeds Community Healthcare EPRR Exercise Schedule 2024 - 2026

Participants	Exercise Lead	Focus of Exercise	Date of Exercise	Debrief Completed
Trustwide – On-call Managers	IT \ EPRR	Cyber	2nd October, 2024	Yes
Children's Business Unit – BC test	Service Manager \ EPRR	Business Continuity - Cyber	3rd December, 2024	Yes
Specialist Business Unit – BC test	General Manager \ EPRR	Business Continuity – Cyber	4th February, 2025	Yes
Adult Business Unit – BC test	Service Manager \ EPRR	Business Continuity – Winter\severe weather Preparedness	20th March, 2025	Yes
EPRR \ IPC	IPC \ EPRR	Exercise Pegasus - Pandemic	22 Sept \ 13 Oct \ 3 Nov, 2025	National\Regional feedback awaited
Trust wide	EPRR \ AEO **Ex Commander** – Jenny Allen	Fuel Disruption Tabletop	20th April, 2026	Draft
Specialist Business Unit – BC test	SBU \ EPRR **Ex Leads** Nicky Copley Rachel Phillips	Civil Unrest	30th April, 2026	Yes

On-call Managers	Security \ EPRR Live exercise **Ex Leads** Andrew Stephenson Rebecca Todd	Live Lockdown exercise at Chapeltown HC	6th May 2026	In progress
Ops Forum	EPRR \ AEO **Ex Lead** Rebecca Todd	Fuel Disruption	7th May, 2026	Draft
Informatics, EPRR	Head of IG & DPO **Ex Leads**: Richard Slough Steve Creighton	Test of Trust Cyber Incident Response Plan	12th May 2026	Draft
Trustwide	Head of IG\DPO \ EPRR **Ex Lead**: Steve Creighton	Information Governance In person - Cyber Security & Remote Working Exercise	19th June, 2026	Draft
CBU BC Test			8th September 2026 (date recently confirmed)	
ABU BC Test – tbc				

NHS
Leeds Community Healthcare
NHS Trust

Quality Strategy Implementation Plan 2024-2027

Gil Ramsden, December 2024. Version 6.0

Quality Strategy Priorities
2024-2027

NHS
Leeds Community Healthcare
NHS Trust

Our priorities:

Safe
Ensuring patient safety is our top priority

Effective
Providing care that achieves the best care and outcomes for people

Experience
Creating a positive experience to improve how satisfied people are when engaging with our services

We will gather feedback from service users to track progress towards our priorities so that we can stay on track and improve care.

What we will do to continually improve:

We will improve patient safety by fully implementing the National Patient Safety Strategy.

We will improve outcomes by delivering evidence-based care and comply with statutory and regulatory standards

We will improve patient experience by fully implementing the Parliamentary and Health Service Ombudsman (PHSO) standards and building partnerships with the people who use our services

Priorities for implementation:

Safety: Ensuring patient safety is our top priority

1. We will regularly ask if people felt safe in our care and we will use that insight to improve our care for everyone through the implementation of PSIRF

Effectiveness: Providing care that achieves the best care and outcomes for people

2. Our processes will fully comply with Care Quality Commission (CQC) standards.

3. Feedback will inform and improve safety and quality of care

Experience: Creating a positive experience to improve how satisfied people are when engaging with our services

4. We will implement PHSO standards to ensure effective feedback

5. We will consider quality & equity in our quality and safety improvements

SAFE

SAFE: Key Priority 1 (Aligns with CQC Quality statements 3, 4. 10, 14, 15, 16, 17, 18, 20, 21, 23, 25, 26, 27, 29, 32, 33)

We will regularly ask if people felt safe in our care and we will use that insight to improve our care for everyone through the implementation of PSIRF

	Strategic action:		What we will do:		Evidence:
Year 1 1 April 2024 – 31 March 2025	**1.1.1**	We will have trained and supported six LCH Patient Safety Specialists (PSS), in line with the national patient safety syllabus (level 3 and 4 training). They will have undertaken specific training, allowing them to focus on broad patient safety initiatives, conduct investigations, analyse data, and implement systemic improvements across LCH **COMPLETED AT LAST REPORT**	1.1.1	Our patient safety specialists will use investigation tools to promote system thinking and quality improvement methodology in 100% of their reports and will explain the process to colleagues involved in the learning process, so more colleagues can take the learning methodology forward.	**1.1.1**: Certificate of completion for all Patient Safety Specialists Completed The safety team will hold a database of all investigations and those involved in investigations Completed
			1.1.1b	100% patient safety incident investigations (PSII) will be conducted in line with the Patient Safety Incident Response Framework (PSIRF) and the LCH Patient Safety Incident Response Plan (PSIRP), ensuring a thorough and balanced response that prioritises learning and indicates how services will evidence / measure improvement.	**1.1.1** **6** monthly report to Board for learning from PSII Completed
	1.1.2	We will ensure that we offer adequate support to colleagues affected by patient safety incidents, and we will be able to demonstrate our 'just culture'	1.1.2	80% of staff involved in incidents will be issued with verbal information explaining where to access support, including via the LCH Health and Wellbeing Hub . A survey will be developed to monitor impact and identify ongoing process improvements, so we know our staff are as well supported as possible	**1.1.2:** Feedback will inform improvements – narrative from survey – narrative box in survey
	1.1.3	We will report our incidents to the national Learn from Patient Safety Events (LFPSE) system. **COMPLETED AT LAST REPORT.**	1.1.3	LCH will contribute to the LFPSE system national system to improve learning and help make care safer	**1.1.3**: Exception reporting through Performance Brief if LFPSE uploads do not take place Completed
	1.1.4	We will ensure all appropriate system-wide patient safety incidents led by LCH are carried out as a joint investigation with partners to ensure patients / families receive one single joined up response. **COMPLETED**	1.1.4	We will demonstrate collaboration through joint investigations in 100% appropriate situations, and the lessons leaned will be shared across the organisation / system in a way that is transparent to patients / families	**1.1.4** Multi-agency Patient Safety Incident Investigations will be evident
	1.1.5	We will develop dashboards for use by the Chairs of the Trust Improvement Groups which align to the LCH Patient Safety Incident Reporting Plan (PSIRP) **COMPLETED**	1.1.5	Review of the data visualised in the dashboard will reveal trends in activity supporting the interrogation of the information to be understood and remedial action implemented when necessary.	1.1.5: Information and assurance will be reflected in reports to QAIG and by exception to Quality Committee Completed

