Bundle Public Board Meeting 17 September 2026

0 Agenda
Final Agenda Public_Board_Meeting_17 September_2026

1 09:30 - Welcome, introductions and apologies

2 Declarations of interest-Information from Declare
Item 2 Board Declarations September 2026

3 Questions from members of the public
Minutes adoption for approval

4 Minutes of previous meeting action log and matters arising

4.a Minutes of the meetings held on: 23 July 2026 - for approval
Item 4a Draft PUBLIC Board minutes 23 July 2026 v2 Chair and CEO Approved

4.b Action log
Item 4b Public Board Action Log - 17 September 2026 (as at 27 07 2026)

4.c 09:40 - Patient Lived Experience: Community Stroke Team

5 10:00 - Interim Chief Executive's report
Item 5 CEO LCH Sept paper

6 10:10 - Health Equity Strategy
Item 6 Board equity update Sept 2026 v5

7 10:20 - Winter Planning 2026/27 - For approval
Item 7 Winter Planning 26-27v2 10 09 2026

8 10:40 - Quality Committee Chair's Assurance Report: 8 September 2026
Item 8 Chairs assurance report Quality Committee September 2026

9 10:45 - Patient Safety (including patient safety incident investigations) Update Report
Item 9 Patient Safety report August 2026

10 10:50 - Business Committee Chair's Assurance Reports: 15 September 2026 (tabled report)

11 10:55 - Charitable Funds Chair's Assurance Report: 2 September 2026
Item 11 Charitable Funds Committee Chair Assurance Report Sep 2026 v3

12.a 11:05 - Integrated Performance Report
Item 12ai Cover paper - Performance Brief_Board Sep
Item 12aii IPR - August 2026

12.b Sickness Absence - NOF Update
Item 12bi Public Board Sept 2026 Sickness Absence cover report
Item 12bii NOF Sickness Absence update - Board Sept 2026

13 11:25 - Freedom to Speak Up Report
Item 13 FTSUG September 2026 board report (1)

14 11:30 - Medical Director's Annual Report and Statement of Compliance – for approval
Item 14i Annual Medical Directors Report 25-26 - September 26 Board - FINAL
Item 14ii Annual Medical Directors Report annex-a-fqai-updated-2026 - Leeds Community Healthcare NHS Trust for QC and Board

15 11:35 - Significant Risks And Risk Assurance Report
Item 15 Board Significant Risk Report 170926

16 11:40 - Board Assurance Framework 2026/27
Item 16i Board Assurance Framework 2026-27 Q1 report
Item 16ii BAF_2026-25_Sep_2026

17 11:45 - Board Members Service Visits Reports
Item 17 Board member service visits - Sep 2026

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

19 Blue Box Item - Workplan to note
Item 19 BLUE BOX ITEM Trust Board Workplan Public v7 2026-2027 27 07 2026

20 Blue Box Item - Glossary
Item 20 BLUE BOX ITEM - Glossary - v2.2 - April 2026

Leeds Community Healthcare NHS Trust

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

Date 17 September 2026
Time 9.30am – 11.50am
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: • 23 July 2026 – for approval	**Y**
4b		Action Log	**Y**
4c	9.40	**Patient Lived Experience:** Community Stroke Team	**N**
STRATEGY AND PARTNERSHIPS			
2026-27 5	10.00	**Interim Chief Executive's Report** *(Dr Sara Munro)*	**Y**
2026-27 6	10.10	**Health Equity Strategy** *(Dr Ruth Burnett)*	**Y**
2026-27 7	10.20	**Winter Plan 2026/27 – for approval** *(Sam Prince)*	**Y**
BREAK – 10 minutes			
QUALITY AND SAFETY			
2026-27 8	10.40	**Quality Committee Chair's Assurance Report: 8 September 2026** *(Anne Cooper)*	**Y**
2026-27 9	10.45	**Patient Safety Update Report** *(Heather McClelland)*	**Y**
FINANCE, PERFORMANCE AND SUSTAINABILITY			
2026-27 10	10.55	**Business Committee Chair's Assurance Reports**: 15 September 2026 (tabled report) *(Lynne Mellor)*	**N**
2026-27 11	11.00	**Charitable Funds Chair's Assurance Report:** 2 September 2026 *(Helen Thomson)*	**Y**
2026-27 12	11.05	**a) Integrated Performance Report** *(All Execs)* **b) Sickness Abscence – NOF Update** *(Jenny Allen)*	**Y** **Y**

2026-27 13	11.25	**Freedom to Speak Up Report** *(John Walsh)*	**Y**
2026-27 14	11.30	**Medical Director's Annual Report and Statement of Compliance – *for approval*** *(Dr Ruth Burnett)*	**Y**
GOVERNANCE AND WELL LED			
2026-27 15	11.35	**Significant Risks And Risk Assurance Report** *(Dr Sara Munro)*	**Y**
2026-27 16	11.40	**Board Assurance Framework 2026/27** *(Dr Sara Munro)*	**Y**
2026-27 17	11.45	**Board Members Service Visits** *(Dr Sara Munro)*	**Y**
CLOSING BUSINESS			
2026-27 18	11.50	**Any Other Business. Questions On Blue Box Items And Close** (Acting Trust Chair) The Board resolves to hold the remainder of the meeting in private due to the confidential or commercially sensitive nature of the business to be transacted.	**N**

All items listed (Blue Box) in blue text, are to be received for information/assurance, having previously been scrutinised by committees. The Acting Chair will invite questions on any of these items under Item 18.

***Blue Box Items – To Note**		
2026-27 19	**Workplan**	**Y**
2026-27 20	**Glossary**	**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: 23 July 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
	Dr Ruth Burnett	Executive Medical Director
	Anne Cooper (AC)	Non-Executive Director
	Catherine Hall	Associate Director of People Solutions (Deputising for the Director of People)
	Professor Ian Lewis (IL)	Associate 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
In attendance:	Jane Parojcic	Community Matron, Armley Neighbourhood Team (For Item 29)
	Laura Hollins	Community Matron, Armley Neighbourhood Team (For Item 29)
	Helen Robinson	Company Secretary
Minutes:	Liz Thornton	Corporate Governance Officer
Apologies:	Jenny Allen (JA) Rachel Booth (RB) Alison Lowe OBE (AL)	Director of People Non-Executive Director Non-Executive Director

Item 2026-27 (25): Welcome introduction, apologies, and preliminary business

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

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

Item 2026-27 (26): 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 (27): Questions from members of the public

There were no questions from members of the public.

Item 2026-27 (28): 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 six actions on the log to review:

2026-27 (7) – Incident Management and Investigation Report received by the July Quality committee would be considered under Item 8 on the Agenda. **Action Closed.**

2026-27 (8a, b and c) – Mortality Reports: the Executive Medical Director referred to the reports which were in the Blue Box (Item 18). These reports had been discussed at the Quality Committee on 14 July 2026. The Board was satisfied that the actions were addressed in the papers in the Blue Box. **Actions Closed.**

2026-27(9) – Business Committee AAA Report 19 May 2026: Health & Safety AAA Report actions- this action related to some issues related to reporting in Datix. It was agreed that this would be considered by the Business Committee in September 2026. **Action closed.**

2026-27 (13) - Business Case: PND Assessment Pathway: a Quality Committee spotlight item had been timetabled. **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 (29): Patient Lived Experience

The Board welcomed Jane Parojcic and Laura Hollins, Community Matrons from the Armley Neighbourhood Team.

They spoke about the challenges and successes the Team had experienced in providing care for an insulin dependent type 3 diabetic patients who maintained a semi- homeless lifestyle. The patient also had a pattern of substance misuse; aggressive behaviour and the conditions of his living arrangements made it difficult to ensure the safety of staff when visiting, making planning and delivering his care more complex and challenging.

They explained that despite the challenges they had worked closely with community social workers, the Trust's homeless and health Inclusion team, safeguarding team and third sector partners to support the patient in the best way possible. After a period as an inpatient in the acute hospital the patient had secured a place in a nursing home, an arrangement which was working well for him.

The Acting Trust Chair thanked the Team for presenting such a powerful story and thanked them for their tenacity in continuing to provide care to the patient in such challenging circumstances.

She invited questions from Board members.

The Executive Director of Operations asked whether a nursing home was the right environment for the patient to remain long term. The nursing home had a specialist mental health unit attached to it and this was where the patient lived. He had the freedom to move in and out as he wished and this was working well at the moment.

Non-Executive Director (AC) asked how representative of the Neighbourhood Teams workload this type of case was.

Over the last two years more cases of younger people with drug dependency problems formed part of the regular caseload. Providing care for this type of patient was demanding and stretched capacity within the Team.

The Board discussed the importance of the holistic approach to the care of this patient and how valuable the collaboration with third sector partners was in this sort of situation. The Board also recognised the challenges associated with the care of such complex patients who often lived in poor conditions and displayed aggressive and violent behaviours which could put staff at risk.

The Board thanked the Team for their commitment in caring for such patients and welcomed the positive outcome to this story.

Item 2026-27 (30): Interim Chief Executive's Report

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

Our services and our people

Service Visits:
The Interim Chief Executive spoke about her recent visit to the Wharfedale Recovery Hub and a subsequent 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 - an excellent example of how enhanced care would be delivered as a result of the merger of the organisations.

AGM for the Race Equality Network:
The Interim Chief Executive and other Board colleagues had attended the Network's AGM. To strengthen the approaches to Equality Diversity and Inclusion all Executive Directors would agree an equality objective.

Alignment with Leeds and York Partnership NHS Foundation Trust:
At the Transition Committee in July, the outcomes from the engagement to determine the name for the new organisation had been considered. Following as vote supported by a comprehensive communications campaign the Transition Committee had agreed to adopt the name Leeds Partnership NHS Foundation Trust.

System Update
The report contained updates on a number of developments across the Leeds health and care organisations and wider regional collaboration which were noted.

Lord Mann Review
Following the publication of the Lord Mann Review every NHS organisation was expected to adopt the government definition of anti-Muslim hostility, and the Board was therefore asked to approve Leeds Community Healthcare's sign up to the definition contained in the Interim Chief Executive's report. The Interim Chief Executive said that the Trust had carefully considered the legal implications before proposing that the Board approve the definition.

Outcome: the Board

- approved the definition of anti-Muslim hostility set out following the Lord Mann Review

Outcome: The Board

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

Item 2026-27 (31): Quality Strategy

The Interim Executive Director of Nursing and Allied Health Professionals provided an update on progress against the 2024–2027 Quality Strategy. It was noted that the strategy had initially been agreed in late 2024 and formally confirmed in May 2025, meaning the organisation was currently at the end of year one and transitioning into year two.

The Strategy set out the Trust priorities against the three key tenets of quality – Safety, Effectiveness and Experience, and aimed 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. She drew attention to the slide presentation which was included in the Blue Box for this meeting which set out the detail of the Implementation Plan 2024-27.

The Board noted that the actions within the strategy would continue to be developed over the next year as the Trust moved through transition. Work was already underway to understand differences and similarities in quality management and improvement across the two Trusts and an external consultancy company had been commissioned to support this work. To provide assurance to the Board, reports would continue to be made to the Quality Committee.

Non-Executive Director (LM) asked if the Trust had been able to identify any productivity or efficiency savings as a result of the implementation of the strategy.

The Executive Medical Director said that a benefits realisation exercise had not yet taken place and the data quality had not been quantified.

Outcome: the Board

- noted progress of the Quality Strategy.

Item 2026-27 (32): People Strategy and Headlines Update

The Associate Director of People Solutions presented the paper which provided the Board with an update on progress against the Trust's Strategic People Framework, as well as sighting the Board on key aspects of the national NHS people agenda. It covered four key areas of people activity; Leadership and Management, Transforming our People Services, Staff Experience and Transforming our Organisation.

The Board noted that the work done on improving the skills of managers in relation to reasonable adjustments had been well received, and engagement with the Trust's Disability Neurodiversity and Long Term Conditions Network had significantly improved processes.

Non-Executive Director (KR) commented that implementing the strategy was a significant piece of work for the Trust and careful planning to determine high and low priorities would be required together with a pragmatic use of resources.

Non-Executive Director (LM) commended the work done to improve the quality of data which had ensured that the People and Culture Committee received comprehensive reports containing rich data. She added that the significant focus on staff sickness had resulted in a positive trajectory of improvement.

Outcome: the Board

- noted the people headlines presented in the report.

Item taken out of agenda order.

Item 2026-27 (33): Business Committee Chair's Assurance Reports

Associate Non-Executive Director (LM) presented two reports. The following points were highlighted:

16 June 2026

- Finance Redesign – the Committee had welcomed the presentation from the Finance Team and asked the People and Culture Committee to consider whether the coaching and learning methodology approach which had been used throughout the re- design programme should be shared across the organisation as an exemplar to be used in other transition programmes.

21 July 2026

- Quality and Value Update - the Committee discussed the continued risk regarding the balance between Quality and Value and integration benefits, with assurance sought on deduplication and ensuring benefits realisation including the risk to recurrent benefits. The Committee received some assurance that the corporate review and the due diligence output would provide a more comprehensive view in September 2026 as the Integration Full Business Case was built.

- As part of a discussion on the Digital, Data and Technology Strategy the Committee discussed workforce capacity across the organisation and asked for a review of the risk scores and mitigations associated with digital resilience and people capacity on the corporate risk register.
- Estates and Facilities Performance Management Quarter 1 Report - the committee noted the concerns raised by staff at several LIFT (leased) sites about the lack of adequate ventilation and absence of cooling systems during the heatwave. Some portable air-con units had been purchased but more were required. The Committee had also asked for more assurance on fire safety compliance across the Trust and water safety testing following an incident at Burmantofts Health Centre.

In relation to Quality and Value the Executive Director of Finance and Resources provided assurance that there were processes in place to reduce the risk of double counting. The challenge was to convert non-recurrent savings into recurrent savings without losing the spirit of the Quality and Value Programme.

In relation to water testing, she was able to confirm that a recent retest of the water supply at Burmantofts Health Centre had resulted in a negative result. A stronger digital plan had been put in place which would strengthen the water testing process, the Infection Prevention and Control Team were closely involved and updates would be made to the Business Committee as part of routine health and safety reports.

Significant investment had been made to install air conditioning in estate owned by the Trust and efforts were being made to influence the landlords of LIFT buildings. A number of portable units had been purchased but there was a shortage in supply and these had to be deployed in the most effective way.

The Board noted that concerns around various aspects of health and safety were becoming a common theme which was reported into various committees.

The Interim Chief Executive suggested that the risk scores for environmental risks on the corporate risk register were reviewed by the Risk Review Group.

Action: The scores of environmental risks on the corporate risk register to be reviewed by the Risk Review Group.

Responsible Officer: Interim Chief Executive Officer.

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

- noted the Business Committee Chair's Assurance Reports.

Item 2026-27 (34): Audit Committee Chair's Assurance Report 14 July 2026

Non-Executive Director (KR) presented the report. He highlighted the following points:

- Alert to the Board: 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 and the risks this posed to the Trust. An action plan and trajectory was being developed to achieve full compliance and processes and policies were to be reviewed and strengthened. An update on progress would be provided to the Chair of the Committee at the end of August 2026.
- The Committee discussed a number of changes to the internal audit plan which were either agreed or deferred for further discussion.
- 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.

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

- noted the Audit Committee Chair's Assurance Report.

Item 2026-27 (35): Charitable Funds Chair's Assurance Report

The Acting Trust Chair presented the report on behalf of Non-Executive Director (AL). She highlighted the alert to the Board related to the tightening financial projections, the need to support the Charitable Funds Officer in identifying opportunities through the merger and increasing staff engagement to ensure that the committee was not exposed to risks in the future.

Outcome: the Board

- noted the Charitable Funds Committee Chair's Assurance Report.

Items returned to agenda order.

Item 2026-27 (34): Quality Committee Chair's Assurance Report 14 July 2026

a) Assurance Report 14 July 2026

Non-Executive Director (IL) presented the report from the meeting on 14 July 2026 on behalf of Non-Executive Director (AL). The following discussion points were highlighted:

- There were no alerts to the Board.
- Service spotlight – Sexual Health Service: the Committee received an update on a syphilis outbreak among street-based sex workers. The team had developed a flexible, outreach-based model for delivering treatment. Plans were outlined for ongoing monitoring, surveillance, and potential research collaborations to assess the project's impact.
- Safeguarding Strategy Update – the Committee noted that most actions had been completed. Work was ongoing on self-neglect and changes in responsibilities for looked after children.
- Adult Business Unit bed mobilisation: the Committee received an update on the mobilisation of the new recovery hubs and Wharfedale beds, focusing on partnership arrangements with Leeds City Council.
- Leeds SEND Inspection Report 2026 – the Committee had discussed the outcomes of the recent SEND inspection, which identified systemic failures in supporting families and leadership challenges. An action plan was being developed to address inspection findings which would be presented to the next Committee meeting in September 2026.
- Incident Management and Investigation oversight update – the Committee noted only partial assurance. Weekly oversight meetings and action plans had been implemented to address delays in incident investigations. Concerns were raised that incident reviews were too focused on process rather than extracting meaningful learning and there was a need for a cultural shift towards proactive organisational learning.

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

Outcome: the Board

- noted the Quality Committee Chair's Assurance Report.

b) Incident Management and Investigation Oversight Update

The Interim Executive Director of Nursing and AHPs presented the report which provided an update on the previously identified incident management delays and investigation backlogs. Its purpose was to reaffirm the Trust's position of assurance and set out progress to date.

The Interim Executive Director of Nursing and AHPs outlined the ongoing and revised strategic requirements needed to address the systemic issues in order to achieve sustainable improvement. She informed the Board that performance had improved over the past four weeks, demonstrating the positive impact from interventions implemented since the previous report. Systemic causes of delay were now better understood, enabling a more targeted and informed approach to improvement. There was a greater emphasis on process controls, structural reform and oversight was strengthening governance and reducing reliance on training and bespoke support alone. Continued monitoring and assurance activity would be in place to monitor continuing improvement and move the Trust from a limited assurance position to a reasonable assurance position.

Outcome: the Board

- Noted the findings of the update report.

- Noted the limited assurance position based on the current update and reliance on operational capacity within services.

Item 2026-27 (35): 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.

The Board welcomed the excellent progress made so far to reduce waiting times.

Non-Executive Director (KR) noted the significant backlog in the Musculoskeletal Service (MSK) and asked what was being done to try and improve the situation.

The Executive Director of Operations informed the Board that the MSK service was undergoing substantive recruitment and was also scoping the potential for additional administrative resource to cope with the current backlog and options for use of nonrecurrent underspend. The current recruitment was not likely to improve the waiting list and position until Quarter 3.

Non-Executive Director (LM) reported that the Business Committee had noted that the MSK service was reintroducing resources taken out by the Quality and Value Programme and also requested that both the digital and operational 'asks' of the service were reviewed.

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

Outcome: the Board:

- received and noted the IPR report.

Item 2026-27 (36): National Oversight Framework

a) Segmentation Update

The Executive Director of Finance and Resources presented the report which provided an overview of changes in the NOF framework for 2026/27. She pointed out that organisations would no longer be benchmarked to determine their overall segmentation, and a number of new measures across the domains had been added.

Outcome: the Board:

- received and noted the report.

b) Sickness Absence Update

The Board received 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.

Outcome: the Board:

- received and noted the report.

Item 2026-27 (37): 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 10 June 2026, highlighting the following key areas of discussion:

- Alert to the Board: Sustainability Annual Report – the Committee noted the challenges due to the lack of a dedicated sustainability lead in the Trust and asked for confirmation of a recruitment timeline for the Sustainability role with LYPFT.
- A member of staff had shared his personal and professional journey from Zimbabwe to clinical leadership in the NHS. The 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.

- The Committee discussed the outcome from the Staff Survey Board Workshop. Further data analysis and follow-up actions noted that despite high appraisal completion rates, a significant proportion of staff felt appraisals did not help them improve in their roles.

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

Outcome: the Board

- noted the People and Culture Committee Chair's Assurance Report.

Item 2026-27 (38): Significant Risks and Risk Assurance Report

The Interim Chief Executive Officer presented the update report which provided the Board with an overview of the Trust's material risks currently scoring 15 and above (extreme risks). It summarised all risk movement, the risk profile, themes and risk activity since the last risk register report was received by the Board (May 2026).

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 (39): Board Assurance Framework (BAF) 2026-27

The Interim Chief Executive presented the report which summarised the process undertaken to review the BAF in readiness for the 2026/27 financial year and shared the draft Strategic Risks and suggested risk appetite with the Board for review and approval.

Outcome: the Board

- Noted the process for review of the strategic risks, gaps in controls and sources of assurance for 2026/27.
- Approved the Strategic Risks for 2026/27.
- Approved the risk appetite for all 2026/27 strategic risks.

Item 2026-27 (24): Any Other Business, Questions On Blue Box Items, And Close

No matters of any other business were raised.

Items in the Blue Box were noted.

No questions were raised.