SAFE

SAFE: Key Priority 1 (Aligns with CQC Quality statements 3, 4. 10, 14, 15, 16, 17, 18, 20, 21, 23, 25, 26, 27, 29, 32, 33)

We will regularly ask if people felt safe in our care and wewill use that insight to improve our care for everyone through the implementation of PSIRF

Evidence for Quality Committee May 25		

Year 1
1 April 2024 – 31 March 2025

1.1.2:
Feedback will inform improvements
Update:
This work has not progressed due to vacancies in the Patient Experience and Engagement Team who were supporting development of a survey and vacancies and significant increased demand from inquests in Patient Safety (Opel 3e). This work will be restarted as part of the recently established Patient Safety/Engagement monthly meetings.
May 26 Update: A meeting has been held with the Patient Safety and Patient Engagement Managers. A survey is being developed. A One Minute Guide is also in development which will be provided to staff affected by Patient Safety Incidents, this will include information around the PSIRF principles of system learning, human factors and being fair, the wellbeing support available and a QR code for a feedback survey to inform improvements, this will be available on Datix to be shared with staff by incident investigators and handlers. A QR option will also be available. **ONGOING**

1.1.4:
Multi-agency Patient Safety Incident Investigations will be evident.
Update:
Four of the five PSII led by LCH which concluded in Quarter One and Two had multi provider involvement and reports were reviewed and approved via partner organisations internal governance processes prior to final LCH approval, the remaining incident did not require other provider involvement.
Four of the five PSII led by LCH which concluded in Quarter One and Two had multi provider involvement and reports were reviewed and approved via partner organisations internal governance processes prior to final LCH approval, the remaining incident did not require other provider involvement.
May 2026 update:
LCH continues to commission and lead multi agency Patient Safety Incident Investigations and contribute to those led by other providers across the system where applicable. **COMPLETED**

1.1.5:
Information and assurance will be reflected in reports to QAIG and by exception to Quality Committee.
May 2026 Update: BI have set up the initial dashboards. Quarterly reports are agenda'd and now received for QAIG with escalations to Quality Committee. **COMPLETED.**

SAFE	Key Priority 1 continued			
Year 2 1 April 2025 – 31 March 2026	1.2.1	We will support and train 15 Learning Response Leads (LRLs) to work on improving patient safety, recognising and addressing unwarranted variation in care delivery in line with the national patient safety syllabus. They will lead investigations, gather views from patients, families, and staff, analyse data to find trends and areas to improve, make changes to prevent future incidents via a range of internal processes by involving the Patient Safety Specialists (PSS).	1.2.1	Our 15 LRLs will have successfully completed selected Health Services Safety Investigations Body (HSSIB) modules, in line with national requirements and availability of the national training)	**1.2.1**: Safety Team maintain a record of training undertaken and refresher dates
			1.2.1b	We will be able to demonstrate a greater understanding of the gap between 'work-as-done' and 'work-as-imagined' and the improvement activity needed to reduce this.	**1.2.1b**: This will be reflected in the improvement activity undertaken in the Trust. COMPLETE
			1.2.1c	100% of staff involved in incidents will be issued with written information explaining where to access support, including via the LCH Health and Wellbeing Hub. A survey will be developed to monitor impact and identify ongoing process improvements, so we know our staff are as well supported as possible	**1.2.1c**: Feedback will inform improvements
			1.2.1d	We will ask for feedback from all service users who have been involved in a patient safety incident to ensure we focus on the things that are important for our service users when investigating and improving safety	**1.2.1d**: Feedback will inform improvements
	1.2.2	We will contribute to the development of the 'LCH Learns' platform for all staff and then work with our Patient Safety Partners (PSP) to extend the learning platform to our patients, carers and stakeholders when it is appropriate **COMPLETED AT LAST REPORT**	1.2.2	The PSP journey will have been shared at Board and we will have: • Evidence of co-produced system learning to reduce harm and innovate through new ways of working together. • Evidence of patient, staff and others involved in patient safety incidents throughout our quality and safety assurance process. It will be inclusive of people with any protected characteristics • The Patient Safety Partner Policy PL390 will be updated in partnership with our Patient Safety Partners by March 2025 • The Trust's quarterly Patient Safety Summit will be formalised within the Trust governance structure for sharing learning from a variety of feedback sources	**1.2.2**: A. Learning and improvements to be captured in PSII reports to Board B. Those involved in investigations will be captured in PSII reports signed off by Trust Executive Directors C. Policy to be accessible on Trust intranet D. Evidence of shared learning at safety summit and feedback in to Trust governance processes as agreed COMPLETE
Year 3 1 April 2026 – 31 March 2027	1.3.1	We will make a strategic shift from learning reactively when failures and errors have already occurred (Safety-I) to include learning from things that are going well (Safety-II)	1.3.1	Patient safety investigations will incorporate tools to explore system thinking and human factors science, to identify meaningful quality and safety improvements.	**1.3.1**: Evidence in PSIIs of application of new learning tools

SAFE	Key Priority 1 continued	
	Year 2 1 April 2025 – 31 March 2026	**1.2.1**: Safety Team maintain a record of training undertaken and refresher dates **Update**: Complete where training has been completed. **May 26 Update:** Availability of HSSIB courses remains a challenge. A risk is being assessed in relation to Engagement of those affected by Patient Safety Incidents with actions in place to improve this including a review of whether funding is available to source training for the group awaiting to receive this. **ONGOING**
		1.2.1b: Demonstrate a greater understanding of the gap between 'Work-as-Done (WAD)' and 'Work-as-Imagined (WAI)' will be reflected in the improvement activity undertaken in the Trust. **May 26 Update:** MDT/Walkthrough/AAR have continued to be used as learning responses/methodologies to improve Patient Safety including work as imagined/work as prescribed vs work as done. There are local, trust and overarching improvements groups with actions to address the learning in addition to specific action plans from PSII. **COMPLETE**
		1.2.1c: Staff feedback will inform improvements **May 26 Update:** a meeting has been held with the Patient Safety and Patient Engagement Managers. A survey is being developed. A One Minute Guide is also in development which will be provided to staff affected by Patient Safety Incidents, this will include information around the PSIRF principles of system learning, human factors and being fair, the wellbeing support available and a QR code for a feedback survey to inform improvements, this will be available on Datix to be shared with staff by incident investigators and handlers, this builds on the existing leaflet in place available on the intranet. **ONGOING**
		1.2.1d: Patient feedback will inform improvements **May 26 Update:** A meeting has been held with the Patient Safety and Patient Engagement Managers. A survey is being developed and will be added as a QR code to the Final Duty of Candour letters. **ONGOING**
	Year 3 1 April 2026 – 31 March 2027	**1.3.1**: Evidence in PSIIs of application of new learning tools **Update:** Evidence of inclusion is varied currently. Work continues to develop the governance process of the supporting meetings to ensure the report content is at the standard expected by the Clinical Governance Team. Those meetings include setting the standard at the initial Terms of Reference meeting, assessing progress of the use of the tools at the interim update meeting and ensuring they have been included at the final approval meeting. There is also a planned workshop at QAIG to discuss the quality of the PSII reports currently being submitted by the Business Units, to the Patient Safety Team, and the work involved by Clinical Governance to bring those reports to an acceptable standard to submit for Exec Director sign off. A risk will be assessed from the workshop and added to the risk register. **May 26 Update:** A guide has been developed for format, content and structure to support Lead Investigators and to improve the quality of reports. A Patient Safety Specialist is aligned to each PSII to support in terms of the PSIRF methodologies. A meeting is planned with PSS to discuss the structure of the PSII and moving the report template to a SEIPS based structure to better utilise the methodology. **ONGOING**

Effective (CQC)

Key Priority 2 (Applies to CQC Quality Statements 1, 2, 4, 5, 6, 9, 10,11, 13, 20, 23, 25, 26, 31)

Our process will fully comply with Care Quality Commission standards (CQC).
By working closely with you, we will ensure that our care not only meets regulatory standards but is also truly responsive to your needs and preferences

	Strategic action:		What we will do:		Evidence
Year 1 1 April 2024 – 31 March 2025	2.1.1	We will use our Quality Challenge Plus (QC+) programme to align with the CQC Single Assessment Framework (SAF). This includes the self-assessment process to gather evidence around the CQC quality statements which be uploaded directly to the CQC portal, once this is available to the Trust.	2.1.1	• Pilot of the proposed approach to be undertaken by 0-19 PHINS, Neuro Rehab, CAMHS and Diabetes to establish training requirements and documentation required. • Services will pilot the evidence matrix to ensure all key questions are answered • 100% of LCH clinical services will have a named SAF Champion by March 2025 who is responsible for: i. Attending CQC SAF internal training and keeping their team / service fully informed of change. ii. Ensuring the QC+ self assessment form and improvement plan is completed accurately, on time and shared with CET.	**2.1.1** Feedback from pilot to inform final model **2.1.1i**: CET will maintain a record of training undertaken, achieved and refresher dates **2.1.1ii:** CET maintain a database of all QC+ assessments and outcomes **COMPLETED AT LAST REPORT (2.1.1ii)**
	2.1.2	To explore the potential for a digitalised Clinical Effectiveness Plan to provide an automated approach to oversight - enabling identification of non-compliance and to inform reporting and assurance	2.1.2	CET to initiate and track progress of conversations re concept of digital clinical effectiveness plan by February 2025, setting realistic milestones for design and analysis. Start to engage with commercial teams / procurement. Aim to have consensus within 6 months to enable development of business case.	**2.1.2:** Business case to be developed in year 2 after scoping in year 1 COMPLETE

Effective (CQC)

Key Priority 2 (Applies to CQC Quality Statements 1, 2, 4, 5, 6, 9, 10,11, 13, 20, 23, 25, 26, 31)

Our process will fully comply with Care Quality Commission standards (CQC).
By working closely with you, we will ensure that our care not only meets regulatory standards but is also truly responsive to your needs and preferences

Evidence for Quality Committee May 2025:		

Year 1
1 April 2024 – 31 March 2025

2.1.1
Quality Challenge Plus (QC+) programme to align with the CQC Single Assessment Framework (SAF). Feedback from pilot to inform final model
Update: Two teams, Neuro Rehab and 01-9 PHINS, piloted the evidence log to identify documentation supporting the QC+ self-assessment. While the pilot demonstrated that substantial and high-quality evidence exists for each key question, the process was time-intensive. Additionally, Quality Walkers were unable to access evidence stored in shared folders, limiting the model's practicality for wider implementation. In addition, the Clinical Effectiveness Team is currently operating at Opel 3, which has significantly limited capacity to implement planned updates. As a result, the rollout of this model to other services has been paused. However, learning will be taken forward to inform final model.
Mitigation Measures and Next Steps:
The CQC is currently reviewing its approach to the Single Assessment Framework. To date, we have not been asked to submit evidence via email or the portal but continue to submit evidence when requested at time of inspection.
A consolidated list of suggested evidence has been shared with services to support their QC+ self-assessments.
Services have documented relevant evidence within their QC+ self-assessments, which can be retrieved if requested by the CQC.
The Clinical Effectiveness Team (CET) is reviewing Quality Walk process to support efficiencies within this part of the QC+ whilst further information is disseminated from CQC to inform next steps for the self-assessments. This will be phased improvement work and will aligned through the Quality and Value transformation plan and schedule.
May 26 Update: The Quality Challenge Plus report has been aligned with the CQC Single Assessment Framework for 2026/27, the self-assessment will be aligned for 2027/28 pending any CQC changes from their consultation on the Single Assessment Framework. **ONGOING**
2.1.1i:
CET will maintain a record of training undertaken, achieved and refresher dates
Update: CET provided training in March 2025 regarding the self-assessment framework and disseminated information via MyLCH and midday brief. Planned training sessions in Q1 and Q2 have not been completed due to competing demands and Clinical Governance reporting Opel 3.
May 26 Update: Training on the new report format has been completed. This will be recorded and made available as a remote/digital option. The Clinical Governance Quality and Value workstream of training is due to commence in May 2026 and will assess any additional training offers required. **ONGOING/ PARTIALLY COMPLETE**

2.1.2:
Business case to be developed in year 2 after scoping in year 1
Update: Scoping for digital products is ongoing as this needs to be aligned to all Clinical Governance workstreams to support the vision that the various governance processes align and evidence concordance with the CQC Key Questions that are demonstrated within the Trusts Quality Challenge Plus programme.
There has been progress on automating the record keeping audit using Sharepoint, which has reduced email traffic, improved transparency, increased accountability for staff. This will be utilised for the Clinical Audit plan when this is launched for 2026-27 programme.
May 26 Update: Work has continued to develop automated options within our existing digital portfolio. Folders have been established for all teams in Sharepoint/Teams channel whch will be developed to create shared spaces for the various functions, in line with the Record Keeping Audit model. At this stage, this will