The Acting Trust Chair closed the meeting at 12noon

Date and time of next meeting

Thursday 17 September 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: 17 September 2026

Key		Key colour code
Total actions on action log	1	
Actions on log **completed** since last Board meeting on 23 July 2026 with a **proposal to close**		
Actions due for completion by 17 September 2026 – for update at the meeting	1	
Actions not due for completion before 17 September 2026		
Actions outstanding at 17 September 2026**: not having met agreed timescales and/or requirements**		

23 July 2026				
Agenda Item Number	**Action Agreed**	**Lead**	**Timescale/ Deadline**	**Status**
2026-27 (33)	**Business Committee Chair's Assurance Report 21 July 2026:** The Board noted that concerns around various aspects of health and safety were becoming a common theme which was reported into various committees. The risk scores for environmental risks on the corporate risk register to be reviewed by the Risk Review Group.	Interim Chief Executive Officer	Next Risk Review Group meeting	**Update on 17 September 2026**

ACTIONS CLOSED AT MEETING ON 23 JULY 2026				
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 Action closed**
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 Action closed**
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 Action closed**
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 Action closed**
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*		**Update on 23 July 2026 Action closed**

		advise when appropriate to report into Committee		

Agenda item:	2026-27 (5)
Title of report:	Interim Chief Executive's Report
Meeting:	Trust Board Meeting Held in Public
Date:	17 September 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	
	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 • Progress on the creation of Leeds Partnership NHS Foundation Trust • System Update

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

Link to strategic goals: (Please tick any applicable)

Work with communities to deliver personalised care	✓
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	x	Why not/what future plans are there to include this information?	

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

List of Appendices:	No appendices

1. EXECUTIVE SUMMARY

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

2. OUR SERVICES AND OUR PEOPLE

National Inclusion Week

2.1 As National Inclusion Week takes place during the week of this Board meeting, the Trust is reaffirming its commitment to creating an inclusive culture where all colleagues feel valued, respected and able to contribute fully. Inclusion remains central to our Trust Strategy, supporting colleague wellbeing, equality of opportunity and the delivery of high-quality care. The Trust continues to focus on inclusive leadership and improving workforce experience, recognising the positive impact of inclusion on both organisational performance and patient outcomes and activities across the week have highlighted their importance.

National Oversight Framework

2.2 The results for **Quarter 1 2026/27** have now been finalised and are expected to be published shortly. We have been informed we are in segment **3 and** this remains unchanged since Quarter 4 2025/26 and where we predicted we would be.

2.3 Our average metric score is **2.52** (lower the score the higher performing in range between 1 and 4) and our ranking in the national league table for non-acute NHS providers is **43/58** compared to Quarter 4 2025/26 ranking position 45/61 representing an improvement in position.

2.4 At the time of writing, we are still awaiting the detailed scoring. Once received we will review to identify those areas to prioritise for action and improvement.

Farewell to West Yorkshire Police Custody

2.5 Later this month we will be formally handing over the police custody services for West Yorkshire to Mitie. This follows the Trust decision not to retender for the service. I wanted to note formally in the public board our thanks to all the staff who will move across and those who will remain and have been pivotal to leading the service and ensuring a safe transition over the past few months. We wish the new provider well as they mobilise the new service offer.

3. PROGRESS ON THE CREATION OF LEEDS PARTNERSHIP NHS FOUNDATION TRUST

3.1 Significant activity has taken place over the last 6 weeks with highlights including:

- Submission of our checkpoint report to NHSE on the 4th of September.
- Formal endorsement from NHSE for the new Trust name post-merger.

- Conclusion of the phase one 'Best of Both' staff engagement events to inform our culture diagnostic.
- Workshops planned to begin phase two to develop our values and behaviours framework for the new trust.
- Recruitment to the new Trust board got underway starting with the new Trust Chair Helen Thomson.
- Letters to all local MPS to update on our plans and request an opportunity to meet in person.
- Working ongoing developing a new Trust Strategy
- Work ongoing and on track on full business case, patient benefit cases, and post transaction implementation plan.

4. SYSTEM UPDATE

National Update

4.1 Since the last board meeting there has been significant change in political leadership and personnel. We now have a new secretary of state for health and social care – Yvette Cooper. We have had an initial CEO meeting with the SoS in which she shared her observations of the progress and challenges in health and social care. She also talked about areas of personal focus which centred on the importance of national standards delivered locally, working in partnership and with citizens and communities. Key service areas of interest include maternity service improvements and children and young people's mental health.

4.2 On the 10th of September we are expecting a ministerial visit to the Reginald centre in Leeds from Minister Diana Johnson. She holds the portfolio for public health and patient safety which includes community healthcare, general practice, children's health and neighbourhood health. The brief is to visit a neighbourhood health facility and meet with a range of staff. More information can be shared at the public board meeting.

West Yorkshire ICB Updates

4.3

- Permanent CEO appointed, Jonathan Webb who was the ICB Chief Finance Officer
- New structure came into effect on 1st September however still ongoing management of change and vacancies in key positions such as place based Director of Integration for Leeds and for Bradford. Now out to external recruitment and interviews scheduled for 5th October.
- Locala CEO Karen Jackson has stood down – interim arrangements are in place pending permanent recruitment**.**

Leeds Place Updates

4.4

- Timescales for delegation of commissioning functions from the ICB to place based partnerships has now been revised to April 2028 reflecting the significant work involved.

- Tim Ryley has now taken up post as our Director of Leeds Provider Partnership working for the partners in the city to support us develop our arrangements to take on delegated functions from the ICB. Tim will work closely with the Director of Integration once they have been appointed.
- Caroline Baria – Director for Adult Services in Leeds City Council has announced she is retiring. Recruitment will get underway this month for a replacement.

5. Recommendation:

The Board is recommended to:

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

Agenda item:	2026-27 (6)

Title of report:	Health Equity Update

Meeting:	Trust Board Meeting Held in Public
Date:	17 September 2026

Presented by:	Ruth Burnett, Medical Director					
Prepared by:	Anna Ray, Public Health Consultant and Em Campbell, Health Equity Lead					
Purpose:	Assurance	✓	Discussion		Approval	

Executive Summary:	Our Health Equity strategy and plans enable us to address unfair and avoidable differences in the health of different groups and communities, by creating equitable care and pathways. This paper provides an update on the first year of delivery of the trust's 5-year tactical plan for equity and compliance with core equity requirements. It includes early analysis of the potential equity benefits and risks in the Trust Integration Programme.

Previously considered by:	None

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?	Progress is being made on reducing average length of wait and missed appointments for target populations.
	No			

Recommendation(s)	• Note progress on delivery of the equity plan • Advise on the most appropriate opportunity to increase board members competence and confidence in interpreting and using the Health Equity Index. • Seek assurance that equity is embedded in all relevant Trust Integration Programme workstreams

List of Appendices:	Appendix 1: year 1 tactical plan update

Health Equity update

1 Introduction

Our Health Equity strategy and plans are LCH's response to how we address unfair and avoidable differences in the health of different groups and communities, by working with communities and partners to create equitable care and pathways. This paper provides an update on the first year of delivery of the trust's 5-year tactical plan for equity and compliance with core equity requirements. It includes early analysis of the potential equity benefits and risks in the Trust Integration Programme.

2 Operationalising the 5-year tactical plan for health equity

The 5-year tactical delivery plan for health equity (approved November 2025) continues the strategic framework of three 'building blocks': creating the conditions for change; supporting action and; reducing inequity in access, experience and outcomes. Each of these has three core priorities. To move from strategic intent to operationalising those priorities, each year has been broken down into clear milestones, quantified targets and detailed implementation actions (Appendix 1).

This work also supports compliance with our statutory and contractual requirements, as well as national guidance relating to health inequalities. These are highlighted in the paper where applicable to the delivery updates.

3 2026/7 delivery update

This paper highlights key successes and risks relating to delivery of the 2026/7 equity plan. The full update is provided at appendix 1.

Partnership working underpins all this work, from membership of key equity-focussed system leadership groups such Healthcare Inequalities Oversight Group, Person Centred Care Expert Advisory Group, How Does It Feel For Me and Migrant Health Board to system-wide practical improvement work, including EQIAs and the Equality Delivery System.

3.1 Creating the conditions for change

3.1.1 To **strengthen governance and accountability for health equity**, alongside senior leaders we have reviewed completion of the equity question on the current committee cover paper and will implement the following new wording from October 2026:

What does this paper tell us about equity and inclusion for patient care and/or workforce? Please include demographic analysis of any data provided or state why this is not available.	Patient care:	Workforce:

This will support improved consideration of equity in papers, delivery of the intention plan from the staff survey to ensure EDI is considered in all board decision-making and demonstrate compliance with our Public Sector Equality Duty to consciously and rigorously give due regard to eliminating discrimination and inequalities.

To further strengthen compliance with this requirement, guidance on completion for paper authors will be included in calls for papers. Annual effectiveness reviews for committees and board will also include a summary of completion of the equity question in their papers, providing assurance of consideration of equity and inclusion and demonstration of 'due regard'.

3.1.2 Our objective to **expand the capacity and capability of the organisation to take action on health equity** supports delivery of the 'improving quality' domain in the new NHS Leadership and Management Framework. At board-level, leaders and managers are expected to "make a strategic commitment to building a culture of accountability focused on equity, efficiency and consistently high-quality personalised support and care". This commitment is clearly demonstrated in LCH Board through the explicit consideration of equity by Committee Chairs in papers and decision-making. In June, the Board equity workshop also included the NHS Leadership Overview training from the national Veterans Covenant Healthcare Alliance, highlighting the needs of the Armed Forces community as one of our target populations at risk of worse health outcomes.

The Fairer Healthier Leeds programme provides equity training and support for staff across the health and care partnership. LCH Equity team have been involved in the planning, design and delivery of the programme which is led by the Leeds Health and Care Academy. LCH staff members have been actively engaged with modules for leaders and managers, public-facing staff and an introductory video (see table below). We continue to work with the academy to refine resources, expand their reach, evaluate impact and plan for ongoing sustainable delivery of the most successful aspects of the programme.

The Fairer Healthier Leeds training for leaders and managers is strongly recommended by the Healthcare Inequalities Oversight Group for authors of EQIAs and people involved in reviewing them. Engagement with this training, along with continued citywide improvement work on EQIAs, may help to align EQIA processes across LCH and LYPFT ahead of integration. This training programme could also support integration workstream leads to understand how to maximise opportunity for health equity and mitigate risks within their workstreams.

Health Literacy Awareness is delivered by Leeds Libraries for Health colleagues and supports increased understanding of the scale of literacy and numeracy issues among the population as well as the impact this can have on access, experience and outcomes in healthcare.

	Completed	**Booked**
Fairer, Healthier Leeds (Mar-Jul 2026)		
Introductory video	41	23
Public facing staff	16	18
Leaders and Managers	6	20

National Armed Forces Healthcare Training and Education Programme (Dec-Jun 2026)		
Introductory video	215	
Leadership overview	10	
Health literacy awareness (Apr-Aug 2026)	36	
Oliver McGowan		
Tier 1 non clinical staff	375	
Tier 2 clinical staff	1016	
Recognising deterioration in people with LD (Feb – Jun 2026)	61	

3.2 Supporting action

3.2.1 Strengthen health equity data from collection to use in decision making

Improving data collection and recording of key demographic details form part of our response to the Ethnicity Data Improvement Framework, Racial Equity in Care (PCREF), Accessible Information Standards, Reasonable Adjustment Digital Flag and the Armed Forces Covenant. Last year's Annual Statement on Information on Health Inequalities also introduced a new domain, focussed on improving data quality, collection and analysis.

Across open referrals, we have now achieved **97% of ethnicity data with valid ethnicity codes**, significantly above the national benchmark (71.6%) for community trusts and an improvement from 94% in 2025/6. Work continues to improve ethnicity recording, especially in the lowest performing services.

The roll-out of the **About Me** digital questionnaire is also expected to support data improvements in demographics, communication and other reasonable adjustments while people are on waiting lists. The implementation of the digital questionnaire forms phase 2 of the About Me project, where we have brought together all demographic and equity recording requirements into one SystmOne visualisation. Launched in January 2026, About Me makes it easier to identify when an aspect has not been completed, prompt annual reviews, share across services, report on progress and use data for analysis in other reports.

The digital questionnaire has been developed to enable patients and carers who are digitally able to provide this information themselves. The questionnaire is designed to:

- improve accuracy of recording as it is self-reported, aligning to best practice
- provide information at an earlier stage of the patient journey so that care can be adapted as required during waiting times and data quality of waiting lists is improved
- reduce admin and clinical time for completion, freeing up time to focus on those who need support to provide this information

The About Me dashboard has also now been launched on PIP, supporting trustwide and service-level monitoring of completion. The pilot of the digital questionnaire is running from June to September 2026 with 0-19, CUCS, Children's SLT and cardiac services. The business case for future actions is being considered in September and will inform the next steps of roll-out.

Trust Integration and the use of different EPR systems poses a risk to:

- continuation and embedding of About Me
- our ability to realise the benefits to data quality and patients About Me can bring
- a likely reduction in ethnicity recording rate achieved at LCH.

We have opportunity to mitigate these risks through early identification of the importance of demographic and reasonable adjustments requirements in the procurement of a shared EPR. Sharing the learning from the implementation of the About Me project in LCH provides an opportunity to roll out About me to a broader patient population, better meeting the 'share' principle embedded in Accessible Information Standards and Reasonable Adjustments.

3.2.2 Use of data

Through our engagement in the Leeds Healthcare Inequalities Oversight Group, LCH have been involved in developing the Health Equity Index to strengthen our ability to respond to inequity in our services. The index provides a single quantitative summary measure that allows us to monitor progress on equity over time related to one or many performance indicators. It helps us answer the questions "are we making progress on equity? How can we be assured we're not worsening inequity?".

Equity reporting in the BAF will use the Health Equity Index from November and will, for the first time, include analysis of equity related to ethnicity as well as deprivation. From November, the Index will also begin to be incorporated into the Integrated Performance Report, with the ambition in time to have the index reported across all performance indicators. While the Health Equity Index will make it easier to analyse and understand where inequities exist and track progress, there is a need to provide support for staff to understand how to interpret the index to provide actionable insights. This includes the need to strengthen board members capability and confidence in its interpretation and use. The index is not a stand-alone solution and will require the exploration of our other more granular data collections to inform action. To support staff in the use of the index, a one-page guide and video are being developed.

Recommendation: Advise on the most appropriate opportunity to increase board members competence and confidence in interpreting and using the Health Equity Index. This could be through a short development session or materials (video/slides) circulated.

To mitigate risks relating to equity data in integration, we have been working in partnership with LYPFT on this from the beginning to create a single way we report on equity across Leeds (through HIOG). There will be significant opportunity to advance this work across a wider patient group if we continue our commitment to integrate the index into standard performance reporting.

3.3 Reducing inequity in access, experience and outcomes

This year we have two core equity improvement measures, focussed on waiting times and missed appointments.

3.3.1 **The difference in waiting times has been reduced for all target groups and the difference has narrowed for people in deprivation and racialised communities**

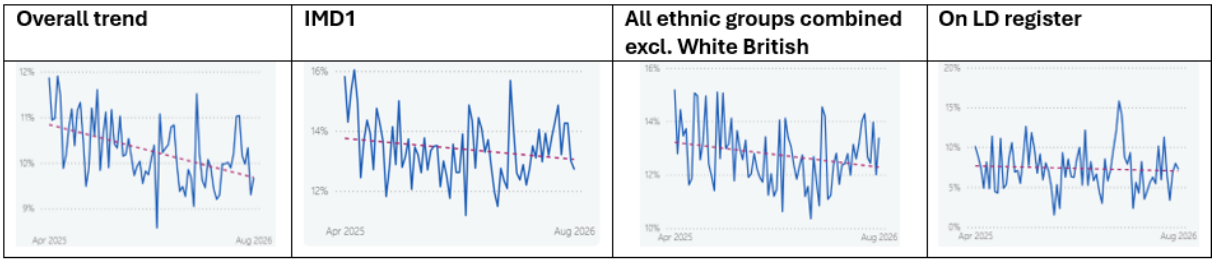
	Overall (comparison group)	IMD1	All ethnic groups combined excluding White British	Learning Disability
Average length of wait, Jan 2026 (in weeks)	19.6	22.5	21.1	16.9
Inequality gap in average length of wait Jan 2026 (in weeks)	-	+ 2.9	+ 1.5	- 2.7
Average length of wait, Aug 2026 (in weeks)	13.4	14.3	13.7	12.9
Change in average length of wait Jan-Aug 2026	↓ 6.2 weeks	↓ 8.2 weeks	↓ 7.4 weeks	↓ 4 weeks
Inequality gap in average length of wait Aug 2026 (in weeks)	-	+ 0.9	+ 0.3	- 0.5

Not only have interventions reduced waiting times, they have also reduced inequity in waiting times. The difference in average length of wait has narrowed by 2 weeks for people in deprived areas and 1.2 weeks for racialised communities. This reduction in inequity has only occurred because of specific consideration of groups facing disadvantage and ongoing monitoring. Through Access LCH meetings, services with the longest waits are regularly reviewing waiting lists data by ethnicity and IMD. All services have access to self-service reporting on the PIP responsiveness dashboard which can be filtered by deprivation, ethnicity, LD and interpreter requirement and also enables consideration of intersectionality across different characteristics. Learning must be harnessed to act as a blueprint for further service improvement work.

Integration provides us with an opportunity to expand this work and share learning across wider number of services.

3.3.2 **Missed appointments are reducing overall but the rate for some target populations remains higher**

Missed appointments by people in IMD1 have reduced by 0.6% YTD, with a further 1.4% reduction required across the rest of 2026/7 to meet our annual target. The trend in overall missed appointment rates has reduced, but slower progress from an already higher rate in IMD1 and racialised communities indicates that the difference may be widening.



Further service-level analysis is underway to identify drivers of this difference and identify any particular trends and learning relating to missing a first appointment (and therefore impacting on length of wait) or missing follow-up appointments. The Access

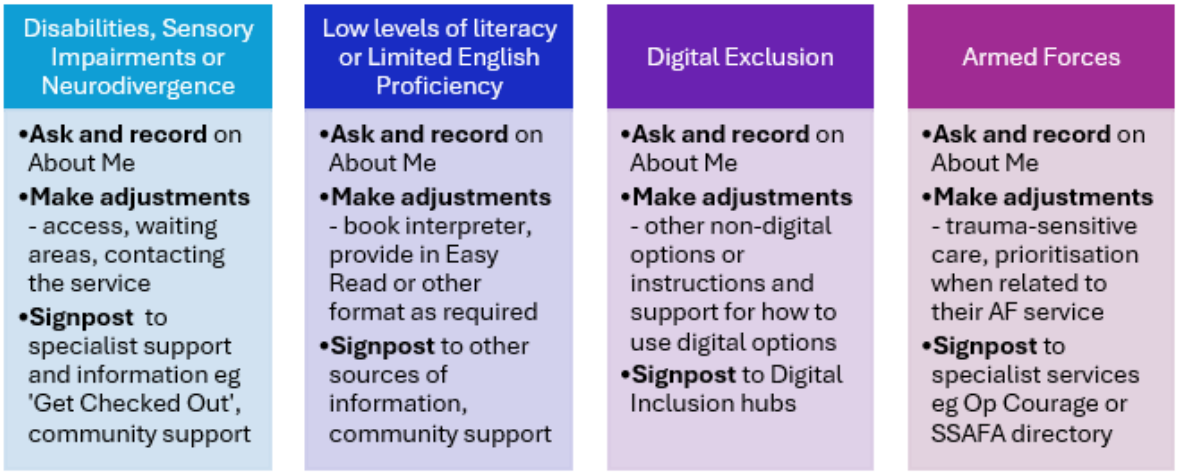
LCH group is continuing oversight of this and strengthening delivery of the identified improvement actions identified.

3.3.3 We are also working to **tackle known inequities faced by specific population groups.** This includes people living in deprivation, racialised communities, people with disabilities, sensory impairments and who are neurodivergent and the Armed Forces community. We recognise the intersectionality between these groups and are working to address some common barriers to care: communication; digital exclusion and health literacy.

We have a three-part approach to support improvements, strengthening our compliance with Accessible Information Standards and Reasonable Adjustments Digital Flag and aligned to NHS England » Improvement framework: community language translation and interpreting services:

Ask and record	About Me template brings all this together in one place, shared across services so the person does not need to keep giving the same information about their needs.
Adjustments to care	Work with the person to do what is reasonable to meet those needs. Think creatively about different options.
Signpost or refer	Signpost to other sources of specialist or community support.

Examples of this in practice:



4 Trust Integration Programme

Equity is not a given. Merging of LCH and LYPFT offers opportunities for advancing equity but also risks of worsening inequity.

There are many opportunities, examples include:

1) Sharing good practice and exploring opportunities to 'fast forward' progress by applying good practice across a larger patient population
2) Work more closely together between physical and mental health services to tackle the significant inequalities those with serious mental illness and learning disability experience in their health outcomes.

3) The equity teams have already been working closely, especially because of the shared consultant in Public Health capacity. This has led to the two existing organisations having shared a broadly similar vision, commitment and strategic direction on health equity.
4) Opportunity to reflect on successes, bring together a variety of expertise, reimagine team and re-prioritise resource for maximal outcomes for the communities we serve.

There are also significant risks.

1) The complexity and challenge of integration may mean workstreams and services across LCH and LYPFT neglect to consider equity sufficiently within their transition plans. Work on equity may be lost, and some decisions may worsen inequity.
2) During the transition period, where temporary service disruption may occur and disproportionately impact particular groups or communities
3) Possible centralisation or service efficiencies may disproportionately impact some communities (whether geographic or based on deprivation).
4) Where specific improvement work at LCH is not mirrored at LYPFT (i.e. around EQIAs, waiting times, reasonable adjustments, data) we risk these not progressing, not being embedded, progress stalling or reverting to previous practice.

To reduce these risks we are:

1) Engaging with the Trust Integration Programme workstream leads, Transition Board and Exec to Exec Team discussions to develop assurance processes that equity considerations are embedded in integration.
2) Working closely with LYPFT colleagues to review equity strategies and work programmes, to capture the best of both and support delivery of the equity strategic priority in the new organisation.