Effective (CQC)	Key Priority 2				
	Year 2 1 April 2025 – 31 March 2026	2.2.1	We will implement our approach to the CQC Single Assessment Framework	2.2.1 • Develop a training programme for SAF Champions to disseminate; attendance at service-level training will be monitored against a plan developed by March 2025. • All Services will be prepared and ready to action their live submissions to the CQC Provider Portal • Work with SAF Champions and ensure that as an organisation we are developing key principles • Services will collect examples of evidence according to each of the five key questions • Services will use the evidence matrix to ensure all key questions are answered • The CET will ensure Director approval then upload to the CQC portal.	**2.2.1** CET will maintain a record of training undertaken, achieved and refresher dates CET will maintain a database CQC portal will be in active use **CLOSED AS NOT POSSIBLE**
		2.2.2	To progress concept of digital clinical effectiveness plan including engagement with commercial teams / procurement if agreement to proceed with business case and funding approved.	2.2.2 • Develop a business case and take it through standard processes including sourcing potential funding • If successful, monitor progress of procurement conversations / commercial teams involved, ensuring successful agreements and smooth processes or escalating delays / concerns. • If a digital solution is not possible, work with the Chief Information Officer (CIO) and Business Intelligence Team (BI) to create a good oversight tool (compliance spreadsheet) until a case for change is developed / funding made available.	**2.2.2:** See priority 2.4

Effective (CQC)	Key Priority 2		
	Year 2 **1 April 2025 – 31 March 2026**	**2.2.1** Develop a training programme for SAF Champions. CET will maintain a record of training undertaken, achieved and refresher dates **Update:** This has not progressed due to the changes with CQC portal. A decision was taken to focus on Quality Walks whilst further information is disseminated from CQC. **May 26 Update:** This action remains ongoing, the Quality Challenge Plus programme is the internal accreditation and provides CQC preparedness for teams, work is required to develop a Trust handbook with one in draft and one from another provider being reviewed. A document of potential information requests is populated and will be made available on the Clinical Effectiveness intranet and a spreadsheet with CQC's best practice guidance has been developed to support corporate teams consider their evidence for a CQC visit – this will also be made available for teams to assess against. A paper will be shared with Quality Committee in May 2026. CET will maintain a database **Update:** As above **May 26 Update:** As above CQC portal will be in active use **Update:** Paused as CQC have not launched the use of the portal. **No Further Action Possible - Closed**	

Effective (CQC)	**Key Priority 2**				
	Year 3 01 April 2026 – 31 March 2027	2.3.1	We will improve the processes implemented in year 1 and 2 in relation to the SAF, embedding 5 principles to demonstrate effectiveness: • Is it person-centred? • Is it inclusive? • Is it evidence-based? • Is it ambitious? • Is it affordable?	2.3.1	• The Trust will seek to improve ways of gathering and using data, including the impact of patient experience, working in conjunction with Patient Experience Team (PET). • The Trust will continue involving patients, families, and staff in learning and improvements and include this feedback in the evaluation of the 2024-27 strategy and inform the successor document • Seek and apply learning from SAF design process and incidents to continually improve. • Service level CQC Champions will ensure service-level sign-off • Service-level CQC Champions will quality assure all evidence and save in the specified secure drive and confirm action complete via the CET	**2.3.1**: Evidence of feedback informing quality and safety improvements Case studies to be added to patient information hub
		2.3.2	Implement the most cost and clinically effective compliance tool, making the most use of innovations and funding streams available	2.3.2	• Deliver on the implementation of any successful business case	**2.3.2**:Clinical effectiveness compliance tool to be operationalised

Effective (CQC)	**Key Priority 2**		
	Year 3 **01 April 2026 – 31 March 2027**	**2.3.1**: The Trust will seek to improve ways of gathering and using data, including the impact of patient experience, working in conjunction with Patient Experience Team (PET). Evidence of feedback informing quality and safety improvements. **Update**: Data is not currently available and has been escalated via the AAA QAIG report for onward discussion. **May 26 Update:** No further progress Case studies to be added to patient information hub **Update:** Not yet initiated due to Patient Safety and Patient Engagement capacity. **May 26 Update:** No further progress	
		2.3.2:Clinical effectiveness compliance tool to be operationalised **Update:** Scoping for digital products is still ongoing as this will be aligned to all governance workstreams. **May 26 Update:** No further progress	

Effective

Key Priority 3 (Applies to CQC Quality Statements: 2, 3, 4, 5, 7, 9, 10, 11, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 31, 32, 33)

Feedback will inform and improve safety and quality of care

Strategic actions			What will we do:		Where to find the evidence:
Year 1 1 April 2024 – 31 March 2025	2.4.1	We will make patient data more available and accessible so we can improve how we address equity and health outcomes	2.4.1	A series of follow-up meetings is booked between the Chief Information Officer, Business Intelligence Manager and other strategic leads following an initial QAIG and QC workshop (held 28/10/2024 with a range of strategic colleagues). They will enable LCH to reach a consensus on which metrics are deemed most appropriate to measure effectiveness across the organisation.	**2.4.1:** Agreed metrics to be included in Trust reporting
	2.4.2	We will strengthen our commitment to evidence-based practice by addressing consistency in the ways we work, especially regarding compliance with local and national requirements in: • Clinical audit • Clinical and corporate policies • Equity and Quality Impact assessments (EQIAs) • National Institute for Health and Care Excellence (NICE) This will ensure clinical effectiveness remains a priority throughout LCH as we deliver against the quality and value programme and other innovations and transformation across the Trust	2.4.2	We will move from efficiency-based metrics to outcome and impact-based metrics to demonstrate learning and improvement aligned with the Trust key performance indicators	**2.4.2**: These metrics will be reported on within appropriate existing reports to Board +/- sub-committees Relevant audit against Trust policies reflected in annual clinical audit plan and reported to QAIG and Quality Committee through existing corporate governance arrangements

Effective

Key Priority 3 (Applies to CQC Quality Statements: 2, 3, 4, 5, 7, 9, 10, 11, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 31, 32, 33)

Feedback will inform and improve safety and quality of care

Evidence for Quality Committee May 2025:		

Year 1
1 April 2024 – 31 March 2025

2.4.1:
Agreed metrics to be included in Trust reporting
Update: An update was presented to QC in July 2025. Goal Based Outcomes (GBOs) have been selected as a Trust-wide effectiveness metric due to their simplicity and evidence base. Pilots are underway in the Active Recovery Unit and Children's Business Unit. The effectiveness dashboard has been paused to align with KPI development, ensuring integration and resource efficiency. Clinical Systems and BI teams are collaborating on GBO data infrastructure. Patient reported outcome measures and equity-linked metrics are being explored for broader use. Other effectiveness data is collected but not yet centralised with BI access. Timeline pressures and dependencies on other workstreams have delayed progress, but alignment with existing initiatives aims to optimise resources and reduce duplication
May 26 Update: Through 2025/26 a stocktake of equity reporting was undertaken. Plans that align to consistent city-wide approach have been developed and included in the Health Equity Tactical Plan. In 2026/27 The Health Equity Index will be implemented in LCH as it will in providers across Leeds. In the first phase the Health Equity Index will be applied to the following measures: Consultant led 18 week standard, consultant led 52-week standard, non-consultant led 18 week standard, and diagnostic waits standard and will examine variation in care for the following characteristics: ethnicity, IMD, LD, armed forces and people with a disability.
To align with NHS England's updated statement on information on health inequalities, measures examining the completeness of ethnicity recording including where it is recorded as "not known" or "not stated" (also known as residual codes) will be added to the Trust's KPIs and examined in the IPR.

2.4.2:
We will move from efficiency-based metrics to outcome and impact-based metrics to demonstrate learning and improvement aligned with the Trust key performance indicators
These metrics will be reported on within appropriate existing reports to Board +/- sub-committees.
May 26 Update: An update was presented to Quality Committee in January 2026. Goal Based Outcomes (GBOs) have been selected as a Trust-wide effectiveness metric due to their simplicity and evidence base. Pilots are underway in the Active Recovery Unit, Children's Business Unit and Specialist Business Unit. Clinical Systems and BI teams are collaborating on GBO data infrastructure with the aim of confirming that automated reporting will be available from the pilot. When they are ready to report GBOs will form the first KPI included in the effectiveness dashboard.

The Trust's updated KPI list contains several outcome-focused measures. In 2026/27 these will be reviewed and gradually implemented alongside GBOs to triangulate impact, including patient-reported effectiveness, NHS Talking Therapies recovery/improvement (NHSTT), remain-at-home at 90 days, reduced 30-day readmissions, premature mortality, preferred place of death and cost per effective outcome.

Effective	Key Priority 3				
	Year 2 1 April 2025 – 31 March 2026	2.5.1	We will ensure the Trust uses all feedback to evidence +/- improve quality care	2.5.1	• Ensure feedback is gathered from all service user groups so all voices are heard • 100% services will fully align their 2025/26 clinical audit plan to LCH vision, priorities and risks. • CET will undertake quality assurance checks on at least 25% clinical audits and policies to assess adherence to agree processes. • Provide advanced training for staff to enhance their skills in applying evidence-based practices across teams; develop broader training networks where they add value • Use analytics and research skills to review patient level data so we can better understand how protected characteristics affect patient experience and outcomes and identify health disparities for redress. • Collaborate with university research partners to learn how to deliver and monitor effective, evidence-based care when there is insufficient evidence or assurance	**2.5.1:** Board and relevant sub-committees to be informed about feedback through existing reporting structure COMPLETE 2025/26 clinical audit plan to reflect the alignment to Trust priorities and risks Increase in research activity to be reflected in information shared to QAIG. COMPLETE The Trust will ensure they are able to identify and report on the number of staff trained on how to use data analysis and interpretation tools / methodology

Effective	Key Priority 3	
	Year 2 1 April 2025 – 31 March 2026	**2.5.1:** Board and relevant sub-committees to be informed about feedback through existing reporting structure. **Update:** A six-monthly experience and a six-monthly engagement report are completed for Quality Committee that includes Friends and Family Test information, feedback and learning. There are now separate quarterly AAA reports to QAIG in addition. **May 26 Update**: The above reporting continues, in addition overarching themes are included in the annual Quality Account. **COMPLETED** 2025/26 clinical audit plan to reflect the alignment to Trust priorities and risks **Update**: The 2026-27 audit plan will clearly identify audit priorities and where audits are unable to be completed due to competing demands, which can then be logged as a risk on the risk register. Quality assurance checks for compliance with clinical audits is completed monthly through business unit reporting. Compliance with policy process is completed for all policies through CCPG meeting and review of Policy database. The planned 26/27 approach to the audit plan will include consideration of the Trust Strategic and Important Goals since movement away from priorities. **May 26 Update:** The Annual Audit Plan has been remodelled to include all audits that are required of services, these are not all for completion every year but services and Clinical Governance can then support prioritisation of audits annually across the rolling programme. There is a development of encouraging service to consider where multiple audits can be combined into one audit episode, this is already in place in some areas from 2025/26, for example there is one Falls audit that encompasses the Falls Policy matrix, the NICE Quality Standard, Falls clinical compliance audit and will inform the Falls Trust Improvement Group and plan. Next steps will be to align it to the Trusts strategic goals and risks. **ONGOING** Increase in research activity to be reflected in information shared to QAIG **Update:** - The QAIG report has been changed since this measure was written to a AAA format. - There were 60% more studies in 2025/26 Q2 than the previous year (10 to 16, with the Q4 figure being 16 in the previous year). **May 26 Update:** The Research report is scheduled for QAIG with ongoing update. At 2025/26 year end there was an 18% increase in studies compared to the previous year with the highest participation recruitment for five years at 1044. **COMPLETED** The Trust will ensure they are able to identify and report on the number of staff trained on how to use data analysis and interpretation tools / methodology **Update:** This measure is being assessed with the Head of Business Intelligence to understand the requirement to enable an update. **May 26 Update:** Continues to be assessed

Effective	**Key Priority 3**							
	Year 3 1 April 2026 – 31 March 2027	2.6.1	We will ensure the Trust has embedded and sustained a range of robust feedback mechanisms to gather insights and information to assess if the workplace supports effective care delivery		2.6.1	• Use agreed clinical effectiveness measures (including FFT) to provide assurance around new ways of working / service improvement • Ensure that the improvements made re priority 2 in years 1 and 2 are sustained and become part of LCH culture. • Introduce new evidence-based practices and innovative solutions to enhance clinical effectiveness, using insight from audit / EQIAs undertaken between 2024 - 2026 • Measure the impact of initiatives introduced in priority 1 and 2 to track and report key outcomes. • Share best practices and success stories within LCH and with external local / regional / national stakeholders via social media and appropriate networks, including the Future Collaboration Platform. • Seek recognition for achievements through awards and certifications.		2.6.1: Reporting of quality metrics through governance reports Quality Committee workplan Quality account to note local and national awards

Effective	Key Priority 3	
	Year 3 **1 April 2026 – 31 March 2027**	2.6.1: Use agreed clinical effectiveness measures (including FFT) to provide assurance around new ways of working / service improvement: Reporting of quality metrics through governance reports Quality Committee workplan Quality account to note local and national awards **Update:** CET have improved reporting on National Audits relevant to LCH through the development of a new process where the Clinical Effectiveness and Compliance Manager receives monthly updates from audit lead and Clinical Lead. This has led to a better understanding of relevant audits, leading to a further 3 audits being identified as relevant to LCH which we are submitting either full or partial datasets to. Feedback is pending regarding the proposed effectiveness measures from the July 2025 report to Quality Committee per action 2.4.1. **May 26 Update:** Remains in progress.