Recommendation: Board are asked to seek assurance that equity is embedded in all relevant Trust Integration Programme workstreams

5 Impact

- **Quality**

Poor quality care for people already at risk of worse health outcomes exacerbates those differences. Conversely, improving the overall quality of care can contribute to improved health outcomes. By taking an equitable approach to quality improvements, we support targeted approaches that narrow this gap and ensure that improvements that are perceived to be universal do not widen the gap.

- **Resources**

Delivery of our equity ambitions plan will not only have a positive impact on those groups at risk of poorer health outcomes, it will also contribute to overall productivity gains for example in reducing missed appointments and improving access to self-management.

- **Risk and assurance**

BAF risk 7 describes the risk of failure to prevent harm and reduce inequalities experienced by our patients. If the trust fails to address the inequalities built into its own systems and processes, there is a risk that we are inadvertently causing harm,

delivering unfair care and exacerbating inequalities in health outcomes within some cohorts of patients.

The Trust Integration Programme can support equity-related risk and assurance in two ways:

- assurance that the integration itself is not adversely impacting on target populations already at risk of worse health outcomes
- the new integrated trust has a shared understanding of strategic equity risks, and has governance in place to be assured that inequity in its care and pathways is being addressed

6 Next steps

- Engage with the Trust Integration Programme structures to define the strategic equity ambition for the new organisation and develop assurance processes that equity considerations are embedded in integration
- Amend committee paper cover sheet and circulate with guidance on completion
- Support attendance by leaders and managers involved in Integration workstreams, and authors and reviewers of EQIAs on the Fairer Healthier Leeds training
- Continue delivery of communications campaign to increase awareness of and engagement with agreed health equity improvement priorities
- Plan for the integration of LCH and LYPFT equity teams and workstreams, looking strategically at how we maximise opportunities for advancing health equity.

7 Recommendations

Board is recommended to:

- note progress on delivery of the equity plan
- advise on the most appropriate opportunity to increase board members competence and confidence in interpreting and using the Health Equity Index.
- seek assurance that equity is embedded in all relevant Trust Integration Programme workstreams

Anna Ray and Em Campbell
Public Health Consultant and Health Equity Lead

9 September 2026Appendix 1: Health Equity 5-year tactical plan
Year 1 2026-7
Update August 2026

A. Creating the conditions for change

ID	Aim: by 2031	2026-7 objective	Update	Next steps (Q3-4)
Strengthening governance and accountability for health equity				
A1	Reporting on equity is a shared responsibility across all Committees	Analysis of use of equity data by committees Launch of refreshed cover report template to reinforce the inclusion of equity data	Wording of new cover template equity and inclusion question has been considered by SLT and is recommended for adoption by Board: "**What does this paper tell us about equity and inclusion for patient care and/or workforce?** Please include demographic analysis of any data provided or state if this is not available."	• Adoption (pending Board recommendation) • Monitoring of completion and reporting to Committee chairs

ID	Aim: by 2031	2026-7 objective	Update	Next steps (Q3-4)
A2	A thriving Health Equity Leadership Group is fully engaged, has improved coordination, and is delivering change through a clear organisational direction and shared ownership of a clear plan.	Representation from all BUs and key departments at 75% core meetings. Agreed alignment with People Directorate priorities.	Rather than a separate Health Equity Leadership Group, SLT now has equity as a standing agenda item. This is expected to improve engagement, upskill leaders across portfolios (aligned to the new NHS Leadership Framework) and embed equity in decision-making. The subgroups continue to take forwards specific elements of the equity agenda: Racial Equity; Armed Forces; About Me; Health Equity Index.	• Alignment with People Directorate priorities through analysis of equity and inclusion national standards, including implementation of the Mann Report. • Trust Integration Programme identification of shared priorities and continued delivery methods of equity and inclusion across patient care and workforce.
Embed Health Equity within LCH Strategies and Plans				
A3	Equity is embedded in organisational strategy and contributing to the delivery of the NHS 10-year plan	Launch of 5 year Medium Term plan which will have 'equity' as an underpinning thread	This action has been superseded by the creation of Leeds Partnership NHS Trust.	*To align with Trust Integration Programme workstreams*
A4	Action to identify and address inequity is embedded within annual planning cycles and contributes to overall achievement of a share equity ambition	Launch of annual operational plan Development of guidance on 'strategic plans' that will replace existing thematic strategies	This action has been superseded by the creation of Leeds Partnership NHS Trust.	*To align with Trust Integration Programme workstreams*
A5	Equity is embedded within PSIRP, driving safety improvements across safety priorities	Involvement of the patient safety partners in the falls improvement group.	Launch of the new Patient Safety equity dashboard in PowerBI supports improved analysis of equity analysis of incidents including falls, medication and pressure ulcers.	

<table>
<tr><th>ID</th><th>Aim: by 2031</th><th>2026-7 objective</th><th>Update</th><th>Next steps (Q3-4)</th></tr>
<tr><td>A6</td><td>Person-centred care has senior oversight, is integral to service delivery and improvement and is being measured</td><td>Baseline of AIS and reasonable adjustments.
Interpreting and translation managed on new contract</td><td>• Transfer to new interpreting and translation provider in Feb 2026
• About Me launched Jan 2026, digital questionnaire pilot Q2 for roll-out Q3 which will provide baseline for AIS and reasonable adjustment requirements
• 3Cs (communication, compassion, co-ordination) included in Clinical Conference presentation</td><td>• Roll-out of About Me digital questionnaire (pending business case approval) Q3
• National implementation of Reasonable Adjustment digital flag delayed (timescale tbc)</td></tr>
<tr><td colspan="5">Expand the capacity and capability of the organisation to take action on health equity</td></tr>
<tr><td>A7</td><td>Equity is part of training and development programmes including clinical education and leadership development</td><td>Access to modules via LEAD programme
Access to learning bursts on equity via LHCA</td><td>• Delivery of Health Literacy Awareness Sessions ongoing
<table><tr><td colspan="2">National Armed Forces Healthcare Training and Education Programme (Dec-Jun 2026)</td></tr><tr><td>Introductory video</td><td>215</td></tr><tr><td>Leadership overview</td><td>10</td></tr><tr><td>Health literacy awareness (Apr-Aug 2026)</td><td>36</td></tr><tr><td>Oliver McGowan</td><td></td></tr><tr><td>Tier 1 non clinical staff</td><td>375</td></tr><tr><td>Tier 2 clinical staff</td><td>1016</td></tr><tr><td>Recognising deterioration in people with LD (Feb – Jun 2026)</td><td>61</td></tr></table></td><td>• Ongoing engagement in steering group and faculty meetings, supporting session delivery as required.
• Identification of delivery and funding requirements for year 2.</td></tr>
<tr><td>A8</td><td>Ongoing delivery of One Workforce equity development programme</td><td>Implementation of LHCA One Workforce: Health equity education programme

Services are engaged in the pilot delivery</td><td>Welcome to the Fairer, Healthier Leeds information hub - Leeds Health and Care Academy has been launched. Evaluation of the pilots is underway and CPD accreditation being sought.
<table><tr><th></th><th>Completed</th><th>Booked</th></tr><tr><td>Fairer, Healthier Leeds (Mar-Jul 2026)</td><td></td><td></td></tr><tr><td>Introductory video</td><td>41</td><td>23</td></tr><tr><td>Public facing staff</td><td>16</td><td>18</td></tr><tr><td>Leaders and Managers</td><td>6</td><td>20</td></tr></table></td><td>• Ongoing participation in levels 1-3.
• Engagement in level 4 pilot service improvement module.
• EQIA authors and reviewers to attend Level 3 for leaders and managers.
• Support engagement with integration workstream leads</td></tr>
<tr><td>A9</td><td>Capacity to deliver equity has grown across the organisation through staff with dedicated inclusion and equity focus, supported by a specialist function</td><td>• Increase capacity and learning within services through student projects / assignments
• Build staff and student awareness
• Baseline Assessment of SBU understanding and compliance
• Staff Learning and development
• Share best practise and learning at BU and Trust level</td><td>• Dedicated time for equity improvement work now built into CYPMHS, LMWS, MSK and LeMuRS.
• Learning around equity in waiting lists and missed appointments shared through Access LCH meetings.
• Inclusion of equity in preceptorship
• Increase in knowledge and skills through Making Stuff Better, service - specific engagement, fellowships</td><td>• Continued delivery of Fairer Healthier Leeds training
• Information in Induction booklet</td></tr>
</table>

ID	Aim: by 2031	2026-7 objective	Update	Next steps (Q3-4)
A10	All services are engaged with the Cultural Conversations programme and can demonstrate culturally sensitive approaches to care delivery	Baseline of existing engagement and impact. Quarterly delivery of training for leaders.	• Development of conversation prompt resources for staff areas • Survey of Cultural Conversations participants has been undertaken and is now being analysed to establish baseline and learning for further roll-out.	• Work with partners to define scope and best practice across range of support for culturally appropriate care (eg cultural humility, anti-racism, reciprocal mentoring) • Roll-out of Cultural Conversations, based on learning from survey

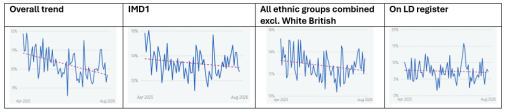
B. Supporting action

ID	Objective: by 2031	Year 1	Update	Next steps
Strengthen health equity data from collection to use in decision making				
B1	Improved data quality and streamlined data collection around key health equity variables through the "About Me" template	Data quality processes including reporting , monitoring and improvement plans relevant to "About Me" roll out in place	• Ethnicity recording at 97% (up from 94% in 2025/6) and guidance on residual codes shared • About Me complete records at 4% total caseload. 50% response rate to pilot of digital questionnaire with new referrals. • Business case developed to roll-out digital questionnaire to existing caseload.	• Roll-out of About Me digital questionnaire (pending business case approval) Q3 • Monitoring reduction in use of residual ethnicity codes
B2	Equity measures are included in IPR and regularly reported into committees and board	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.	• IPR includes waiting time measure by deprivation. • Access LCH analysis includes waiting times and missed appointments by deprivation, ethnicity and LD	Ethnicity and missed appointment measures to be included in IPR from November 2026
B3	Equity Index is in use as a way to track our progress on key performance indicators	Operational reporting of the Health Equity Index for waiting times by ethnicity, IMD, LD, armed forces and people with a disability available in standard waiting list reporting	Work ongoing with the system-wide Health Equity Index Development Group	• Health Equity Index to be used in IPR from November 2026 for ethnicity and deprivation. • Improved data quality through About Me will enable other lenses to be added

ID	Objective: by 2031	Year 1	Update	Next steps
B4	Access, experience and outcomes measured and able to be analysed for equity, with improvements routinely identified and delivered	Aligned to development of Equity Index for access and experience measures, goal based outcomes (GBO) to be implemented and reported on.	Self-service PIP dashboards, including the new patient safety incident dashboard, can be filtered by equity lenses and available at service, Business Unit levels and trustwide levels.	• Analysis of waiting times and missed appointments at service level to identify support for greater levels of inequity • Launch of GBO dashboard including equity lenses
B5	Key members of the workforce have the capability to interpret relevant health equity reports and data	Videos to support the use of existing equity reporting in place for use by all staff. Ad hoc support with use of data available	• Support delivered by BI to use PIP dashboards and bespoke reports such as Access LCH reporting	Publication of 1 page guide and video on use of Health Equity Index
Voice and influence				
B6	We have strengthened the process of gathering and acting on patient, community and staff insights, particularly in relation to racialised and other marginalised communities.	Continued engagement with 3rd sector, actions from Healthwatch engagement paper, continue to gather broad spectrum patient feedback and service specific bespoke engagement work.	• Attendance at FRESH (Forum for Race Equality in Social Care and Health) • How Does It Feel For Me resources relating to people at risk of worse health outcomes, shared to bring lived experience into meetings. • Ongoing engagement with Migrant Health Board, Forum Central, Healthwatch and community organisations	• System-wide improvement work to increase the engagement used in EQIAs • Integration work with LYPFT PCREF partnership group for racial equity
B7	Engagement / feedback datasets are analysed by demographics with improvements identified and made	FFT analysed by demographics	Patient Involvement Team capacity delayed in completing this work due to supporting gaps in other Clinical Governance work. Postholder now back working in Patient Involvement Team and vacancies recruited to.	FFT development work re-starting in Q3, including consistency in gathering demographic data and analysis by deprivation and ethnicity of both FFT response numbers and FFT reporting good or very good experience.

ID	Objective: by 2031	Year 1	Update	Next steps
Embed equity at the heart of decision-making processes				
B8	Consideration of equity impacts is embedded at the earliest stage of designing service change, leading to an effective, robust formal EQIA process. Cumulative impact is measured and addressed and assurance processes in place.	Review and relaunch of Change and Improvement methodology, which will include learning from QV about considering equity from the start and throughout a change	*This year's action has been superseded by the Trust Integration Programme.*	*To align with Trust Integration Programme workstreams*
B9	Equity is embedded at the heart of decision-making processes including finance, procurement and business development.	Equity to be a standard outcome metric in all change reporting Build into Business case training which is currently being developed. Initially rollout to BCIS.	*This year's action has been superseded by the Trust Integration Programme.*	*To align with Trust Integration Programme workstreams*
B10	Development of an equity in waiting list tool is applied more broadly across LCH	A tool to manage equity for the people waiting for LCH care is developed and implemented.	HEARTT project was closed prematurely prior to the planned implementation in April. Following detailed review, it was determined that the product treatment codes used within the HEARTT solution did not align or meet the requirements for community trusts. As a result, the solution was deemed unfit for purpose and unable to support the Trust's operational requirements and objectives.	Engage with supplier, University Hospitals Coventry and Warwickshire (UHCW) to discuss options for recovering the licensing costs incurred. BI team continues to support the Access LCH group by providing regular reporting on equity of waits, including comparisons of waiting time experience between patients living IMD1 vs in IMD2–10

C. Reducing Inequity in access, experience and outcomes

<table>
<tr><th>ID</th><th>Objective: by 2031</th><th>Year 1</th><th>Update</th><th>Next steps</th></tr>
<tr><td colspan="5">Working with services to reduce inequalities in access through reducing missed appointments and waiting lists</td></tr>
<tr><td>C1</td><td>The average length of wait is the same for patients in IMD-1, those with learning disability and racialised communities as for others and all reducing overall</td><td>Continued progress on IMD1 waiting times. Baseline for ethnicity established and improvement plans in place for equal length of wait.
Data Analysis: Audit current waiting times
Community Engagement: Consult with affected groups to understand barriers
Staff Training
Pilot Projects: Launch small-scale interventions</td><td>Reduction in average length of wait for all target groups, and the difference in average length of wait for people in deprivation and racialised communities.<table><tr><th></th><th>Overall (comparison group)</th><th>IMD1</th><th>All ethnic groups combined excluding White British</th><th>Learning Disability</th></tr><tr><td>Average length of wait, Jan 2026 (in weeks)</td><td>19.6</td><td>22.5</td><td>21.1</td><td>16.9</td></tr><tr><td>Inequality gap in average length of wait Jan 2026 (in weeks)</td><td>-</td><td>+ 2.9</td><td>+ 1.5</td><td>- 2.7</td></tr><tr><td>Average length of wait, Aug 2026 (in weeks)</td><td>13.4</td><td>14.3</td><td>13.7</td><td>12.9</td></tr><tr><td>Change in average length of wait Jan-Aug 2026</td><td>↓ 6.2 weeks</td><td>↓ 8.2 weeks</td><td>↓ 7.4 weeks</td><td>↓ 4 weeks</td></tr><tr><td>Inequality gap in average length of wait Aug 2026 (in weeks)</td><td>-</td><td>+ 0.9</td><td>+ 0.3</td><td>- 0.5</td></tr></table></td><td>Ongoing delivery of improvement actions to reduce waiting times and improve attendance at appointments</td></tr>
<tr><td>C2</td><td>The missed appointment rate is the same for patients in IMD1, those with learning disability and racialised communities as for others and all reducing overall</td><td>2% reduction in IMD1 missed appointments (11.2%-9.2%)
Data Audit: Analyse missed appointment rates by IMD quintile, learning disability status, and ethnicity.
Barrier Identification: Engage with affected communities to understand reasons for DNAs
Staff Training
Pilot Reminder Systems</td><td>0.6% reduction YTD in missed appointments by people in IMD1.
The trend in overall missed appointment rates has reduced, but with slower progress from an already higher rate in IMD1 and racialised communities.  </td><td>Increase staff and patient awareness of reasonable adjustments that can be put in place to support attendance.
Improve access to translated appointment letters and supporting information</td></tr>
<tr><td colspan="5">Tackle known inequities faced by specific population groups</td></tr>
</table>

ID	Objective: by 2031	Year 1	Update	Next steps
C3	Continuous improvement approach embedded to Accessible Information Standards, Reasonable Adjustments and health literacy	Identified leadership and understanding our baseline: AIS, RADF, health literacy self-assessments and identification of priorities Actions as per C2	Roll-out of About Me supports earlier identification of people with: • communication needs and other reasonable adjustments • literacy and numeracy support needs • risk of digital exclusion • Increased range of resources in Plain English, Easy Read and available through Information Hub accessibility tools	• Delivery of Reasonable Adjustment Digital Flag compliance (pending confirmation of timescales from NHSE) • Digital letters programme implementation that supports provision of accessible information
C4	Delivering improvement programmes in relation to racial equity in care	Interpreting and translation identified leadership and understanding our baseline Anti-racism / allyship	• Racial Equity in Care group meeting alternate months, chaired by Director of Nursing. • Priority improvement actions underway to deliver data that supports racial equity, access to interpreting and translation and the provision of culturally appropriate care	• Increase use of digital interpreting options to increase access to rarer languages • Increase availability • Scope and test inbound interpreting
C5	Meeting the LD Standards	Meeting LD standards: RA and Oliver McGowan training	82% compliance with Oliver McGowan training. Programme of work around reasonable adjustments, aligned to roll-out of About Me being delivered. Each LD death being reviewed as part of mortality processes.	Presentation of LD deaths in racialised communities being presented to Racial Equity in Care Group. Ongoing focus on Reasonable Adjustments.
C6	Trauma-sensitive approaches in place	Identification of existing practice	Equity fellowship completed on reasonable adjustments to support attendance at appointments	LMWS engagement work with Angels of Freedom on trauma-sensitive care
C7	Data enables identification of inequity for wider range of groups/communities	Reporting on waiting times for people with a disability or learning disability, by ethnicity, armed forces status and IMD available	• Monthly Access LCH waiting list reporting by deprivation • Additional analysis undertaken 6-monthly by ethnicity and LD	• Transfer of waiting times data by deprivation and ethnicity to Health Equity Index from November 2026 • Improve data quality of disability and Armed Forces status through roll-out of About Me

ID	Objective: by 2031	Year 1	Update	Next steps
C8	Each Business Unit has a measurable plan and targets to address inequity in their area of work	Baseline audit: Assess current compliance with AIS across services & identify gaps Review staff training requirements Review patient feedback assessment tools and co-design with patients to be able to identify gaps in service provision. Trial Reasonable Adjustments in targeted services	Core improvement measures all have dashboards in place available at service and business-unit level: • Waiting times • Missed appointments • Completion of About Me Waiting times and missed appointments improvement plans overseen through About Me and Productivity groups.	Agree reporting route for completion of About Me to track progress
Exploring prevention as a route to tackle inequity				
C9	We understand existing practice in services around hypertension and smoking and deliver improvement work	On hold for Year 1 due to lack of PH resource and capacity		
C10	Learning from prevention approaches is expanded to engage effectively in other priority prevention programmes	On hold for Year 1 due to lack of PH resource and capacity		

Leeds Community Healthcare NHS Trust

Agenda item:	2026-27 (7)
Title of report:	Winter Plan 2026-27
Meeting:	Trust Board Meeting Held In Public
Date:	17 September 2026

Presented by:	Sam Prince, Executive Director of Operations
Prepared by:	Nicola Day, Operations Business Manager Samantha Steede, Head of Business

Purpose of the report:		
This report provides the Board with the LCH 2026 winter plan. The plan aligns directly to a series of assurance statements which require Board approval prior to being submitted to NHS England at the end of September. Further information on system pressures will be added following further regional planning exercises taking place in September.	Approval	x
	Discussion	
	Assurance	

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

Summary of Key Issues:

- This report contains the Trust's Winter Plan, covering prevention, occupancy and discharge, capacity, flow, IPC, leadership and operational grip.
- The LCH Board is required to sign a series of Assurance Statements for NHS England on the Trust's Winter Planning arrangements.
- The deadline for Submission to NHS England is the end of September.
- Further planning from the system and wider data on predictions on winter flu trends will be added in prior to submission to NHS England.
- The final section (7.3) includes the overarching assurance statements which also require sign off from the Board.
- A separate EQIA was taken to the panel in August.

Previously considered by:	Winter Planning Working Group EQIA Panel – August
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?	A separate EQIA has been submitted as part of this planning.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	Review the assurance statements provided throughout this plan and approve for submission to NHS England.

List of Appendices:	Appendix 1 – Data Samples Appendix 2 – Communications Plan

Leeds Community Healthcare NHS Trust Winter Plan 2026/2027

Contents

Introduction

Winter places significant and sustained pressure on health and care services across the system. This Winter Plan outlines how Leeds Community Healthcare NHS Trust (LCH) will prepare for and respond to these challenges to maintain safe, high-quality, and resilient services for the people of Leeds. This plan aligns with and directly feeds into the system level ICB plan. Winter pressures in the context of this plan include an increase in referrals/service demand due to increased system flow, a general increase in respiratory infections, adverse weather events and increased staff unavailability/absence.

LCH works closely with system partners on winter planning and will be supported by and fed into a regionally led exercise on 6th July at Merrion House. An EQIA has also been produced which went to panel on 27th August 2026 and was passed. The next regional exercise is planned for 14th September.

This year's plan has been structured around the required NHS England assurance statements and has been numbered and organised accordingly. At the end of each section the relevant statement is included for ease of reviewing. Additional information for Board Assurance that does not align directly with these statements is provided from Section 7 onwards. The final section (7.3) includes the overarching assurance statements which also require sign off from the Board.

Some key points for awareness this year:

- Planning this year is taking place at a time of major change within the Trust including the Leadership Review Project, Trust Integration Programme, Admin Review Project and several other service changes.
- New NOF Metrics on Agency and Bank usage are now in place. A paper on balancing these competing pressures is going to People and Culture Committee for discussion in October.
- Uncertainty on Fast Track End of Life patients following major changes in ICB arrangements. This has been escalated to both the ICB and ASL.
- System pressures as covered within the wider Leeds plan.
- New Community Beds Service still embedding.
- Ongoing waiting list work.
- The Trust is also currently bidding to receive an 80-100% share of £575k to increase staffing levels in response to respond to Type 1 and 2 falls to reduce ambulance conveyance and admission (TBC)
- Potential for additional ACM capacity within Transfer of Care (TBC)

Services in Scope

Each service area that experiences increased demand during winter or is directly affected by system flow has contributed to this plan. Contributions are based on expected seasonal pressures, learning from previous years, and current forecasts for the upcoming winter period. The following services have been included:

ABU	Neighbourhood Teams inc. Neighbourhood Nights Neighbourhood Clinics Home Ward Frailty/ Response Transfer of Care Services (Community Discharge Assessment Team, Bed Bureau, TOC) Health Case Management Community Therapy Service (Patient Flow Services, Active Recovery) Wharfedale/Community Care Beds
CBU	Children and Young People's Mental Health Crisis Service (CYMPHS) Children's CIVAS
SBU	Home Ward Respiratory Community Stroke Rehabilitation Team Community Intravenous Administration Service (CIVAS) Homeless and Health Inclusion Team
OPS	Administration Services

Prevention

1.1 Frontline Vaccination Campaign

Plans are in place for the Winter Flu Staff Vaccination Programme in line with Criterion 10 of the Health and Social Care Act Code of Practice (2008, updated 2022). During winter 2025/2026, 53% of frontline staff received their flu vaccination. For 2026/2027, the target is 60%, as outlined in the National Flu Immunisation Programme Letter from NHS England.

Flu vaccinations have been ordered via Moorhouse Medicines Management at LTHT and are scheduled for delivery in late August to Chapeltown Health Centre, with a proposed campaign start date of 1st October 2026. Depending on vaccine availability from the manufacturer, the IPC team will be offering to vaccinate opportunistically at large team events from mid-September.

Vaccinating will begin in 1st week of October. We have regular bank staff who deliver most bookable appointments at different locations/times across the city and their welcome day is on 01/09/26 where we will ensure that staff receive the correct training and supervision to prepare them for this. LCH IPC nurses are also joining staff events such as celebration days, team meetings, networks to vaccinate opportunistically and take vaccines to fit testing sessions and training.

IPC are working with business intelligence to refresh the internal booking and recording system (Cassandra) and ensure that flags are correctly applied to ESR. All staff are trained and have log ins for RAVS. Staff will be invited to book vaccination

appointments via the Cassandra internal booking system, where campaign data will be recorded and monitored in real time. IPC will receive weekly uptake reports from business intelligence throughout the campaign to support communications and enable a more targeted offer.

IPC are currently developing the comms plan for the campaign, through tailored messaging, inclusive communication strategies, and targeted engagement activities, the campaign seeks to engage hearts and minds across the LCH workforce. This is by ensuring that messaging is accessible, supportive, and resonates with all staff groups, ultimately supporting higher vaccine uptake across the Trust. The campaign will be supported by regular messaging from the Head of IPC and Trust Leadership Team. A dedicated vaccination web page has been updated on LCH Oak and contains information about the vaccine, how to book appointments and answers to FAQs.

In the last week of November, the IPC team will conduct a 'Jabathon' focused on a final push towards vaccinating in areas of lower uptake; this is in recognition that December is a month where many decline the vaccine due to the run up to Christmas holidays and related social events.

Engagement with the Executive Team will encourage leadership support and visibility. A combination of existing campaign materials and videos will be reused, supplemented by new resources where possible. Consideration as to how we can link communications in line with the staff survey will be considered.

Consideration is also being given to the use of incentives to encourage uptake; however, evidence suggests these are most effective when combined with clear communication and strong leadership endorsement.

Finally, system-wide collaboration continues, with benchmarking of innovative ideas and best practice across partner organisations. A collaborative system meeting will monitor progress, share insights, and review uptake figures across the region.

1.2 Staff Health Measures

Updates will be provided through governance route for IPCC via Quality committee to the Board.

1.3 Inpatient Vaccinations

The GP Confederation in supporting LCH with plans for patients requiring a vaccination whilst an in-patient in one of our Short Terms Beds.

The above is in relation to the following statements:

1.1 The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: • the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; • that both walk-in and bookable appointments are available; • that all FHCW vaccination activity will be recorded

on Record a Vaccination Service (RAVS); and • the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.

1.2 The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.

1.3 The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.

Occupancy and Discharge

2.1 Bed Demand and Occupancy

As a System Partner we are fully involved in the city-wide planning arrangements for winter and will be maximising discharges pre-holiday periods to support flow and also maintaining flow throughout the holiday period, our services will be operating throughout the holiday period.

2.1.1 Discharge to Assessment (D2A) pathways

Element	Description	Capacity (Current/Planned)	Admission/Discharge Criteria	Integration with SPA/Community
D2A Pathway 1	Discharge home with support; reablement and Active Recovery services	Majority of discharges; capacity increased via HomeFirst.	Medically optimised patients needing short-term support at home	Coordinated through triage hubs; integrated with LCH and LCC services
D2A Pathway 2/3	Short-Term Community Beds and Residential/Nursing placements	Beds expanded for winter; surge capacity planned	Patients requiring further assessment or rehabilitation in a bedded setting. Commitment from jointly delivered active recovery service, to accept earlier step down from short term community beds, for	Managed via Care Transfer Hub and SPA; social care and health teams collaborate. Short term community beds are jointly delivered with LCC and GP

			ongoing rehabilitation.	Confed, all with a commitment to reducing no reason to reside length of stays

2.2 Discharge Pathways

We are fully engaged with system partners in supporting a 7 day a week discharge process to support flow out of acute beds and have escalation and governance arrangements in place to identify peaks in demand an activate agreed system action cards to manage pressures. We have weekly Active System Leadership Meetings during winter periods and report and escalate as required to the Active System Leadership Executive Group as required and ensure they are updated of trends, surges and escalations. Working closely with the operations directorate in LTHT to reduce the number of referrals that are received during consolidated periods in the week (e.g., Wednesday – Friday) to support flow. Daily LCH review, monitors and actions any delays related to P1and P2 and supports system partners in managing surge and escalation through the Transfer of Care Hub, working with system partners within the Leeds System. This year ABU is also carrying out an internal review of our Triage processes and efficiency to better support system flow and timely discharge.

The configuration of our EPR units enables us to have better sight of the demand and capacity and flow from the acute sector and BI colleagues continue to improve our internal system visibility dashboard to facilitate this.

IPC provides a 7-day service, enabling support to be offered to care settings experiencing outbreaks. Measures are implemented, where possible, to cohort patients'/service users rather than requiring full closure of establishments. This approach supports system flow and, where clinically safe, allows admissions to continue into care homes / adult social care establishments.

2.2.1 Coordination and Oversight

The operational elements set out in this plan are overseen through established Trust governance structures. During the winter period, the Trust will maintain regular oversight through its internal business unit structures, performance oversight groups, operational command arrangements and winter planning leads.

Issues and escalations identified through OPEL reporting, business continuity triggers, or via the on-call system will be reviewed and escalated as necessary through Operational (Bronze), Tactical (Silver) and Strategic (Gold) command structures, in line with the Trust's EPRR and Incident Response arrangements. We

have both an internal escalation process and external escalation process. EPRR manager ensuring that all on call managers are compliant with the strategical and tactical on call training.

2.2.2 Surge Planning

In the event of a surge, individual services will manage flow based on patient need, applying cohorting arrangements and established escalation processes. The table below outlines how key services in the plan will manage patient flow in the event of surge.

Service	Average Referrals	+10%	+20%	+30%	Impact and Mitigation
Neighbourhood Teams	634 (week)	697	670	824	Please note that since last year, referrals have been separated within S1 into Referral Management and Response Call Outs (unplanned referrals). Data quality continues to improve and is providing a more accurate picture of true demand. Average referrals per week (Referral Management and Response Call Outs combined): Current average: 1,750 10% increase: 1,925 20% increase: 2,100 30% increase: 2,275 The Triage Hub remains the main operational pressure point within the Neighbourhood Team model, responsible for the timely clinical assessment and prioritisation of referrals to support patient flow, discharge pathways and community-based care. Demand has increased significantly, with referrals rising by over 40% since 2023 and continuing to grow by approximately 10% annually. Workforce modelling completed in 2026 identified a minimum requirement of 32-33 WTE, compared to a funded establishment of 21.12 WTE, leaving a gap of approximately 11 WTE.

					Demand currently exceeds capacity by around 35%, and the service continues to operate under Business Continuity Plan (BCP) arrangements. Mitigating actions include daily operational oversight, escalation processes, flexible resource deployment, and close system working. A dedicated Standard Operating Procedure supports clinical decision making, escalation, safety-netting and risk management during periods of reduced capacity. Workforce planning has also established the minimum safe staffing level required to meet demand. In preparation for winter, recruitment opportunities are being explored alongside options to strengthen triage capacity. Work is also ongoing with Business Intelligence colleagues to improve demand, capacity and escalation reporting, as well as reviewing productivity, skill mix, administrative support and service improvement opportunities to increase resilience. Despite these actions, the current workforce remains significantly below the level required to meet existing demand, providing limited assurance that the service can safely absorb significant winter pressures without impacting timeliness, performance and patient experience. The workforce requirement identified represents the minimum needed to meet current demand and does not include future growth associated with the national Neighbourhood Health agenda. Work is underway to introduce separate Triage Hub OPEL reporting, as current reporting sits within wider Neighbourhood Team metrics and does not fully reflect triage pressures.

					Future reporting will also include patient safety intelligence, incidents and mortality review learning where delayed triage has been a contributory factor. Due to the sustained workforce deficit, rising demand and continued reliance on BCP measures, the Triage Hub remains on the Trust Risk Register. While mitigating actions and service improvements continue, recurrent workforce investment remains the key requirement to provide sustainable assurance that winter demand and future service growth can be managed safely and effectively.
Community Stroke Rehabilitation Team	70 (month)	77	84	91	Referrals have continued to increase over the last 12 months, with the service receiving an average of 78 referrals per month. This represents an increase of eight referrals per month, or approximately 10%, compared to the previous year. To manage periods of increased demand, the service continues to hold 15 appointment slots per week for urgent cases. During surge periods, additional slots can be created where required to accommodate urgent patients, with demand and capacity monitored on a weekly basis. While this flexibility helps ensure timely responses to urgent referrals, it can have an impact on waiting times within the professions from which these additional slots are drawn. The service is also implementing a new Transition to Home pathway, designed to support the timely discharge of patients from acute services and reduce delays in transferring care. This pathway is expected to help mitigate winter pressures, which are often associated with initiatives to increase acute bed

					capacity through accelerated patient discharge. Additional staff have been recruited to support the Transition to Home pathway and are expected to be in post within the next 6 to 8 weeks. Once fully trained, this additional resource will strengthen the team's ability to manage increasing demand and support patients to return home safely and promptly.
Home Ward Respiratory	60 (month)	66	72	78	HWR 'beds' are capped at 10. In exceptional circumstances this can be increased to 12 depending on staffing levels and acuity of patients. Risk – high sickness within the team. This would be mitigated with extra hours / overtime and BCP to maintain patient care on skeleton staffing.
CIVAS	73 (month)	80	87	95	Each admission triaged for need dependent on number of daily visits required. Zoledronic Acid patients to be temporarily 'paused' to allow for hospital discharges to be accommodated. Liaise with OPAT to discharge patients on / transfer patients to oral antibiotics if safe to do so to maximise capacity. Extra hours / overtime to be utilised for unplanned absence.

2.2.3 Administration Support

To support organisational resilience over the winter period, Administration Services is actively progressing a programme of cross-skilling and workforce development to increase flexibility across teams. Staff are being equipped with the skills and knowledge required to support priority services and organisational priorities, with work aligned to C1, C2 and C3 activities. This approach will enable resources to be deployed more effectively in response to fluctuating demand, service pressures and unforeseen operational challenges.

In addition, Administration Services is implementing a new operating structure based on three functional hubs. This model is designed to enhance resilience, improve workforce flexibility and ensure that priority work can continue to be delivered during

periods of increased winter demand. By bringing teams together within functional hubs, we will be better positioned to share resources, maintain service continuity, provide broader cover for essential activities and respond more effectively to changing organisational priorities.

Collectively, these initiatives will strengthen our ability to support frontline services, ensure critical administrative functions remain operational, and contribute to the delivery of the Trust's winter pressures and organisational objectives

2.2.3 Urgent Community Response (UCR)

UCR has been strengthened for 2026, with a centrally coordinated citywide triage and response model operating as a 24-hour service. Delivered through a multidisciplinary team approach, the service provides rapid assessment and intervention in community settings to help prevent avoidable hospital admissions and support system flow. Performance against the 2-hour response standard remains strong, with the service aiming to maintain an average achievement of 85%+ throughout winter. Workforce capacity is being maximised within available resources to meet anticipated demand, and close integration with triage hubs and SPUR supports coordinated assessment, prioritisation and deployment of urgent community care.

UCR rates in 2025/2026 saw the trust move from segment 2 to segment 1 for this performance metric of the National Oversight Framework.

2.3 Christmas Planning

Alongside system partners, LCH will support the implementation of pre-Christmas occupancy reduction plans by maximising and expediting discharges from acute settings and community bed-based services, ensuring patients are transferred to the most appropriate setting in a timely manner.

A full list of festive building and service opening hours will be circulated to On Call Managers in early December by the EPRR Manager.
Any specific arrangements will be shared with staff that have on-call responsibilities over the Christmas and New Year Holiday Period. Christmas on-call arrangements are now split between on call managers, with additional changeovers, to ensure that the responsibilities are shared fairly. The Trust’s arrangements will also be shared with the system through circulation of the WY Christmas and New Year Holiday Plan.

2.4 Same Day Emergency Care

Our Community Discharge and Assessment Team (CDAT) work alongside LTHT staff in A&E, SDEC and Admission wards to support people home at the earliest opportunity, where it is safe to do so. LCH staff are able to link in with Social Care, Short Term Beds provision and community teams to avoid admission where possible.

2.5 Frailty Pathways

Element	Description	Capacity	Managing Demand
Virtual Ward - Frailty	LCH Home Ward for frailty supports patients at home with MDT input The home ward (frailty) provides support and care for people who become acutely unwell, within agreed criteria but can be safely cared for in their own home (it also supports people return home from hospital sooner if safe to do so). Consultant led service including rapid access to diagnostics and treatments that can be safely delivered at home (intravenous antibiotics or diuretics). Support can include home visits and care overnight if necessary. A citywide partnership approach also helps people being cared for to access support from the third sector and therapy services where needed. Referrals via SPUR and community teams; aligned with HomeFirst	55 beds	Figures in Appendix 1 show the ward occupancy averaged over 70% during last winter peaking at 78.5% in January. A similar or higher demand is anticipated for this year. Daily MDT's and close monitoring of staffing and capacity on home ward We have been recognised by NHS England as this being one of the key services, which has seen a reduction in the admission of over 80s in the acute sector, with an overall reduction of 12.1%. Being a distinct outlier nationally.

The above is in relation to the following statements:

2.1 The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.

2.2 The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: • coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. • executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. • targeted operational actions to reduce long discharge delays. • Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.

2.3 The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.

2.4 The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.

2.5 The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.

Capacity

3.1 Workforce Resilience and Staffing Levels

Workforce resilience planning is underpinned by robust workforce and service planning arrangements designed to support safe service delivery throughout periods of increased demand, including winter pressures. Safe staffing levels are supported through effective temporary staffing arrangements, with an expanded internal Bank workforce and improved Bank fill rates helping to reduce reliance on agency staffing and strengthen workforce resilience.

Where required, the Trust has established arrangements with a range of approved framework providers to support clinical staffing requirements. The Trust's comparatively low reliance on agency staffing provides additional contingency capacity should demand increase significantly, whilst maintaining compliance with the principle that agency staffing is used only after all available internal workforce options have been exhausted.

Clear rostering guidelines and workforce planning processes are in place to enable services to plan capacity in advance, manage planned absences and maintain safe staffing levels. The Trust also has access to a Staff Mobility and Workforce Sharing Protocol across Leeds, providing additional flexibility to respond to urgent pressures and mutual aid requirements where necessary. Appropriate skill mix is maintained through established staffing models, professional oversight and workforce deployment arrangements.

Workforce resilience is further supported through a dedicated sickness and absence management improvement programme, with established governance arrangements focused on maximising workforce availability and attendance throughout periods of operational pressure. This is supported by comprehensive sickness and absence dashboards which have been developed this year. Staff health and wellbeing remain a key component of the Trust's resilience approach, with a comprehensive range of wellbeing support offers available and actively utilised by colleagues, helping to support workforce wellbeing, attendance and retention.

Whilst workforce-related risks cannot be wholly eliminated during periods of sustained demand, these risks are recognised, actively monitored and managed through the Trust's governance and risk management processes. Collectively, these controls and mitigations provide confidence that the Trust has the flexibility and resilience required to maintain safe, effective patient care and service continuity during periods of increased operational pressure.

On Call arrangements are covered in section 6.1

Staff wellbeing offers are covered in section 6.7

3.2 & 3.3 Assurance Statements Not Applicable for LCH

3.4 4-hour,12 hour and RTT trajectories

The 4- and 12-hour targets refer to the A&E targets and as these are acute targets we did not submit against these in the medium-term plan and there are no trajectories to impact these.

The winter plan will support the system to achieve these targets by providing resilience and the continued ability to respond to system pressures through winter. Our Children and Young People's Mental Health Crisis Service (CYMPHS) is required to respond to very urgent referrals for children and young people in crisis within 4 hours. The plan outlined successfully mitigates against missing this target due to pressures by ensuring effective pathways are available post-crisis intervention, carefully managing staffing and collaboration with LYPFT to access CYPMHS inpatient beds. Where referrals are for patients within LTHT beds or A&E this will facilitate their discharge and release pressure.

None of the services in scope for winter planning contribute to our RTT submission. This means that they are unlikely to experience increased demand during winter and are not directly affected by system flow. The trajectories submitted in the medium-term plan should therefore not be affected by winter pressures

3.5 Operational Action Plans and Prioritisation

Urgent community capacity will be prioritised through established triage, MDT and operational management arrangements. During periods of increased demand, referrals are prioritised according to clinical acuity, risk of deterioration, admission

avoidance requirements and discharge urgency. Daily demand and capacity reviews, business continuity plans and system escalation arrangements ensure available resource is focused on those with the greatest clinical need.

Service	Prioritisation Approach
Neighbourhood Teams	Central triage hubs prioritise referrals by urgency, with admission avoidance and discharge support patients prioritised during periods of pressure.
Home Wards	Daily MDT review of capacity, acuity and caseload to prioritise highest-risk patients.
Community Care Beds	Capacity coordinated through system flow processes, prioritising patients requiring discharge or rehabilitation support.
Health Case Management	Fast-track and end-of-life referrals prioritised according to clinical need.
Transfer of Care	Workforce focused on patients requiring urgent discharge support to maintain flow.
Therapy Services	Referrals prioritised according to clinical need, discharge requirements and risk of deterioration.
CYPMHS Crisis Services	Crisis assessments and urgent mental health presentations prioritised through roster and capacity management arrangements.
CIVAS / Home Ward Respiratory	Capacity prioritised for admission avoidance and discharge-supporting activity during periods of surge.

When demand exceeds available capacity, urgent community services prioritise patients according to clinical acuity, risk of deterioration, admission avoidance requirements and discharge urgency, ensuring available resource is directed to those with the greatest need.

The above is in relation to the following statements:

3.1 The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.

3.2 The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.
3.3 The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.

3.4 The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.

3.5 The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.

Flow

4.1 Emergency Department Crowding

Although LCH does not provide Emergency Department services, the Trust contributes to the wider system response through its role in admission avoidance, discharge support, community urgent care services and collaborative planning with system partners to reduce pressure on acute hospitals and support safe patient flow during periods of increased demand.

4.2 Ambulance Handover plans

Whilst LCH does not provide ambulance handover services, the Trust supports system-wide initiatives to improve patient flow, reduce ambulance delays and facilitate timely access to care through community services, admission avoidance and discharge support.

The Trust is also currently bidding to receive an 80-100% share of £575k to increase staffing levels in response to respond to Type 1 and 2 falls to reduce ambulance conveyance and admission.

4.3 Escalation arrangements with system partners

The IPC team provides support for care homes 7 days a week. This includes advice on the isolation and cohort of patients in an outbreak scenario to avoid closure of homes to aid patient flow. There is a year-round programme of education, training and auditing of care homes to support good IPC practice. This is bolstered through system partnership with Leeds city council cooperation agreement.