Key Priority 4 (Applies to CQC Quality Statements: 1, 2, 3, 4, 5, 6, 7, 8, 13, 14, 18, 23, 24, 27, 29, 31, 32, 33, 34)

We will implement PHSO standards to ensure effective feedback

	Strategic action:			How will we do it:		Evidence:
Experience	**Year 1 1 April 2024 – 31 March 2025**	3.1.1	We will have identified required improvements to embed the 2023 Parliamentary Health Service Ombudsman Standards into our Patient Experience / Complaint pathway	3.1.1	By March 2025 we will have: • Completed a PHSO benchmarking exercise to inform required improvements • Identified training requirements • Sought staff and patient feedback to inform improvements • Improve how we analyse 3C information collected via the incident management platform to align with Leeds priorities • Undertake a baseline audit of compliance with complaint processes to inform improvements • Develop a process to gather patient feedback regarding complaints process, from all patients and understand whether we receive feedback from all patient groups • Utilise a new dashboard for monitoring trends and themes	**3.1.1:** Improvement plan to be in place and evidence of progression, reported through Patient Experience reports and clinical fellow activity. COMPLETE
Experience	**Key Priority 4**					
	Year 2 1 April 2025 – 31 March 2026	3.2.1	We will further embed the 2023 Parliamentary Health Service Ombudsman Standards into our Patient Experience / Complaint pathway	3.2.1	• We will deliver training and act on feedback • We will ensure resources are easily accessible for staff • 100% of complainants will be offered a resolution meeting • 100% of staff participating in resolution meetings will be asked for their feedback • We will ensure and evidence that we are communicating with people in line with their communication needs and that we record and act on reasonable adjustments	**3.2.1:** Metrics will be reported through governance processes Feedback will inform improvements
Experience	**Key Priority 4**					
	Year 3 1 April 2026 – 31 March 2027	3.3.1	We will confirm we are a mature organisation that has significant and proven development in handling complaints and is an exemplar site.	3.3.1	We will be able to demonstrate evidence of shared decision making in line with NICE guidance	**3.3.1:** Evidence of compliance with PHSO standards

Experience

Key Priority 4 (Applies to CQC Quality Statements: 1, 2, 3, 4, 5, 6, 7, 8, 13, 14, 18, 23, 24, 27, 29, 31, 32, 33, 34)

We will implement PHSO standards to ensure effective feedback

Strategic action:	How will we do it:	Evidence:
Year 1 **1 April 2024 – 31 March 2025**	**3.1.1:** PHSO implementation: Improvement plan to be in place and evidence of progression, reported through Patient Experience reports and clinical fellow activity. **Update:** The PHSO improvement plan is progressed on weekly basis and reported through the patient experience workstream. Phase one of the pilot for PHSO rollout is completed with CYMPHS and MSK being the first two services. Phase two of the pilot is due to commence and will bring ABU North Neighbourhood Teams, SBU Leeds Mental Health and Wellbeing Service and Leeds Sexual Health and CBU ICAN Team into the pilot. Learning from phase one is to deliver some PHSO standards training and update the Datix feedback module (completed) prior to initiation. The training is being developed with a planned phase two start of 1 December 2025. The Clinical Fellow role ended in September 2025 with a handover to the Patient Experience Manager to have oversight of the end of Phase One of the pilot and suggested next steps. **May 26 Update:** Phase 1 and 2 of the pilot have been completed and those teams are now working within the Standards. The rollout for all teams in now being developed. Reporting of progress continues through the AAA QAIG report when needed. **COMPLETED**	

Experience

Key Priority 4

Year 2 **1 April 2025 – 31 March 2026**	**3.2.1:** We will further embed the 2023 Parliamentary Health Service Ombudsman Standards into our Patient Experience / Complaint pathway. Metrics will be reported through governance processes: **Update**: Training is being developed for teams to provide an overview of the standards prior to the team coming into the pilot. There is elearning available via the PHSO website that will be shared when the Clinical Governance training portfolio is developed for the Quality and Value transformation plan. Resolution meetings are being offered when assessed appropriate and currently when a response does not resolve the initial issue for the complainant. There is a plan to offer a resolution meeting at first contact as part of the early resolution element of the PHSO standards and requires further alignment with the PHSO project outlined in 3.1.1. **May 26 Update:** Please see 3.1.1 **ONGOING** Feedback will inform improvements **Update:** Feedback will be sought once the base processes are established. **May 26 Update:** Feedback from Phase One informed Phase Two and feedback and learning from Phase Two will inform the rollout. For example, a recent complaint included the confusion when moving from an Early Resolution to a Closer Look complaint for a persistent complainant whose complaint become increasingly complex during the complaint journey. **ONGOING**	

Experience

Key Priority 4

Year 3 **1 April 2026 – 31 March 2027**	**3.3.1:** Evidence of compliance with PHSO standards **Update:** Will be assessed when the standards have been implemented fully **May 26 Update:** For year three, however those working within the PHSO Standards now are monitored via the standard Patient Experience Team processes. **ONGOING**	

Experience (EQIA)

Key Priority 5 (Applies to CQC Quality Statements: 1, 2, 3, 4, 14, 15, 16, 18, 19, 23, 24, 25, 28, 29, 31, 32, 33)

We will consider quality & equity in our quality and safety improvements

Strategic actions:			What will we do:		Evidence:
Year 1 1 April 2024 – 31 March 2025	3.7.1	• We will establish and evolve the EQIA process across the Trust	3.7.1	• We will deliver training which will include the need for system-level engagement and patient inclusion. • Case studies and impact statements will be added to our intranet and extranet so all can see the impact we are making. • We will develop a dashboard, using data extracted from the incident management platform (Datix) to evidence progress and highlight where attention should be focused next	**3.7.1:** EQIA dashboard to provide updates to Quality & Value Board

Experience (EQIA)