Leeds wide guidance to support colleagues coordinating discharge is being revised with partners to assist in the safe placement of residents with infection/colonisation, or who are being discharged from an area where there is active infection. The daily care home outbreak log is shared with system partners, and the IPC team will support gold meetings when there are concerns about system flow.

We are actively engaged and co-creating System Action Cards to support both flow and escalation routes to ensure that we are maximising opportunities to manage surge. We are supporting LCC SW Teams with LCH Assistant Case Management support that can be deployed to undertake some SW Delegated Duties in the Acute, Short-Term Beds and Community (referrals from NT) to avoid delays to service provision and discharge from services.

The above is in relation to the following statements:

4.1 The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.

4.2 The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.

4.3 The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.

4.4 The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.

IPC

5.1 Assurance Statement Not Applicable for LCH

5.2 IPC Engagement

As part of the Cooperation Partnership agreement with Leeds City Council there is a 7-day IPC provision in place across the IPC team supporting staff with ad-hoc queries and outbreak management and advice. For larger or more significant outbreaks Leeds partners work collaboratively to ensure whole system engagement. Management of high consequence infectious disease sleeping contract is in place between the ICB and LCH, this coincides with a roles and responsibilities matrix held by Leeds City Council for system response to specific infections / outbreaks. The governance route for escalation is via the IPCC to QC with AAA report, concerns/assurance can then be provided to the Board.

5.3 Fit Testing

To ensure the health, safety, and wellbeing of staff and to maintain full compliance with Infection Prevention and Control (IPC) standards, as stipulated in the *Health and Social Care Act: Code of Practice* (2008, updated 2022) and the Health and Safety Executive (HSE) INDG479 guidance, LCH operates a comprehensive fit testing programme for relevant clinical and frontline staff. This programme ensures that respiratory protective equipment (RPE) is both suitable and correctly fitted, thereby safeguarding staff during periods of heightened clinical risk.

The fit testing process is currently transitioning to a fully digital, in-house platform with date of roll out yet to be confirmed; the application and has been designed to streamline and strengthen governance around fit testing by incorporating:

- A mandatory risk assessment for all clinical and frontline staff to determine individual fit testing requirements.
- An integrated booking system enabling staff to schedule fit testing appointments directly.
- Delivery of quantitative fit testing undertaken in-house by appropriately trained personnel.
- automated daily data import from ESR, ensuring that staffing information — including starters and leavers — remains accurate and up to date.

In August 2026 a full-time fit test practitioner began in post and will complete most fit tests undertaken in the Trust. This will allow for more fit test appointments and offer flexibility to scale up fit testing in a scenario where there is a surge in requirement for respiratory protection such as large-scale outbreak or new and emerging pathogens. From October the number of fit test appointments offered will increase by 50% with capacity to offer more sessions where needed.

The Head of IPC has communicated with Senior Operational Leads to emphasis the responsibility of those in leadership positions in ensuring that teams can retain resilience when staff are exposed to pathogens which require respiratory protection. Since this time there has been improved uptake of available sessions across all business units and this continues to be monitored. Governance route as above per IPCC, via QC and Board. Monthly figures are shared with the Clinical Leads.

5.4 Control of infections and outbreak management

The Board receives the IPC Board Assurance Framework (BAF) on a 6 monthly basis which provides assurance on the outbreak plans in place. Any concerns or escalations are made via the AAA report from the IPCC (DIPC) to QC.

Identification, management, and containment of outbreaks procedures are fully aligned with national guidance, including the *UK Health Security Agency (UKHSA)* framework, and supported by the Infection Prevention and Control (IPC) team's expertise to minimise disruption, protect patients and staff, and ensure the continuity of safe, effective care.

In addition, LCH works in close partnership with Leeds City Council (LCC) and wider system partners through a formal Cooperation Agreement to ensure a coordinated, system-wide response to outbreaks. This collaborative approach enables:

- Real-time information sharing across system partners to facilitate rapid action.
- Joint decision-making regarding outbreak control measures and resource deployment.
- Consistent communication of public health messages and guidance.

- Integration of outbreak response plans across LCH, LCC, and other system stakeholders.

This coordinated system response strengthens resilience across health and care services, ensuring that outbreak management remains timely, effective, and aligned with both local and national requirements.

A specific outbreak management plan for LCH has been developed along with the Roles and Responsibilities matrix for the system response to outbreaks.

The above is in relation to the following statements:

5.1 The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.

5.2 The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.

5.3 The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.

5.4 The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, is in place that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.

Leadership and Operational Grip

6.1 On Call Arrangements

The Trust maintains a 24/7 senior manager on-call function throughout the year, ensuring timely leadership support for urgent operational issues and incident response. This consists of a first and second on-call manager operating on a weekly rota system. The first on-call manager is the initial point of contact for out of hours calls and responsible for managing operational queries and incidents as they arise. Where necessary, they will escalate to the second on-call manager for senior oversight, advice, reassurance, or the establishment of a formal command structure. The on-call manager can be contacted via the dedicated number: **0845 265 7599**.

The on-call arrangements are designed to provide an immediate out-of-hours response and ensure safe and effective service continuity until normal business hours resume. These arrangements form a key part of the Trust's EPRR infrastructure and ensure that operational decision-making and escalation can happen. In hours calls are directed to the second on-call manager.

6.2 Opel Framework

While currently under review and subject to future change, LCH continues to operate an internal Operational Pressures Escalation Levels (OPEL) framework, categorising service pressure from Level 1 to Level 4. Services can update their status daily, and this feeds into a daily cascade shared with relevant Trust leaders. LCH also contributes to the external system-wide OPEL reporting process to support the monitoring of wider system pressures.

6.2.1 Data Monitoring

To support system flow throughout the winter period, LCH will closely monitor key data indicators to track demand, capacity, and discharge activity across services. This will enable timely interventions, support effective resource allocation, and maintain patient flow across the wider health and care system.

A new System Visibility Dashboard (sample included in the appendix) has been launched within LCH that includes wider information to support system flow including Home Ward, Health Case Management and CAMHS data.

This year's NHS Oversight Framework has included monitoring of the 2-hour community urgent care response. LCH have been consistently and significantly above standard throughout the year.

A new Performance and Accountability Framework has been implemented. This provides improved visibility of key KPIs in the PIP Hub dashboard where KPIs that are changing or not meeting targets are automatically highlighted. Service managers use this dashboard to inform what requires comment and/or escalation via performance meetings. Further work will be undertaken to ensure a full set of relevant KPIs to support patient flow.

The key datasets which the Trust will monitor over Christmas include:

Indicator or Dataset	Monitoring Frequency	Used For	Responsible Lead/Team
System visibility dashboard - new release to include NT demand, response times, home ward	Weekly including at weekly Winter Group meeting.	Monitoring flow, capacity and demand in key services.	Built by Business Intelligence – individual services to respond to data

occupancy, NT case load size			
Leeds system visibility dashboard	Daily	System Flow	Gill Warner, Operational Head of Portfolio linking in for LCH
PIP Hub	Weekly update. Monitored monthly at a minimum	Monitoring key performance KPIs	Built by Business Intelligence – individual services to respond to data
Responsiveness - dashboard on contacts, waiting lists and referrals	Weekly report distributed. General dashboard available for services to do deep dive	Monitoring waiting lists across Trust,	Built by Business Intelligence – individual services to respond to data
Workforce absence rates	Monthly on PIP Well Led Dashboard and via specific sickness management dashboard developed this year. Daily on ESR for services when uploaded	Assess staffing resilience and trigger workforce plans as applicable	ESR data accessible by service managers. Well led dashboard built by Business Intelligence and People Directorate.
OPEL Report as per national definitions reported externally	Daily via email and on PIP	Real-time system status and escalation coordination. Covers Wharfedale Community Bed Occupancy, No longer meeting criteria to reside, UCR 2-hour	Sam Prince, Executive Director of Operations Gill Warner and Victoria Storton Operational Heads of Portfolio in ABU monitoring

		response, Virtual Ward occupancy.	
Internal OPEL levels (currently under review) via daily LCH Managing Escalations report.	Collects OPEL service from every service each day and circulated daily.	Monitoring real-time service pressures. Can be used to begin bronze/silver/gold command levels as necessary	Distributed by Business Intelligence, services update individually.
Health Equity Data – service level data available on PIP	Available on Power BI for services to access	Referrals, missed appointments, waiting times, broken down by IMD and ethnicity.	Individual services to engage with the data regularly and act accordingly.
Winter Vaccination rates (staff only) - Casandra	Weekly	Track uptake across LCH Staff	BI manage report. Liz Grogan, Head of Infection Prevention and Control leading for LCH.

6.3 Mutual Aid

Across the system there is a Staff Mobility and Workforce Sharing protocol available for use across Leeds, which could be particularly useful for urgent Mutual Aid situations. Clear rostering guidelines and protocols are in place, to enable services to plan-in-advance to ensure appropriate capacity is available, including the management of safe staffing levels and planned absences. There is also a WY Community and Mental Health Trust MOU in place to provide EPRR guidance\support should a partner organisation be without EPRR expertise due to sickness or annual leave.

Within LCH, locally aligned teams offer mutual aid such as across the Neighbourhood Teams and CCBs, which could be stepped up if required.

6.4 Business Continuity Plans

Business Continuity Plans (BCPs):
In the first instance, any service-level escalations will follow the service's internal BCPs. The Trust has a Business Continuity Management System in place which requires the completion of a Business Impact Analysis (BIA) and a Business Continuity Plan (BCP). These are reviewed and updated annually and all services contributing to this winter plan have confirmed that their BCPs have been updated to

ensure timely and effective escalation procedures are in place. The Trust annual BCP audit will take place in September 2026.

Emergency Preparedness, Resilience and Response (EPRR):
LCH has a suite of incident specific Emergency Preparedness, Resilience and Response (EPRR) plans including a New and Emerging Pandemic Plan. These should be used in conjunction with the Trust's on-call procedures and service-level BCPs to ensure a coordinated and robust response to emerging risks or incidents. As part of this suite LCH maintains a formal Incident Response Plan (previously the Major Incident Plan), which aligns with local, regional, and national emergency planning guidance and frameworks and is designed to be flexible and adaptable across a range of scenarios.

6.5 Adverse Weather Preparedness

The Trust Adverse Weather Plan is reviewed and updated annually and is part of a suite of incident specific Emergency Preparedness, Resilience and Response (EPRR) plans and policies developed to provide the framework by which LCH will respond to specific incidents\events.

Adverse weather is also a designated section within service level BCPs which have been reviewed this year in line with this plan. Below is a summary of the Trust's local adverse weather preparedness arrangements.

Area	Details or Mitigation Plan	Named Lead	Partner Agencies Involved
Local adverse weather plan in place	In place and reviewed annually as part of our Trust EPRR arrangements	LCH - Rebecca Todd, Emergency Planning Manager	Partner Trusts ICB WY Local Resilience Forum Informal arrangement with WY 4x4 Club (limited capacity - to try if possible)
Staff travel disruption	Whilst there isn't a trust plan, local arrangements included in service level BCPs under the headings of; severe weather, loss of staff and building denial HR policy	LCH - Rebecca Todd, Emergency Planning Manager	Generally managed on a local level. Partner Trusts ICB

	Fuel disruption plan		
Adverse Weather Preparedness – Service-Level Reviews	Ongoing work for the Winter Planning Group looking at reviewing options on snow socks, snowshoes and 4x4 tyres in services. Undertake a review with affected teams to confirm winter travel preparedness.	TBC – Findings to be collated and reviewed by the Winter Planning Group.	Internal piece of work
4X4 specific arrangements	Memorandum of understanding in place with WY 4x4 Club, however capacity is limited therefore not always available when required. Currently an area of potential **risk** for certain services. Public transport, localised\ grouped visits or taxis may need to be considered. Some options come with associated costs and potential delays. WY ICB have developed a list of criteria for 4x4 providers and are negotiating with the wider voluntary sector to source additional capacity through the WY and NY Local Resilience Forums. Voluntary Action Leeds are also being contacted to see if they can support. Remains a high risk for certain services.	LCH – Rebecca Todd, Emergency Planning Manager	MOU with WY 4x4 Club

Communication with Partner organisations	In place through system partnerships	Active System Leadership – LCH Rep LCH local working arrangements	Active system leadership through Silver Group\ICB lead Exec System Leadership – Sam Prince, Executive Director of Operations
Coordination with Voluntary sector	In place through system partnerships	City Silver\ICB	Arrangements in place through Active System Leadership\ ICB LCH has relationship with VCSE through Board membership.

6.6 Industrial Action Contingencies

Any Trust Industrial action response is led by the Medical Director or the Emergency Accountable Officer (AEO) with support from the EPRR Manager. The Trust adopts the battle rhythm as laid out by NHSE and the ICB locally. Depending on the nature of the action an IA group will be established which will include Comms, EPRR, People Services\ESR, general managers and additional subject matter experts as required. WY level meetings are attended by the Medical Director or EPRR and returns (KLOE\Sitrep) are submitted to the ICB as per established timelines. As required the Medical Director or the AEO will liaise with On-call colleagues regarding any returns or meetings which fall out of hours or over weekends\bank holidays.

6.7 Staff Wellbeing

LCH recognises the ongoing pressures staff face over winter, and remains committed to supporting their physical, mental, and emotional wellbeing. A range of health and wellbeing offers are in place to help staff stay well, feel supported, and sustain high-quality care during this challenging period.

Support Initiative	Description	Access Method
Health and Wellbeing Intranet Pages	A range of support including links to financial, mental and physical wellbeing	Available on My LCH
Mental Health First Aiders and Health	A point of contact for an employee who is experiencing a mental	Full list available on My LCH

and Wellbeing Champions	health issue or emotional distress. They are not trained to be therapists or psychiatrists but can offer initial support and provide guidance on support available.	
Occupational Health	Occupational Health Services provided by South West Yorkshire Partnership Foundation Trust (SWYPFT)	https://swy.cohort.hosting/Cohort10/logon.aspx
Employee Assistance Programme (EAP)	A range of support and guidance is available from Health Assured for our staff, including self-help guides, top tips and counselling sessions (6 sessions free).	https://healthassuredeap.co.uk/ Username: Leeds Password: NHS - Phone Service: 0800 030 5182
Staff Wellbeing Clinical Psychologist	A clinical psychologist whose role in LCH is focused on supporting the psychological wellbeing of the people who work in the Trust.	Jen Gardner can be contacted on: Jennifer.Gardner11@nhs.net
Freedom To Speak Guardian at LCH	An independent and impartial service. offering a confidential and supportive space to explore what is happening and what you might like to say about this to the organisation. Concerns can be raised locally or to Chief Executive and/or board level, concerns can be in a person's name or non-identifiable.	John Walsh can be contacted on: john.walsh@nhs.net - 07949102354

The above is in relation to the following statements:

6.1 The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.

6.2 The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.

6.3 The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.

6.4 The Board is assured that business continuity plans have been reviewed and tested where appropriate.

6.5 The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.

6.6 The Board is assured that industrial action contingencies have been reviewed where relevant.

6.7 The Board is assured that plans are in place to support staff welfare through periods of high demand.

Further Assurance and Conclusion

Section 7 of the BAS assurance document relates to Mental Health Hospitals and has therefore not been included in the paper.

7.1 Evaluation plan

LCH will monitor the effectiveness of the Winter Plan through weekly 30-minute huddles with each of the three business units, providing a structured forum to identify emerging pressures, escalations, and support needs in real time. Insights from these huddles will feed into active system leadership and enable responsive decision-making. At the end of the winter period, a debrief workshop will be held with representation from across the Trust to review what worked well, identify areas for improvement, and inform future seasonal planning. This will be held in late April to allow information to be fed into the wider system evaluation workshops in May.

7.2 Communication and Engagement Plan

The Trust has established communication routes and engagement mechanisms to ensure staff and the public are kept informed, involved, and supported throughout the winter period. A comms plan is included in Appendix 2.

7.3 Overarching Assurance Statements:

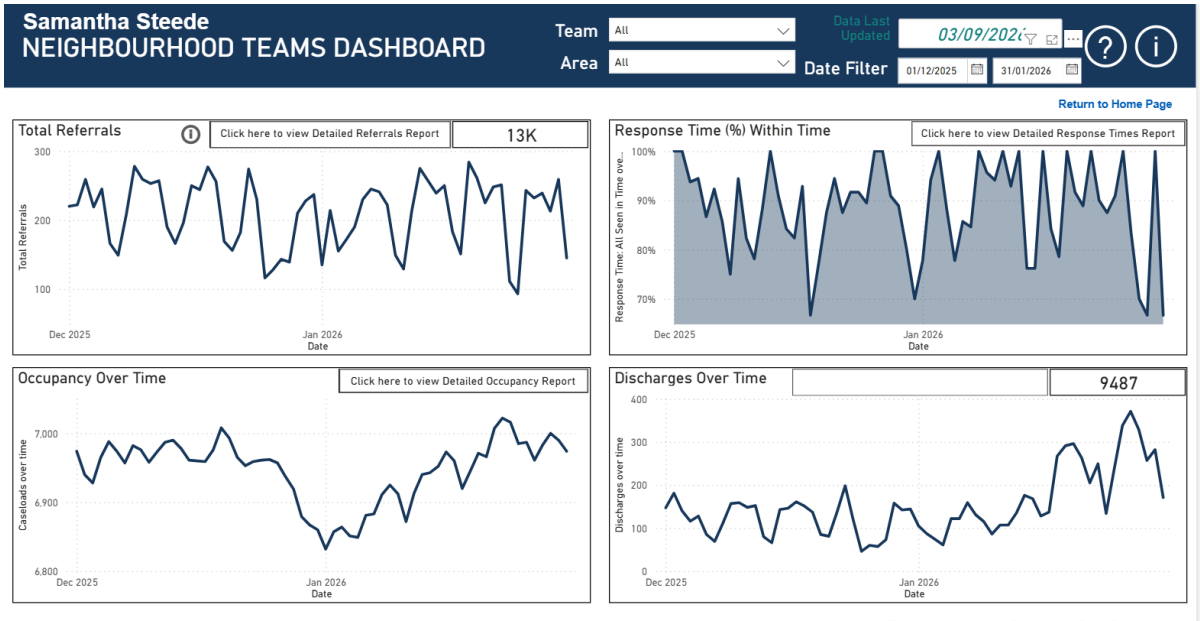
Having now reviewed the report the board is asked to consider the final assurance statements in relation to the Trusts overarching approval of the plan:	
1.1	*The Board has assured the Trust Winter Plan for 2026/27.*
1.2	*The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.*
1.3	*The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.*
1.4	*The Board has tested the plan during a regionally led winter exercise, reviewed the outcome, and incorporated lessons learned.*
1.5	*The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.*

Appendix

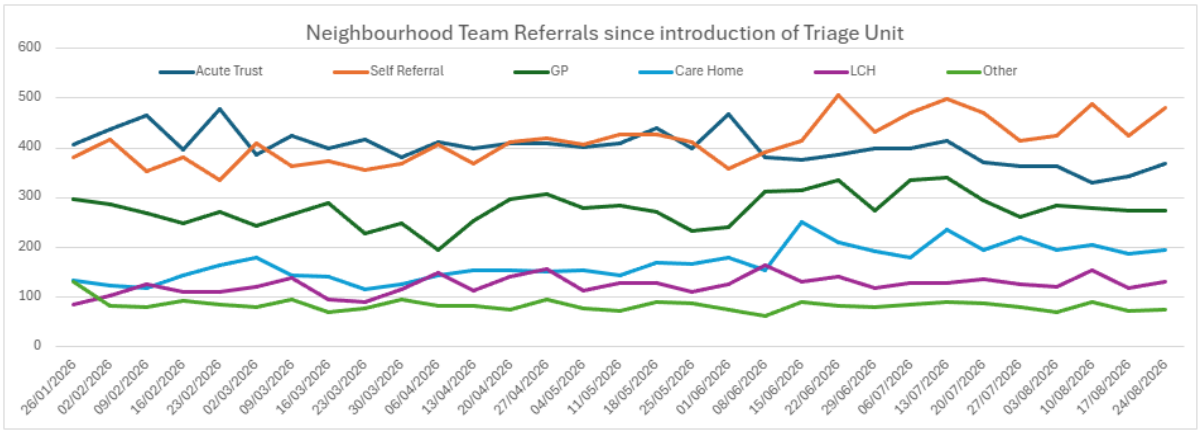
Appendix 1 – Winter 2024-2025 Demand

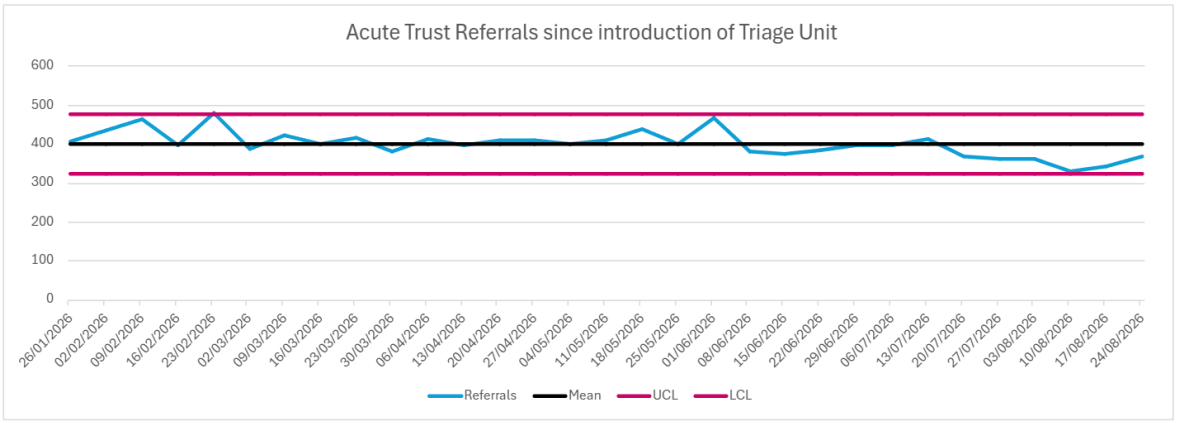
Neighbourhood Team Referrals

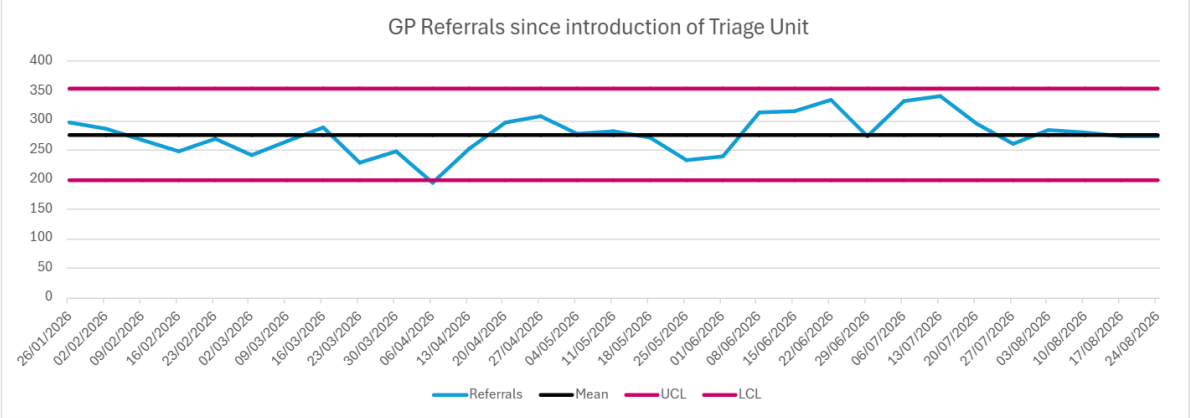
System Visibility Dashboard sample:



The three charts below demonstrate the peaks/surges in demand for the NT over the winter period, with demand consistently above the Mean average throughout the winter period.







Demand Winter 2025-2026 – Virtual Wards

		Oct	Nov	Dec	Jan	Feb	Mar	Average/Notes
Community Stroke Rehabilitation Team	Number of Referrals	65	54	63	74	78	81	61 (monthly average the over year)
Home Ward Frailty	Percentage Occupancy	Unav	Unav	Unav	78.5%	69.2%	73.8%	67.6% (Over first 7 months of 2025, higher than average in the avail winter months)
Home Ward Respiratory	Percentage Occupancy	97%	82%	70%	80%	58%	68%	69.5%
	Referrals	59	52	56	56	52	44	50 (monthly average the over year)
CIVAS	Number of Referrals	75	69	73	83	81	72	70 (monthly average over the year)

Appendix 2 – Comms Plan

Communication Area	Key Messages	Target Audience	Delivery Method
Internal staff bulletins	- Keep staff informed of winter pressures,	LCH Staff	Into the Week, My LCH,

	escalation levels, and service changes - Promote wellbeing support		
Urgent SMS messages to staff	- A suite of messaging to be developed for cascade to staff in the event of bad weather etc.	Staff	Text – logistics being worked through by Winter Planning Group
Staff Winter Vaccination Campaign	-Revised and enhanced internal offer for Flu - Staff invited via Cassandra, an internal booking system to book a vaccine. -Book a session at one of the citywide bookable clinics running through to end of November. Drop-in sessions will then become available at health centres and targeted vaccinations in areas of lower uptake and/or areas of outbreak. -Emails with prompts will be sent until decision logged by recipient. -Addressing myths, concerns and questions. FAQ's and resources available on LCH Oak winter vaccination page. Vaccines for healthcare workers are not provided in pharmacies except for staff in an identified high-risk group.	LCH staff. Extra emphasis on patient facing staff.	My LCH (Intranet) Into the week and My LCH Today (Internal Trust bulletins) Leaders Network emails Posters Email signatures.
Public messaging around NHS pressures	- Where to get urgent help -When to call 111 - Get winter vaccines to help alleviate winter pressures	General public	Social media Patient Information Hub (Website)
National Comms around 111,	-Use NHS 111 service, online or use the NHS App when urgent but not	General public	Social media

pharmacy, and self-care	life-threatening medical need. -111 for mental health. -'Think pharmacy first' campaign that pharmacists can provide some prescription medicines if needed, without seeing a GP. -Stay Well This Winter resources -Looking after neighbours -Hand Hygiene to avoid spread -Cold weather warnings and what to do to keep well -Christmas/New Years pressures- where and how to get help during bank holidays, protect yourself and families during holidays		
Flu Campaign (public)	- Promote vaccination and wellbeing messages. -Emphasis on pregnant women, parents/carers, children and people with long term health conditions. - Includes HPV, measles, RSV and whooping cough	General public	Social media
Urgent Responses e.g. to incidents and press	Comms Incident Response Pack and action cards has been updated (saved on H:drive) for use by On-call Managers\Incident commanders. Senior Trust staff trained to undertake interviews on behalf of the Trust	Press	Varied depending on incident would be coordinated by the Head of Communications and an Exec lead in the first instance.

Committee Escalation and Assurance Report

Name of Committee:	Quality Committee	**Report to:**	Trust Board 17 September 2026
Date of Meeting:	8 September 2026	**Date of next meeting:**	10 November 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. A Service Spotlight on Digital Inclusion was presented by Amanda Jackson, Associate Chief Clinical Information Officer covering the progress the Trust was making to improve access to healthcare through technology.

Alert

None

Advise

- Current system pressures - No significant issues were reported. The Committee noted a recent decision by West Yorkshire ICB to not process fast track referrals over weekends was causing a backlog of cases. The Trust and Leeds Teaching Hospitals NHS Trust had both registered their concern with the ICB.
- ABU beds Mobilisation CQC Registration – The CQC registration process had been finalised. The mobilisation of new recovery hubs and Wharfedale beds was underway, a review of the governance framework would be completed and a further paper presented to the Committee in November 2026.
- Leeds SEND Inspection Report 2026 – An action plan had been developed and agreed to address the SEND inspection findings, which had identified systemic failures in supporting families and leadership challenges. The Committee noted that health input formed a significant element of the action plan and the Trust was in discussion with the ICB about support for delivery of the project. A further update would be provided to the Committee in November 2026.
- Patient engagement Update Report – Received the six-monthly update report noting continuing engagement through the Youth Board, patient safety partners and other city-wide work. The committee requested clearer measurable objectives and a more coherent method for linking Friends and Family Test results, complaints and service-level patient involvement.
- Trust Integration Programme – Received an update on progress across the ten clinical and quality work streams noting that Quality Matters were helping to develop the clinical governance framework.
- Incident Management & Investigation oversight update – Reasonable 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

Committee Escalation and Assurance Report

meaningful learning and emphasised the need for a cultural shift towards proactive organisational learning. The committee would continue to receive update reports.

- Business Case Diabetes Neighbourhood Health Programme (Phase One)– Considered the quality aspects of the proposal and recommended it to the Board for approval on 17 September 2026. The committee suggested the inclusion of longer-term outcome measures as the project develops to look at the long term clinical impacts on patients who participate in the programme.
- Annual Medical Director's Report – Reviewed the annual report and recommended it for Board approval on 17 September 2026.
- Research and Development strategy update – The Committee welcomed the substantial growth in research activity and emphasised the importance of preserving the Trust's community research strengths as part of the integration and establishment of the new Trust from April 2027.

Assurance

- Quality Live Issues – EDoN updated the Committee on two issues:
  - 0-19 Service - the Trust had been notified by Leeds City Council (LCC) that it was not the preferred bidder for the service. The Trust was actively challenging the decision via a legal process with the support of the Independent Patient Choice Panel. The outcome was expected in October 2026 until then the process was paused.
  - Leadership Redesign - work was progressing well with interviews for high level posts underway. The Committee would continue to receive updates on progress but noted the potential for overlap with the People and Culture Committee going forward particularly as the transition to the new organisation progressed.
- NoF waiting List update - Received an update on waiting list reductions. Noting the significant and sustained reduction in long waits. Performance has improved to 84% of patients being seen within 18 weeks. Paediatric Neurodisability (PND) and the Children and Young People's Mental Health Service (CYPMHS) Neurodisability pathway are now the only services with waits over 52 weeks. Committee discussed equity concerns for children from disadvantaged backgrounds and described ongoing initiatives to monitor and address inequities.
- Spotlight – Digital Inclusion – the Committee received a comprehensive presentation about the work in the Trust to support access to digital healthcare and the initiatives to support access across all age groups but with a focus on age, deprivation and complexity.
- Integrated Performance Report - noted positive performance improvements. Further work was required to develop quality indicators, as the report remained largely focused on operational performance measures. Additional quality metrics were expected to begin changing the report from the November cycle to provide stronger board-level visibility of quality.
- Winter Planning – the Trust Board to receive a report at its meeting on 17 September 2026.
- WYOI, Adel Beck and Aldine House assurance paper- Received an assurance paper on the actions being implemented in response to the NHS England surveillance notice for HMYOI Wetherby which outlined current risks, mitigations and progress against the improvement plan. An inspection by HM

Committee Escalation and Assurance Report

Inspectorate of Prisons was expected in November 2026 and the Committee asked for confirmation when this had taken place and escalation to the Committee of any relevant findings.

- Patient Safety Update Report – The Committee noted an improved incident triage process had been introduced, weekly business-unit oversight and a substantial reduction in the active backlog, but suggested the organisation needed to demonstrate a more systematic approach to learning, clearer separation of clinical and non-clinical data and assurance that overdue incidents would not recur in the new organisation. This is all linked to the single datix system for the new organisation.
- QAIG AAA – Noted the alert relating to the Mobilisation of the Short-Term Community Beds Partnership and the actions taken.
- Safeguarding AAA – noted three alerts on the report related to: Key Worker Role, Designated and Named Doctor role and SUDIC Doctor cover (on the risk register), insufficient clinic capacity and medical staffing for Initial Health Needs Assessments and actions taken.
- IPC AAA- Noted two alerts related to: ventilation and water safety and the actions taken.
- Medical Devices AAA – noting partial assurance on the current safety, governance and management of medical devices. Progress in improving asset-register accuracy and addressing historical servicing concerns; and outline the further actions required to establish consistent and effective arrangements across the future integrated organisation were also noted.

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.

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	

Committee Escalation and Assurance Report

to preventable harm, poor patient outcomes, and a diminished patient experience.			
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:	Liz Thornton/Anne Cooper
Role:	Corporate Governance Officer/Committee Deputy Chair
Date:	10 September 2026

Agenda item:	2026-27 (9)
Title of report:	Patient Safety Update Report 01 March 2026 – 20 August 2026.
Meeting:	Trust Board Meeting Held In Public
Date:	17 September 2026

Presented by:	Heather McClelland, Interim Executive Director of Nursing and Allied Health Professionals
Prepared by:	Sarah Yeomans, Patient Safety Manager

Purpose of the report:		
The purpose of this bi-annual report is to provide the Board with assurance that patient safety is being effectively managed across the organisation. The report outlines: Patient safety incident reporting and trends, the application of the Patient Safety Incident Response Framework (PSIRF), Patient Safety Incident Investigations (PSIIs), Never Events, Actions taken to support organisational learning and improve the quality and safety of care, Duty of Candour compliance, Inquest overview, and Central Alert System (CAS) - National Patient Safety Alerts (NPSA), The report will highlight emerging themes, risks, and areas requiring escalation for Board oversight and assurance.	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:

Areas of Good Practice

- Clinical Governance have supported a significant reduction in the backlog of incidents awaiting review, supporting timely progression of proportionate learning responses and identification of learning and actions.
- Early learning is being identified through Rapid Review Meetings, enabling prompt implementation of improvements.
- No Never Events were reported.
- There is a reduction in PSIIs commissioned.

Ongoing Risk

- There is a sustained rise in inquest activity, resulting in increased demand on Patient Safety Team. Despite this there have been no negative implications for the Trust and no Regulation 28 Prevention of Future Deaths Reports received. Mitigating actions include recruitment to increase Patient Safety Team capacity.
- PSII timeliness remains an area for improvement, as investigations exceed planned completion dates. There is a formal extension approval process, providing greater visibility of investigation progress and ensuring delays are appropriately reviewed and escalated.

Key Learning Themes

- Learning from PSIIs has identified recurring themes relating to communication and information sharing, documentation and record keeping, and care coordination. Actions arising from this learning are recorded and monitored through the Trust's incident management system to provide assurance of implementation and completion.

Matters Requiring Oversight

- Fifteen actions arising from PSIIs remain overdue, which may delay the full implementation of learning and associated patient safety improvements. Overdue actions continue to be actively managed, with progress monitored, associated risks reviewed by services, and extension requests subject to appropriate oversight and approval where required. Where actions remain overdue, escalation is undertaken through the Quality Assurance and Improvement Group (QAIG) and the Integrated Performance Reporting (IPR) process.

Previously considered by:	Quality Committee
Outcome of previous discussion/s:	8 September 2026

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

Is Health Equity Data included in the report (patient care and/or workforce)?	Yes		What does it tell us?	
	No	x	Why not/what future plans are there to include this information?	This will be reviewed using the Patient Safety Dashboard once available.

Recommendation(s)	The Board is recommended to: • Receive and note the contents of this paper

Patient Safety update report 01 March 2026 - 20 August 2026

Executive Summary

Patient safety arrangements remain effective, with incident reporting, investigation and learning processes operating as expected throughout the reporting period. The number of PSIIs commissioned reduced from thirteen to seven, reflecting the proportionate application of PSIRF.

Significant progress has been made in reducing the backlog of incidents awaiting review, alongside this learning continues to be identified through Rapid Review Meetings and appropriate learning responses commissioned supporting more timely identification of learning and implementation of actions.

Despite a sustained increase in inquest activity, this continues to be effectively managed with no Regulation 28 Prevention of Future Deaths Reports received.

There were no Never Event incidents reported and Statutory Duty of Candour compliance remained high at 95%. Overall, assurance can be provided that appropriate governance arrangements are in place to support organisational learning and the effective management of patient safety risks.

Introduction

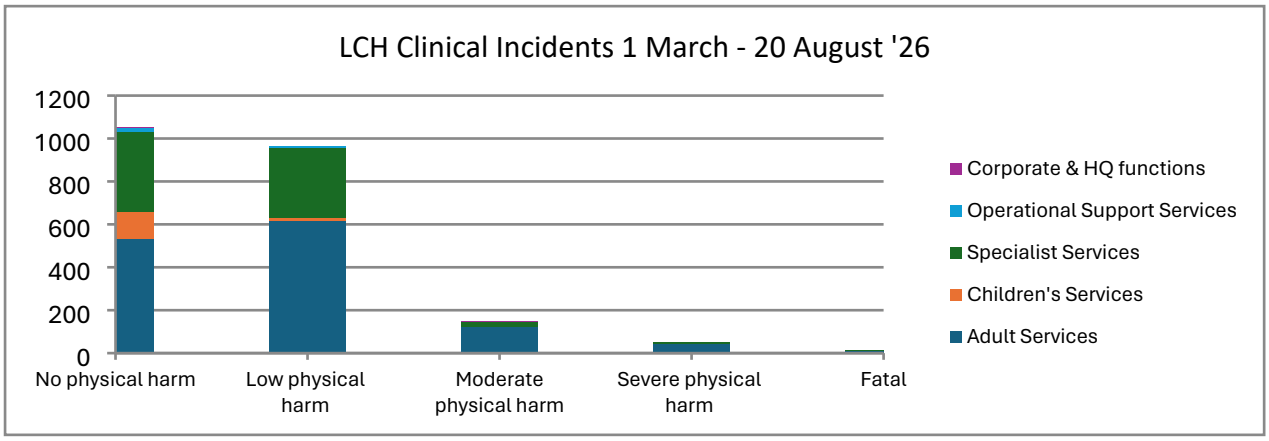
This report provides the Board with assurance regarding the management of patient safety across the Trust during the reporting period. It summarises patient safety incident activity, the application of the PSIRF, including PSIIs, Never Events and the actions taken to support learning and improve the quality and safety of care. The report also includes updates on Duty of Candour, Inquests and Central Alert System - National Patient Safety Alerts, highlighting any significant themes, emerging risks, or matters requiring Board oversight and assurance. Key patent safety indicators are shared below.

Key Patient Safety Indicator Table

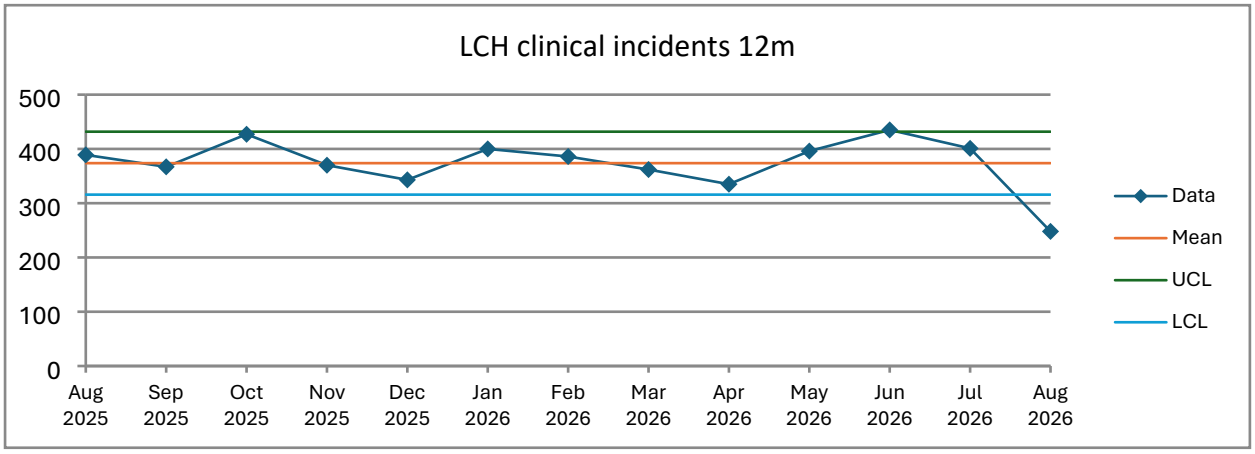
Key Indicators	Current Period 01/03/2026-20/08/2026
Clinical Incidents occurring under LCH care reported	2,177
Moderate Harm Incidents	130
Severe Harm Incidents	45
Fatal Harm Incidents	7
PSII Commissioned	7
PSII Completed	10
PSII in progress at end of the reporting period	13
Never Events	0
Statutory Duty of Candour compliance	95%
Open Inquests	29
Regulation 28 Report	0
NPSA (CAS) overdue	0

Patient Safety Incidents

There were 2177 clinical incidents reported for LCH in the reporting period.



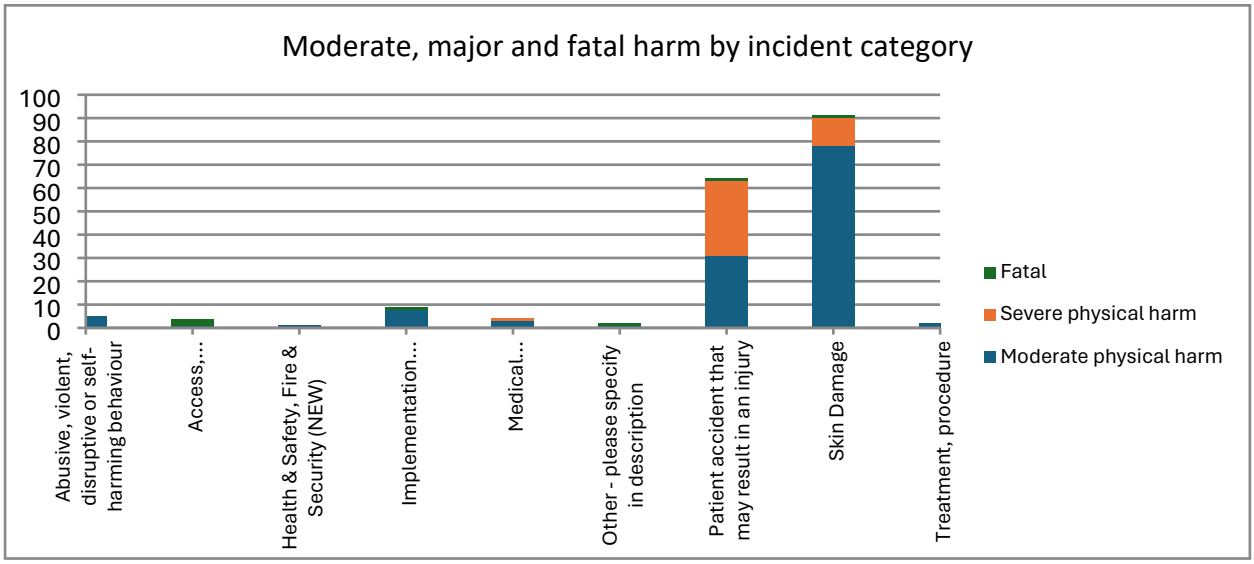
Due to the transition to the national LFPSE reporting of harm in July 2025, there is 12 months comparable data available as shown below. Clinical incident reporting has remained with control limits during that time except for a slight increase in June 2026.