Key Priority 5

Year 2 1 April 2025 – 31 March 2026	3.8.1	• We will consider if and how we can improve digitalisation of the EQIA process in embedding the processes as business as usual	3.8.1	• We will incorporate patient feedback at every opportunity, and we will invite Patient Safety Partners to join our EQIA panel, to strengthen the patient voice • We will request feedback from services 12m after their EQIA has become embedded as business as usual, to identify unexpected learning and impact that can be shared with others • We will set up a system to get feedback from service users to see if they notice any changes in the services we provide, as required by Section 242 of the National Health Service Act 2006	3.8.1: Evidence of appropriate involvement through EQIAs, signed off by Executive Directors

Experience (EQIA)

Key Priority 5

Year 3 1 April 2026– 31 March 2027	3.9.1	• We will audit and evidence the Trusts approach to equality and quality in care delivery changes	3.9.1	• We will audit and evidence the Trusts approach to equality and quality in care delivery changes	

Experience (EQIA)	Key Priority 5 (Applies to CQC Quality Statements: 1, 2, 3, 4, 14, 15, 16, 18, 19, 23, 24, 25, 28, 29, 31, 32, 33)		
	We will consider quality & equity in our quality and safety improvements		
	Strategic actions:	**What will we do:**	**Evidence:**
	Year 1 1 April 2024 – 31 March 2025	**3.7.1:** EQIA dashboard to provide updates to Quality & Value Board **Update:** The action requires Business Intelligence input and will be updated when further information is known. **May 26 Update:** This has not been progressed due to the EQIA Officer vacancy. **ONGOIN/NOT STARTED**	

Experience (EQIA)	Key Priority 5		
	Year 2 1 April 2025 – 31 March 2026	3.8.1: Evidence of appropriate involvement through EQIAs, signed off by Executive Directors **Update:** The Patient Engagement/Involvement Manager has now joined the EQIA panels from October 2025 to provide expert subject matter advice and scrutiny on engagement and involvement at EQIA panels. Provide support and comments on all EQIA submitted in advance of the panel. **May 26 Update:** The Patient Engagement/Involvement Manager is a panel member at EQIA who reviews the EQIAs prior to coming to panel and attends the meetings. There is a plan to involve the Patient Safety Partners with one expressing interest. We see evidence of patient involvement in some but not all EQIAs, this is then discussed in the meetings. **ONGOING**	

Experience (EQIA)	Key Priority 5		
	Year 3 1 April 2026– 31 March 2027	3.9.1: We will audit and evidence the Trusts approach to equality and quality in care delivery changes **Update:** This measure will be assessed as the strategy progresses. **May 26 Update:** No further update. **ONGOING/NOT STARTED**	

GLOSSARY

AGENDA ITEM 2026-27 (24)

Leeds Community Healthcare NHS Trust

A

ACP	Advanced Clinical Practice
AfC	Agenda for Change
AGM	Annual General Meeting
AHP	Allied Health Professional
AI	Artificial Intelligence
AIS	Accessible Information Standard
AR	Active Recovery

B

BAF	Board Assurance Framework
BME	Black and Minority Ethnic

C

CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alert System
CBT	Cognitive Behavioural Therapy
CDS	Community Dental Service
CE+	Cyber Essentials Plus Accreditation
CEO	Chief Executive Officer
CIO	Chief Information Officer
CIP	Cost Improvement Plan
CIVAS	Community Intravenous Antibiotics Service
CMHT	Community Mental Health Team
CQC	Care Quality Commission
CrISPP	Critical Incident Staff Support Pathway
CUCS	Continence, Urology and Colorectal Service
CYPMHS	Children and Young People's Mental Health Services

D

DBS	Disclosure Barring Service
DHSC	Department of Health and Social Care
DNLTC	Disability, Neurodiversity and Long-Term Conditions
DoLS	Deprivation of Liberty Safeguards
DPA	Data Protection Act
DPO	Data Protection Officer
DSPT	Data Security and Protection Toolkit

E

EAP	Employee Assistance Programme
EDI	Equality, Diversity & Inclusion
EPMA	Electronic Prescribing & Medicines Administration
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
EQIA	Equality & Quality Impact Assessment
ESIB	Estates Strategy Implementation Board
ESR	Electronic Staff Record

F

FBC	Full Business Case
FFT	Friends and Family Test
FoI	Freedom of Information
FPPT	Fit and Proper Persons Test Framework
FTSUG	Freedom to Speak Up Guardian

G

GDPR	General Data Protection Regulation
GIRFT	Getting It Right First Time
GoSWH	Guardians of Safe Working Hours

H

HHIT	Homeless and Health Inclusion Team
HSJ	Health Service Journal
HSW	Healthcare Support Worker
HWB	Health and Wellbeing

I

IAPT	Improving Access to Psychological Therapies
ICAN	Integrated Children's Additional Needs Service
ICB	Integrated Care Board
ICO	Information Commissioner's Office
ICS	Integrated Care System
IFRS	International Financial Reporting Standards
IG	Information Governance
IMD	Index of Multiple Deprivation
IMHS	Infant Mental Health Service
IPR	Integrated Performance Report

K

KLOEs	Key Lines of Enquiry
KPI	Key Performance Indicator

L

LA	Local Authority
LCC	Leeds City Council
LCFS	Local Counter Fraud Specialist
LCH	Leeds Community Healthcare NHS Trust
LD	Learning Disability
LeDeR	Learning from Lives and Deaths - People with a Learning Disability and Autistic People
LHCP	Leeds Health and Care Partnership
LIFT estate	Local Improvement Finance Trust Estate

GLOSSARY

LMWS	Leeds Mental Wellbeing Service
LOS/ LoS	Length of Stay
LSH	Leeds Sexual Health Service
LTHT	Leeds Teaching Hospital NHS Trust
LYPFT	Leeds and York Partnership Foundation Trust

M

MARS	Mutually Agreed Resignation Scheme
MDT	Multi-Disciplinary Team
MSK	Musculoskeletal

N

NAO	National Audit Office
NED	Non-Executive Director
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NOF	National Oversight Framework

O

OFSTED	Office for Standards In Education, Children's Services and Skills
OOH	Out of Hours
OPEL	Operational Pressures Escalation Levels

P

PALS	Patient Advice and Liaison Service
PCN	Primary Care Networks
PFI	Private Finance Initiative
PHINS	Public Health Integrated Nursing Service
PIP	Performance Information Portal
PND	Paediatric Neuro Disability
PPE	Personal Protective Equipment
PSED	Public Sector Equality Duty
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Response Framework