During the reporting period there were 182 LCH clinical incidents recorded as moderate, severe or fatal harm, 130 as moderate, 45 as severe and 7 as fatal. They remain within the control limits for Trust reporting as shown below.

On review of the higher reporting teams, an action for a deep dive into incidents at Armley was assessed and closed following escalation by the ABU Quality Assurance

Lead to QAIG. The Therapy Teams report more severe harm falls due to their caseload demographic.



All moderate, severe and fatal incidents are reviewed against the Trust Patient Safety Incident Response Plan (PSIRP) priorities. Unless there is known learning for an incident where there is a Trust Improvement Group (Falls, Skin Damage and Deteriorating Patient), a Rapid Review is completed and presented to panel to assess the harm and determine the need and type of learning response. All potential fatal harm incidents are reviewed at the Rapid Review meeting.

On review the severe incidents all relate to a Trust Improvement Group area, including the medical device incident that related to pressure relieving equipment and skin damage. Three of the seven fatal harm incidents are undergoing a Patient Safety Incident Investigation and four remain in the review process and will be presented at Rapid Review.

Of the 28 moderate, severe or fatal harm incidents that did not relate to fall or skin damage, no new learning or themes were identified by incident reviewers within Datix. For those that continued to Rapid Review, actions and learning would be escalated from that meeting.

Reviewers are required to record whether the existing PSIRF learning themes factor in an incident for falls, skin damage and deterioration, and any new learning must be recorded. There were no themes within new learning recorded on review for this report.
The Falls, Tissue Viability Specialist, and Head of IPC review new learning annually and report this to the respective Improvement Group for discussion and assessment of action.

In July 2026, a QAIG workshop brought together all the leads for different patient safety workstreams to identify shared learning, issues and to create some improvement ideas for the future. This forum included patient experience, inquest learning, improvement group leads, medicines management expertise, audits.

Although skin damage and falls continue to be prevalent in the data, the cross-cutting themes that emerged identified three key priorities to consider for future improvement workstreams;

- Communication and care transitions failures.
- Operational/process reliability failures (admin, waiting lists, follow-up, escalation).
- Detection and management of deterioration.

The outputs from the workshop will be reviewed through the newly established Clinical Reference Group to establish how these will be addressed and integrated into the next Patient Safety Incident Response Plan.

Overdue Incident Reviews

At the time of writing, there are 118 overdue incidents in 'holding' that should be reviewed and moved into 'being reviewed' within three working days, 111 relate to non-clinical teams. Five are LMWS, earliest report date of 5 August 2026 and two are Home Ward, earliest report date 13 August 2026. All except one are no or low harm, one fatal incident has been escalated from this report for urgent review.

There are 217 overdue 'being reviewed' incidents where they should be completed within 30 days. The clinical Business Units account for 171: ABU 67, CBU 5 and SBU 99, dating back to March 2026. There are 16 moderate harm, one severe and one fatal within the overdue 'being reviewed' that are in process. As the data is live, a comparison of overdue incidents in the process cannot be provided.

Support has been provided by Clinical Governance for ABU to reduce their incidents pending Rapid Review. All Business Units now run a weekly incident review meeting with their services to review incidents, monitor significant harm and any themes, and to support services where there are capacity issues. There is also a weekly Executive Oversight 'huddle' for BU's to present current position, and any themes or risks emerging. As a result, the number of outstanding incidents in 'holding' and in 'being reviewed' is actively falling, with each BU addressing their individual blocks.

PSIRF and Learning

Seven PSII's were commissioned in the period compared to 13 in the previous six months. On review all were commissioned in line with the Patient Safety Incident Response Plan (PSIRP), ensuring responses to patient safety incidents are proportionate and focused on maximising learning.

The Patient Safety Team have introduced a weekly Patient Safety Specialist meeting to peer review any initial incidents assessed to be for PSII, this has increased our scrutiny of whether a PSII is required. We have also benchmarked with other Trusts via the Future's platform in relation to the linkage between a physical harm incident leading to a death at some point after the initial incident, reducing the number of nationally mandated PSII's declared.

Two After Action Reviews (AAR) were conducted, and methodologies in line with PSIRF continue to be used, including SEIPS, or Hierarchical Task Analysis. In the previous reporting period, there were two AAR, one Multi-Disciplinary Review using a walkthrough analysis.

At the end of the reporting period, thirteen PSIIs remained in progress. Five are being managed under the extension process with the oversight of the Clinical Lead, Head of Clinical Governance, Deputy Director of Nursing and Quality and with notifications to the Director of Nursing and AHPs. Extensions have been agreed between two and four months for more complex reviews and one for five months where the original author left the Trust. Patients and families remain fully involved where extensions are required.

Of the ten PSIIs completed during the reporting period, one was completed within the agreed timescale, four within six months of commissioning, and five exceeded six months.

Mitigation to delays in report completion include early learning which continues to be identified through Rapid Review Meetings, enabling actions to be implemented prior to completion of the final investigation report.

There is a risk that as these delays will extend during the implementation of the Neighbourhood Model, the Leadership Review and the Transition to a new Trust due to the availability and workloads of the authors. The Patient Safety Manager will assess and record a risk on the risk register and escalate this to the next QAIG.

Themes

PSII reports have identified recurring themes relating to communication and information sharing, documentation and record keeping, and care coordination across services. Actions have focused on strengthening escalation processes, multidisciplinary working, clinical documentation and oversight of patient care. Some reviews also identified workforce and service capacity pressures as contributory factors, which continue to be monitored. These themes will be assessed by the Trust Strategic Action Group for Trust wide improvement opportunities.

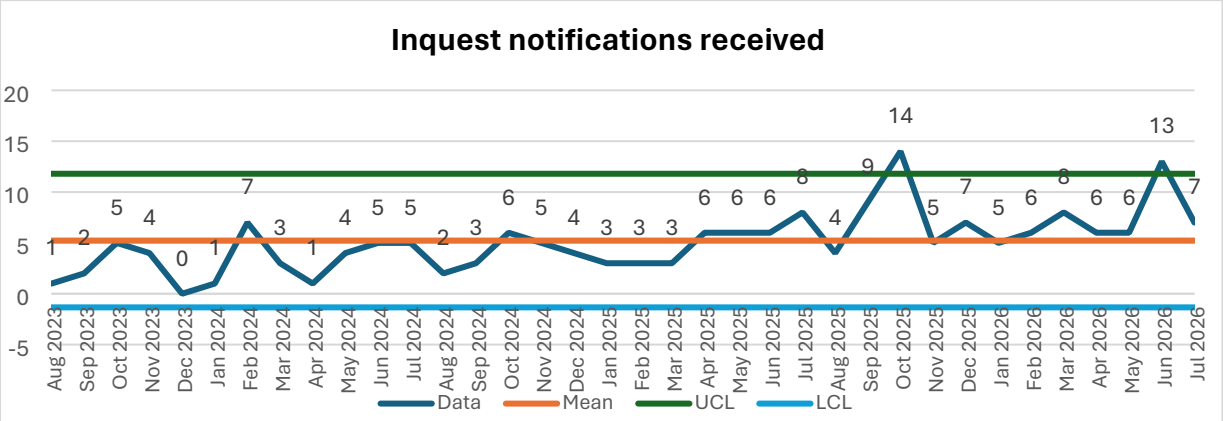
Actions arising from learning continue to be recorded and monitored through the Trust's incident management system to provide oversight and assurance of completion. Whilst 15 PSII actions remain overdue (of 55 in total), these continue to be actively monitored, with associated risks reviewed and extension requests subject to appropriate oversight and approval where required. Where actions remain outstanding and the agreed process is not followed, escalation is undertaken through Quality and Performance reporting routes to ensure appropriate oversight and accountability. Forty PSII actions have been completed in the period.

Duty of Candour Compliance

Twenty-three incidents met the statutory Duty of Candour threshold, with one case currently in progress. Review against the Trust's ten working-day KPI identified 21 cases as compliant (91%). Delays outside the KPI were reviewed and reflected appropriate circumstances, such as patient preference or challenges in establishing contact; however, one case was attributable to a delay in completing correspondence by the responsible service. Ongoing monitoring of statutory Duty of Candour compliance provides assurance that patients and representatives are involved in an open and transparent manner following patient safety incidents and that CQC regulation 20 requirements are met.

Inquests and Regulation 28 Prevention of Future Deaths Reports

Despite a sustained increase in inquest activity, with twenty-nine inquests currently open this continues to be well managed within the Patient Safety Team outsourcing to external legal support when assessed required.



There have been no Regulation 28 Prevention of Future Deaths Reports received following the thirteen inquests concluded in the reporting period. Positive feedback from HM Coroner recognised both the quality of information provided by the Trust and the improvements implemented following a patient's death, with no further actions considered necessary. To support the increasing demand associated with inquest activity and wider patient safety processes, recruitment to a Deputy Patient Safety Manager post is underway, providing additional capacity to maintain robust oversight, timely responses to Coroner requests and continued identification of learning opportunities.

National Patient Safety Alerts (CAS)

There was one National Patient Safety Alert received during the reporting period, which was reviewed, assessed as not relevant to the Trust services and closed within the required timescale. One alert remains in progress and is on track for completion by the required deadline. Two alerts have been closed following review by the Quality Assurance and Improvement Group, with any ongoing incomplete

actions transferred to the Trust's risk register for continued oversight, mitigation and monitoring.

5 Recommendations

The Board is recommended to:

- Receive and note the contents of this paper

Sarah Yeomans
Patient Safety Manager
20/08/2026

Committee Escalation and Assurance Report

Name of Committee:	Charitable Funds Committee	**Report to:**	Trust Board 17 September 2026
Date of Meeting:	02 September 2026	**Date of next meeting:**	14 December 2026
Chair:	Alison Lowe	**Parent Committee:**	Trust Board

Introduction

This report highlights the key issues for the Board from the Charitable Funds Committee held on 2 September 2026. Quorate meeting. The Charity Development Update was stood down for this meeting as there was limited activity to report since the previous meeting.

Alert

Discussed the need for future decisions relating to the charity to be considered through the Transition Committee. Issues of sustainability and resilience would need to be taken into account when determining the future approach to charitable funds within the new organisation.

Advise

- Charitable Funds Finance Report - Fundraising performance remains challenging particularly in relation to Hannah House. Need to review the longer-term charitable funds strategy. Needs an early, open discussion with LYPFT about whether the new organisation wants to retain a charitable funds function, and what funding structure would apply. Also need to determine how Hannah House's charitable activity, donations and governance will be supported if the current charity structure changes.
- Proposed a reflective review with Head of Business, BCIS and Charitable Funds Officer on performance against the current strategy as part of discussions with the Transition Committee.

Assurance

- Forward Plan – The financial sensitivity analysis was included to show the impact of different assumptions and supported the proposed short-term mitigation of recharging part of Charitable Funds Officer's time to the Trust Integration Programme.
- Draft LCH Charitable Funds and Related Charities Annual Report & Accounts – Draft Annual Report and Accounts were presented. The Committee noted the Accounts would be presented to December Committee only if Audit Committee identifies a need, otherwise will proceed directly to Trustees.

Risks Discussed and New Risks Identified

The Committee noted that the proposed Board and Committee structure presented to the Transition Programme Board does not currently include a Charitable Funds Committee. Clarity is required at the earliest opportunity regarding the future of the charitable funds function and its funding arrangements.

It was also noted that relying on a single member of staff reduces resilience.

Committee Escalation and Assurance Report

Author:	Rakhi Palliyath/ Alison Lowe
Role:	CG Officer/ Chair
Date:	03 September 2026

Agenda item:	2026-27 (12ai)
Title of report:	Integrated Performance Report
Meeting:	Trust Board Meeting Held In Public
Date:	17 September 2026

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

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

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

Summary of Key Issues:

- The trust continues to improve performance in relation to waits. Improvements in the time people wait for services continues and we are now seeing significant improvement in more specialist services. There are now no patients breaching the waiting list standard for urgent and routine care from the CAMHS eating disorder service and, in the dental service there are currently only 3 patients waiting over 52 weeks.
- Elsewhere waiting times are increasing. In NHS Talking Therapies the number of people waiting more than 2 weeks for screening and 6 weeks for treatment is increasing. This is due to staffing levels. The service is actively managing capacity and deploying resources to prioritise timely progression from screening to treatment.
- After a peak in December and January sickness had now decreased and is much closer to our 6.5% target. A range of measures remain in place to support attendance management.
- We are consistently reporting a high level of completeness of ethnicity recording that is significantly above the national benchmark of 71.6% for community trusts. This is a foundational step in allowing the trust to identify and respond to areas of inequity in care.
- Our overall data quality as assessed in the Data Quality Maturity Index (DQMI) and NOF is more of a concern. Issues in our Mental Health Data Set have been resolved and will be reflected in the June DQMI scores and Q2 NOF. However, there are now new issues since the annual submission of our Commissioning Data Set (CDS) data. These will impact the DQMI until July.
- The number of Patient Safety Incident Investigations and associated overdue actions continue to receive focus. Incidents are being concluded and approved at a higher frequency than previously. There is ongoing pressure on investigation capacity resulting in extended completion times for PSII. Improvement in the timeliness of PSIIs is dependent on a review of the current capacity constraints for Lead Investigators. Business Units are encouraged to monitor PSII actions through Performance Oversight Groups and local

performance meetings. Improvement is expected over the next 3-6 months as strengthened oversight arrangements are embedded.

- A forecast based on this year's NOF measures has been made. **It is estimated that LCH will remain in segment 3 in the NOF in Q1.** National publication of Q1 scores is expected at the end of August. At that point we will test the assumptions and methods used to calculate the metric scores. Until then this information is only indicative.
- Focus on the measures carried over from 25/26 will be continued. Additional efforts will be focused on the following measures as these have been identified as measures that could improve our overall score:
    - Percentage of people discharged from community mental health services with a paired outcome score recorded (all ages)
    - Data Quality Maturity Index (DQMI)
    - Temporary staffing cost relative band

Previously considered by:	Quality Committee 8 September 2026 Business Committee 15 September 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?	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 consultant-led services are being sustained. Non-consultant led services remain above target, meaning that people in IMD1 remain more likely to wait longer than the rest of the population, and the odds ratio shows early indications of a reversal in the previous quarter's increase in likelihood of longer waits. Targeted work to support attendance at appointments continues, with analysis and oversight of improvement actions by Access LCH and productivity workstreams
	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

August 2026

Reporting on: July 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 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

Leeds Community Healthcare NHS Trust

Summary

The trust continues to improve performance in relation to waits. Improvements in the time people wait for services continues and we are now seeing significant improvement in more specialist services. There are now no patients breaching the waiting list standard for urgent and routine care from the CAMHS eating disorder service. Additional assessments and capacity have been put in place to achieve this. And, in the dental service there are currently only 3 patients waiting over 52 weeks. This is due to missed and/or declined appointments. This is down from 1,436 in January 2025.

Elsewhere waiting times are increasing. In NHS Talking Therapies the number of people waiting more than 2 weeks for screening and 6 weeks for treatment is increasing. This is due to staffing levels. The service is actively managing capacity and deploying resources to prioritise timely progression from screening to treatment.

After a peak in December and January sickness had now decreased and is much closer to our 6.5% target. A range of measures remain in place to support attendance management.

New KPIs monitoring the completeness of our ethnicity information were introduced in the last report. This was in response to NHS England's Statement of Health Inequalities. We are consistently reporting a high level of completeness significantly above the national benchmark of 71.6% for community trusts. This is a foundational step in allowing the trust to identify and respond to areas of inequity in care.

Our overall data quality as assessed in the Data Quality Maturity Index (DQMI) and NOF is more of a concern. Issues in our Mental Health Data Set have been resolved and will be reflected in the June DQMI scores and Q2 NOF. However, there are new issues since the annual submission of our Commissioning Data Set (CDS) data. These will impact the DQMI until July. Work is underway to make these returns monthly and deliver improvements in this data set and improved scores are expected for September's data which will inform the Q3 NOF.

The number of Patient Safety Incident Investigations and associated overdue actions continue to receive focus. Incidents are being concluded and approved at a higher frequency than previously. There is ongoing pressure on investigation capacity resulting in extended completion times for PSII. Improvement in the timeliness of PSIIs is dependent on a review of the current capacity constraints for Lead Investigators. Business Units are encouraged to monitor PSII actions through Performance Oversight Groups and local performance meetings. Improvement is expected over the next 3-6 months as strengthened oversight arrangements are embedded, overdue actions are actively reviewed and Learning Response Leads work with services to develop robust and achievable actions arising from PSII investigations.

Summary Performance

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

Top Highlights

Domain	KPI	Target	Actual	Performance	Assurance
Access to services	% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	>=95%	100%	H	?
Access to services	Number of patients currently waiting over 52 weeks - Dental		9	L	F
People & workforce	Total sickness absence rate (Monthly) (%)	<=6.5%	7%	H	?
Improving health and reducing inequality	Percentage of open records with a valid, non-residual ethnicity code	>=71.6%	97%		P

Top Concerns

Domain	KPI	Target	Actual	Performance	Assurance
Access to services	IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	No Target	57%	L	
Access to services	IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	>=75%	81%	L	P
Patient safety	Number of Patient Safety Incident Investigations (PSII)	No Target	3	↗	
Patient safety	Number of overdue PSII actions	No Target	15	↘	
Finance & productivity	Data Quality Maturity Index (DQMI) - MHSDS dataset score**	>=95%	87%	H	F

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

- A forecast based on this year's NOF measures has been made. **It is estimated that LCH will remain in segment 3 in the NOF in Q1.**
- National publication of Q1 scores is expected at the end of August. At that point we will test the assumptions and methods used to calculate the metric scores. Until then this information is only indicative.
- Focus on the measures carried over from 25/26 will be continued.
- Additional efforts will be focused on the following measures as these have been identified as measures that could improve our overall score:
    - Percentage of people discharged from community mental health services with a paired outcome score recorded (all ages)
    - Data Quality Maturity Index (DQMI)
    - Temporary staffing cost relative band

	Score	Segment
Overall	**2.53**	**3**

Domain	Sub Domain	Measure	Score	Segment
Access to services	Elective care	% of cases waiting over 52 weeks for community care	2.79	2
		% of patients waiting less than 18 weeks for community care	1	1
	Mental Health Care	% of total childrens and young persons mental health patients waiting over 104 weeks for contact	1	1
		% of people discharged from community mental health services with a paired outcome score recorded (all ages)	4	4
Experience of care	Experience	NHS staff survey advocacy rate	2.4	2
	Patient Flow	% of intermediate care beds occupied by patients without criteria to reside	2.58	3
Effectiveness of care	Outcomes	% of NHS Talking Therapies patients completed a course of treatment and achieving reliable recovery	3	3
Patient safety	High quality care	% of urgent crisis response patients to receive face to face care within 24 hours (mental health)	No Score	
	Safe Culture	NHS staff survey raising concerns sub-score	1.4	1

Domain	Sub Domain	Measure	Score	Segment
Finance, productivity and innovation	Finance	Combined Finance Score	1	
		Planned surplus or deficit		1
		Variance to plan year-to-date		1
	Productivity	Relative cost difference (National Cost Collection Index)	4	4
	Innovation	% of clinical trials set up within 90 days	4	4
		Data Quality Maturity Index	3.55	4
People	People and Culture	Sickness absence rate	3.93	4
		NHS staff survey engagement theme score	2.85	3
		National Education and Training Survey satisfaction rate	1.77	2
		NHS staff standards score	1.22	2
		Healthcare Worker Flu Vaccination Rate	1.97	2
	Workforce	Temporary staffing cost relative band	3	3

NHS Oversight Framework (NOF) Performance

Leeds Community Healthcare NHS Trust

Where NOF measures are currently included in the IPR, narrative is provided in the relevant section. The other NOF measures are under development and will be included in the main report in November. Updates for those measures is provided here:

- **Percentage of total children's and young persons' mental health patients waiting over 104 weeks for contact (Score 1, Segment 1)** This measure only includes children and young people (CYP) referred for "group d"/mental health referrals. It excludes CYP with referrals for neurodevelopmental assessments, autism or gender identity. All the CYP waiting more than 104 weeks in our CYP mental health services are waiting for neurodevelopmental assessments. No CYP are waiting more than 104 weeks for a mental health referral.

- **Percentage of people discharged from community mental health services with a paired outcome score recorded (all ages) (Score 4, Segment 4)** This measure applies to CAMHS and PCMH. Both services are currently in segment 4, but we are close to achieving segment 3. We would only need 6 more CAMHS patients to have paired outcome scores to achieve segment 3. Focus will be bought to this area to achieve this. Our PCMH service primarily use Reqol to record outcomes, but this is not on the list of outcome measures that contribute to this score. Work will be undertaken to understand how we respond to this challenge.

- **NHS staff survey advocacy rate (Score 2.4, Segment 2)** This measure combines staff survey scores covering the percentage of staff who say that care of patients is their organisation's top priority, the percentage of staff who would recommend the organisation as a place to work and the percentage who would be happy with the standard of care their organisation provides if a friend or relative needed treatment. Estimates indicate that LCH score 6.95 and are currently benchmarking well against other trusts ranking 29 out of 61.

- **Percentage of intermediate care beds occupied by patients without criteria to reside (Score 2.58, Segment 3)** Our intermediate care beds at Wharfedale and in the Recovery Hubs contribute to this measure. There is no national target set, providers are ranked to determine their segment. LCH reported an average of 25.3% of patients without criteria to reside occupying beds. This means we are ranked 50 out of 94.