Q

QA	Quality Assurance
QAIG	Quality Assurance and Improvement Group
QIA	Quality Impact Assessment
QOF	Quality and Outcomes Framework

R

RAG	Red Amber Green
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RMN	Registered Mental Health Nurse
RN	Registered Nurse
RTT	Referral to Treatment

S

SAR	Subject Access Request
SEND	Special Educational Needs & Disability
SFI	Standing Financial Instructions
SI	Serious Incident
SID	Senior Independent Director
SIRO	Senior Information Risk Owner
SLA	Service Level Agreement
SLT/SaLT	Speech and Language Therapy
SMART	Specific, Measurable, Achievable, Relevant and Time bound
SME	Subject Matter Expert
SOP	Standard Operating Procedure
SPC	Statistical Process Control
SUDIC	Sudden Unexpected Death in Childhood

T

TLT	Trust Leadership Team
TOR	Terms of Reference
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981

V

VCS	Voluntary and Community Sector
VfM	Value for Money
VSM	Very Senior Manager

W

WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent
WYH&CP	West Yorkshire Health and Care Partnership

Y

YAS	Yorkshire Ambulance Service
YOI	Young Offenders Institute
YTD	Year to Date

Leeds Community Healthcare NHS Trust

Trust Board Workplan April 2026 -March 2027
Version: 6 14 July 2026

Agenda Item
2026-27
(25)

Topic	Frequency	Lead Officer	23 July 2026	17 September 2026	19 November 2026	21 January 2027	18 March 2027
STANDING ITEMS							
Declaration of interests	Each meeting	CS	X	X	X	X	X
Minutes of previous meeting	Each meeting	CS	X	X	X	X	X
Action log	Each meeting	CS	X	X	X	X	X
Patient Led Experience	Each meeting	EDN&AHPS	X	X	X	X	X
STRATEGY AND PARTNERSHIPS							
Chief Executive's report	Each meeting	CEO	X	X	X	X	X
Organisational Strategy Development	Annual (November)	EDO			X		
Medium Term Plan/Operational Priorities		EDFR		X			
Estate Strategy	Six monthly (May/November)	EDFR			X		
Learning and Developement Strategy	Annual (March)	EDN&AHPS					X
Health Equity Strategy	Annual (September)	EMD		X			
Quality Strategy	Six monthly (July/ January)	EDN&AHPS	X			X	
People Headlines and Strategy update	3 X per year (March, July and November)	DOP	X		X		X
QUALITY AND SAFETY							
Quality Committee Chair's Assurance Report	Each meeting	CS	X	X	X	X	X
Quality account	Annual (June)	EDN&AHPS					
Mortality reports	Quarterly (May + annual report, July, September and January)	EMD	X Blue Box	X		X	X
Patient safety (including patient safety incident investigations) update report	Six monthly (September and March)	EDN&AHPS		X			X
Infection prevention control assurance framework	Annual (May)	EDN&AHPS					
Infection prevention control annual report	Annual (July)	EDN&AHPS	X Blue Box				
Care Quality Commission inspection reports	As required	EMD					
Safeguarding -annual report	Annual (July)	EDN&AHPS	X Blue Box				
FINANCE PERFORMANCE AND SUSTAINABILITY							
Business Committee Chair's Assurance Report	Each meeting	CS	X	X	X	X	X
Audit Committee Chair's Assurance Report	Quarterly (May, July, November and January)	CS	X		X		X
Charitable Funds Annual Report and Accounts Trustees Meeting only	Annual (January)	EDFR					X
Charitable Funds Committee Chair's Assurance Report	Quarterly (July, Sept, Jan and March)	CS	X	X		X	X
Charitable Funds 6 monthly Update Report (To go to Trustees meeting annually)	Six monthly (May and Nov)	EDN&AHPS			X		
Emergency Preparedness, Resilience & Response Statement of Compliance	Six monthly (July - Annual Report and January)	EDO	X Annual Report only			X	
Integrated Performance Report - with sub-headings of Sickness rate trajectories and waiting list trajectories	Each meeting	EDFR/EDO/DoP	X	X	X	X	X
Performance brief: High Level Performance Indicators for inclusion in the performance brief	Annual (March)	EDFR					X
Financial Plan	Annual (March)	EDFR					X
Annual report	Annual (June)	EDFR					
Annual accounts	Annual (June)	EDFR					
Letter of representation (ISA 260)	Annual	EDFR					
Audit opinion (Internal)	Annual	EDFR					
National Oversight Framework -Segmentation Update	Each meeting	CEO	X	X	X	X	X
Sustainability (Green) Plan	Six monthly (July, and January)	EDO	X Blue box			X	
WORKFORCE							
Staff survey	Annual (March)	DOP					X
Freedom to speak up report	2 x year (March and September)	FTSUG		X			X
Guardian for safe working hours report	Quarterly (May, July +annual report, September and January)	GoSWH	X +Annual Report				X
Medical Director's annual report	Annual (September)	EMD		X			
People Inclusion Improvement Plan 2025 – 2026(incorporating WRES / WDES and Pay Gap reporting)	Annual (November)	DW			X		
GOVERNANCE							
Code of Governance Compliance	Annual (March)	CEO					
Provider Licence Compliance	Annual (May)	CS					
Audit Committee annual report inlcluding Committee terms of reference review	Annual (May)	CS					
Standing orders/standing financial instruction	Annual TBC	CS					
Going concern statement	Annual (March)	EDFR					
Declarations of interest/fit and proper persons test	Annual (March)	CS					
Register of sealings	As required	CS					
Significant risks and risk assurance report	Each meeting	CS	X	X	X	X	X
Board Assurance Framework -quarterly update report	Quarterly May, September, January and March	CS	2026-27 for approval X	X		X	X
Risk appetite statement	Annual (May)	CS					
Management of Risk Policy & Procedure (3 yearly)	(Next due for review in Nov 2028)	CS					
Declaration of interests - information from declare	Annual (September) - from 2025	CS		X			
Board Members Service Visits Report	3 x year (TBC)	CEO					
Business Continuity Management Policy	As required	EDO					
Policy for the Development and Management of Policies (3 yearly)	(Next due for review Feb 2026)	EDN&AHPS					
Health and Safety Annual Plan	Annual	EDFR					
Health & Safety Policy (3 yearly)	(Next due for review Feb 2026)	EDFR					
Senior Information Risk Officer - Annual Report	Annual (May)	EDFR					
Work plan	Each meeting	CS	X	X	X	X	X
ADDITIONAL ITEMS							