- **% of NHS Talking Therapies patients completed a course of treatment and achieving reliable recovery (Score 3, Segment 3)** NHS England has advised that discussions are ongoing about whether this should apply to ICBs only. If this is the case, we will no longer be scored on this measure. That would have no impact on our overall segment. For the present we are progressing with actions. The LMWS Performance Report is currently reporting a rate of reliable recovery of 47.1%. The boundaries for this measure are very close with a range of only 2% between segments. It is possible that our local reporting will differ from the figure NHS England derive from the national data set. With such tight boundaries this could make a difference to our segment score. As soon as national data is available it will be examined and should it be needed work will start on ensuring we are consistent.

- **Percentage of urgent crisis response patients to receive face to face care within 24 hours (mental health) (No Score, No Segment)** LCH does not currently submit any data that would contribute to this measure. This is evidenced in published data and model health dashboard where our data is blank. Most of our Crisis Team referrals are "very urgent" rather than "urgent". They require a 4-hour response and do not contribute to this measure. This matches the locally defined waiting time target. Any "urgent" referrals received as submitted under a different team and are therefore not in scope of the measure. The CAMH service feels that some of our work should contribute. We are reviewing these categorisations to ensure they are correct.

- **Percentage of clinical trials set up within 90 days (Score 4, Segment 4)** This measure looks at the time taken from HRA approval or site selection to recruitment of first patient. The Research Team has delivered improvements in the time to recruit patients in recent months bringing the time down significantly and much closer to the 90-day target. However, in the run up to the inclusion of the measure in the NOF one study has failed the 90-day target. To achieve higher than a segment 4 score a provider has to have 80% of studies achieving the target. Due to the low number of studies LCH have been selected to recruit to it is likely that LCH will remain in segment 4 throughout 26/27 despite subsequent studies recruiting in 90 days.

- **National Education and Training Survey satisfaction rate (Score 1.77, Segment 2)** This measure aims to provide insights into the quality of the learning environment in trusts as research has demonstrated that safer care is provided in high-quality learning environments. This is an annual exercise. LCH's overall score is 81.14. We place 55th out of 211 providers.

- **NHS staff standards score (Score 1.6, Segment 1)** This measure uses the NHS staff survey to assess providers' performance in relation to the NHS Staff Standards. As with other NHS Staff Survey measures this is an annual exercise. Our score will only update when the national staff survey is repeated. Our performance against this measure has been estimated to be 7.87, this puts us at 13th out of 61 providers. However, this assessment should be treated with caution. The staff standards measure looks at 6 domains. The Tackling Racism domain score should only be calculated for survey responses from BME staff only. These data were not available for all trusts at the time the paper was written so the estimate is based on the responses from all staff. The data available shows that the responses from BME staff are significantly different from overall responses, but without data from all trusts we are unable to assess how this translates into our score. Work is in progress to try to identify a data source for this information.

- **Healthcare Worker Flu Vaccination Rate (Score 1.97, Segment 2)** This measure monitors the number of frontline healthcare workers who had a flu vaccine administered by the NHS. In Q1 LCH is reported as having 52.1% of frontline workers with a vaccination. This places us 67th out of 205. Our score will remain the same in Q2. The Q1 figure will be used as there is no flu vaccination programme in the summer.

- **Temporary staffing cost relative band (Score 3, Segment 3)** We are currently predicting that we will be in segment 3 for this new measure. The segment 3 forecast is based on an assumption that we have lower than average spending as a % of total pay bill. We do not yet have national data to prove this. Spending on bank and agency is currently off track. We are currently forecasting to meeting the plan by the end of the year, but there will be challenges in achieving that. Working groups to deliver monitoring and improvements for this measure have been set up. And there are ongoing conversations about what the organisational strategy to improve this should be.

Access to Services Domain Summary

Accountable Exec: Sam Prince

NHS Leeds Community Healthcare NHS Trust

Summary

We continue to see strong improvements across this domain, although there remains further work to do to reach the Trust target of having no wait longer than 52 weeks.

The total number of people waiting is steady at 22,990 at the end of July 2026. However, the number of patients waiting more than 52 weeks continues to decrease, falling to 683 at the end of July 2026, down from 1,647 at the end of December 2025. These waits only remain in PND and CYMPHS ND and are continuing to reduce.

For our Q1 rating the NOF will look at the percentage of patients waiting more than 52 weeks at the end of June. Performance at the end of Q1 improved from 2.1% to reach 1.9%. This performance is estimated to place us in segment 2 for this measure. All these patients sit within our PND Service, which is continuing to improve further in this metric.

The number of patients seen within 18 weeks continues to rise and now sits at 84% for reportable services and 83% for non reportable service. This has now held above the 78% medium term planning target for the whole of 2026 and continues to rise. Achieving this target puts the Trust in segment 1 of the NOF for this measure. Six-weekly forecasts across all Community Sit Rep services are providing an increased grip on trajectories, capacity planning and targeted recovery.

Trust's performance against the Urgent Community Response Standard has risen to 86% in July. Our Children's Audiology Service had 1 breach with over 99% of patients seen within 6-weeks in July 2026.

Domain Summary Performance

Data Quality : High Assurance Performance: On track

KPI	Reporting Month	Target	Actual	Performance	Assurance
Total Patients Waiting for Care - Trust Wide	Jul-26	No Target	22990	L	
Number of patients currently waiting over 52 weeks - Trust Wide	Jul-26	0	683	L	F
Total Patients Waiting for Care - Consultant-Led	Jul-26	No Target	1474	L	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	Jul-26	>=92%	41%	H	F
Number of patients waiting more than 52 Weeks (Consultant-Led)	Jul-26	0	283	L	F
Total Patients Waiting for Care - Community Sit Rep	Jul-26	No Target	19229	L	
Percentage of patients currently waiting under 18 weeks - Community Sit Rep	Jul-26	>=78%	84%	H	P
Number of patients currently waiting over 52 weeks - Community Sit Rep	Jul-26	0	340	L	F
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	Jul-26	>=99%	100%		P
Community health services two-hour urgent response standard	Jul-26	>=70%	86%		P

Access to Services Domain (continued)

Accountable Exec: Sam Prince

KPI	Reporting Month	Target	Actual	Performance	Assurance
Available virtual ward capacity per 100k head of population	Jul-26	No Target	7.8		
Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care	Jul-26	0	0		
% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment	Jul-26	>=95%	100%		
Number of Patients Accessing CAMHS	Jul-26	No Target	1406		
Percentage of Children currently waiting more than 18 weeks for a Neurodevelopmental Assessment	Jun-26	<=5%	77%		
LMWS – Access Target; Local Measure (including PCMH)	Jul-26	24456 by year end	2635		
IAPT - Percentage of people receiving first screening appointment within 2 weeks of referral	Jul-26	No Target	57%		
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	Jul-26	>=95%	99%		
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	Jul-26	>=75%	81%		
Total Patients Waiting for Care - Dental	Jul-26	No Target	1070		
Percentage of patients currently waiting under 18 weeks - Dental	Jul-26	>=92%	54%		
Number of patients currently waiting over 52 weeks - Dental	Jul-26	0	9		

Consultant-led RTT Waiting Times

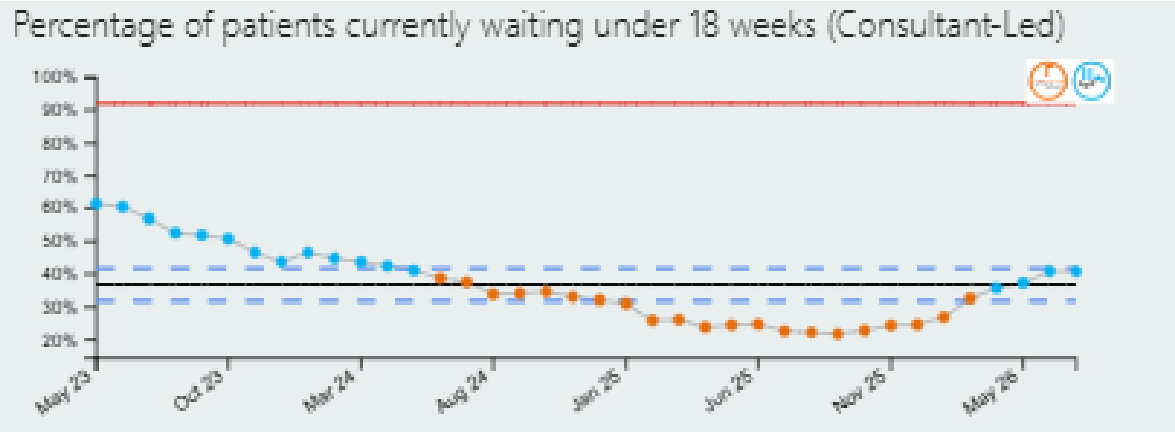
Leeds Community Healthcare NHS Trust

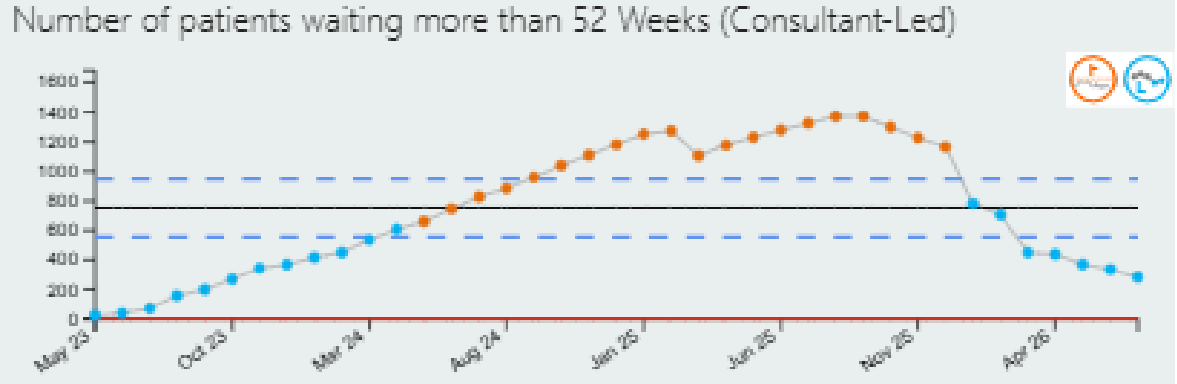
Domain: Access to Services | Accountable Exec: Sam Prince | Author: Samantha Steede

Target: 92% and 0 | Actual: 41% and 283 | 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 300 by the end of July.
Most of those remaining children still waiting over 52 weeks to access the service now sit within the Complex PND Pathway and are now being seen.





What is being done about it?

Following approval of the substantive staffing business case, the service has begun prioritising children on the Complex PND waiting list. Initial focus is 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 is projected to have eliminated all 104-week waits by the end of October and all 52-week waits by the end of November. Interviews for the agreed substantive staffing expansion are scheduled for the first week of October, with successful candidates expected to be in post by early January. The introduction of the new referral form, alongside substantive recruitment, is anticipated to support the effective management of demand and enable the service to maintain a sustainable waiting list moving forward.

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: 84% | SPC Variation: H | SPC Assurance: F | Data Quality: **High Assurance**

What is the trend we see?

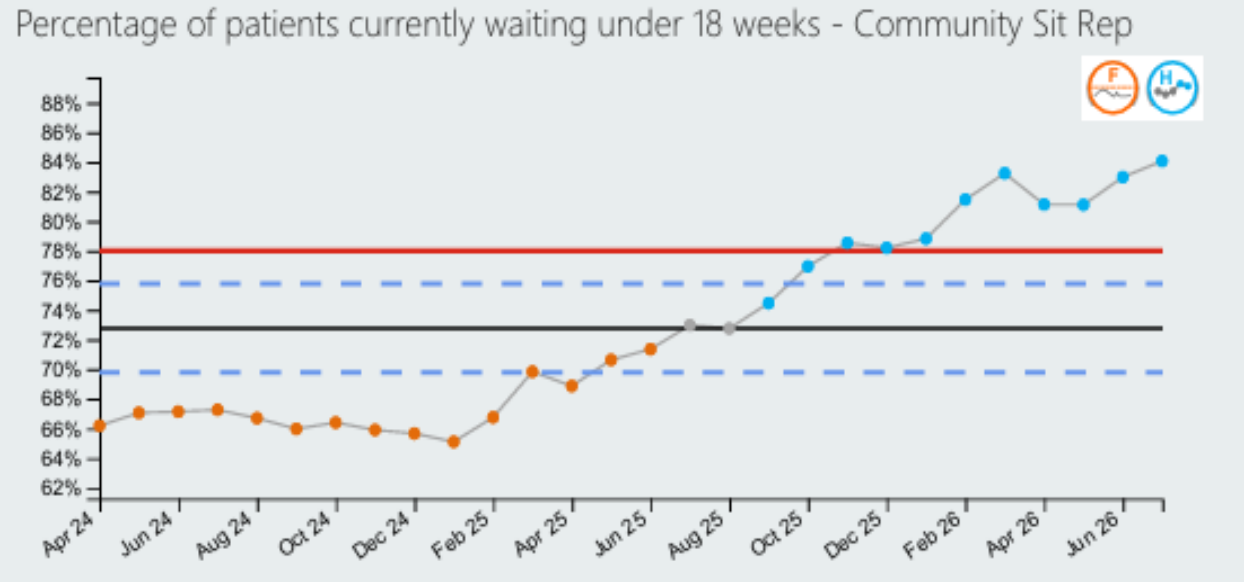
This measure forms part of the NOF and the June position is used for Q1 segmentation. Performance has exceeded the 78% target consistently since January 2026, which should place the Trust in Segment 1 for this measure. Performance has been driven by sustained improvements in access, with both CUCS and MSK now reporting no waits over 40 weeks. MSK long waits have improved following a period of higher numbers over 18 weeks and, given the size of the MSK waiting list, this has had a significant positive impact on the Trust's overall performance against this target.

What is being done about it?

Performance against the 18-week standard and all long waits is closely monitored through Access LCH steering group and routine service and business unit Performance Oversight Groups. Targeted improvement plans are in place within MSK and PND to further reduce long waits and improve patient flow.

When do we expect to see improvement?

Ongoing recruitment within MSK, one of the Trust's largest services, alongside continued improvement work within PND, is expected to deliver further reductions in long waits and support continued improvement against this metric over the coming months.



What are the risks to delivery?

As this metric is heavily influenced by performance in the Trust's larger services, any deterioration in access or waiting time performance within these areas could impact the overall Trust position

Neurodevelopmental Diagnostic Assessment Waiting Times

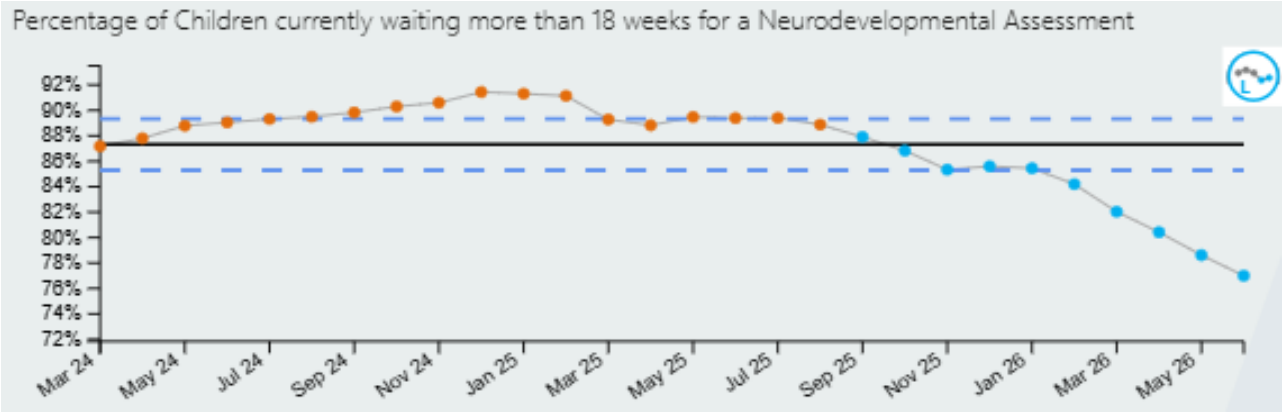
Leeds Community Healthcare NHS Trust

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

Target: 5% | Actual: 77% | 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, 381 children and young people are still waiting more than 52 weeks for an appointment. This number is falling and driving the positive changes seen.



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.

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.

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.

When do we expect to see improvement?

Based on the current waiting list of 381, 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.

Dental Service Waiting Times

Leeds Community Healthcare NHS Trust

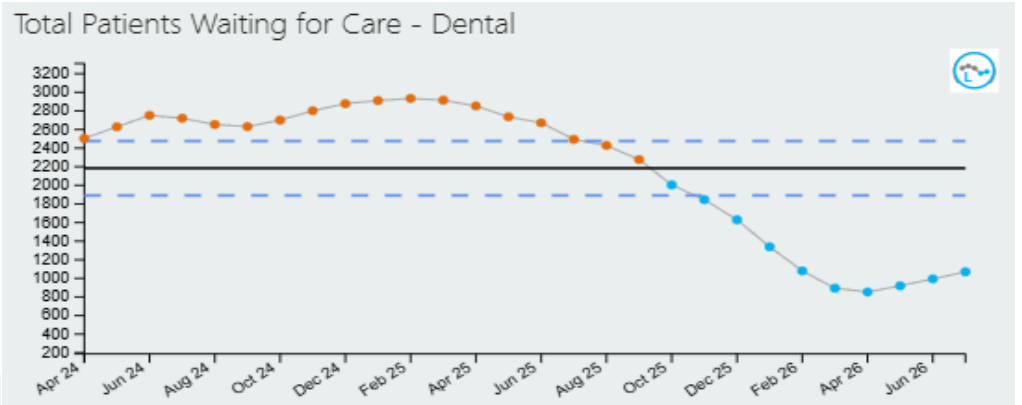
Domain: Access to Services | Accountable Exec: Sam Prince | Author: Samantha Steede

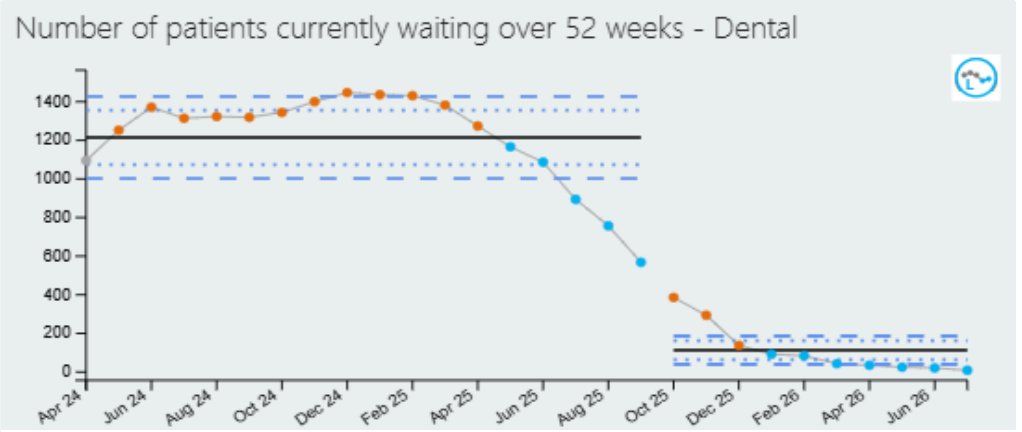
Target: No Target and 0 | Actual: 1070 and 9 | SPC Variation: | SPC Assurance: N/A | Data Quality: Medium Assurance

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 3 compared to 1,436 in January 2025. The remaining patients waiting over 52 weeks have all missed and/or declined appointments.

Following the transfer of patients to the LDI at the end of the last financial year, which led to a dramatic drop in the size of the waiting list and it's 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 patients weekly, and notes are placed on each patient record to flag the importance of appointments (if are cancelled/not attended).

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. The service is also recruiting 4 additional dentists which will support with managing the waiting list.

When do we expect to see improvement?

The remaining 52+ week waits are largely remaining due to last minute appointment cancellations and the service is working through arranging new appointments or discharge options. The service is recruiting 4 new dentists, which will stop the growth in the waiting list.

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. Failure to recruit the new dentists will mean the waiting list will continue to grow again.

CAMHS Eating Disorders Waiting Times

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

Target: 0 and 95% | Actual: 0 and 100% | SPC Variation: H | SPC Assurance: F | Data Quality: High Assurance

What is the trend we see?

Due to the successful implementation of several changes, the service has met all performance targets in July and only recorded 1 breach of the urgent care waiting time standard in June.

What is being done about it?

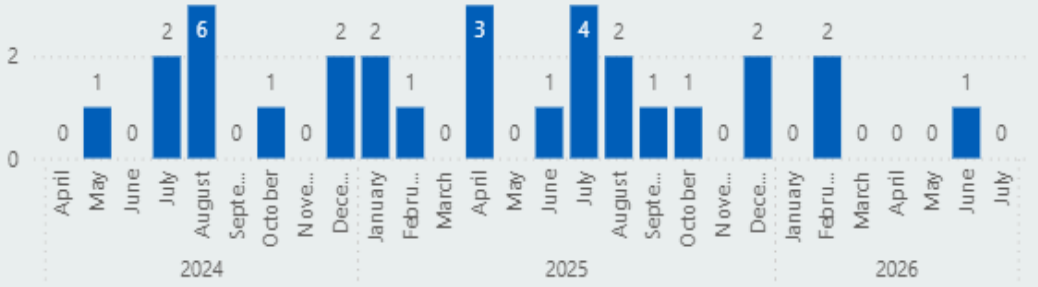
Recruitment has taken place and all new staff have now started and are inducted. Further breaches are not anticipated as there is currently capacity within the team.

Will continue to monitor referral rates each week as summer is known to be a quieter period regarding referrals and there are often spikes on return to education.

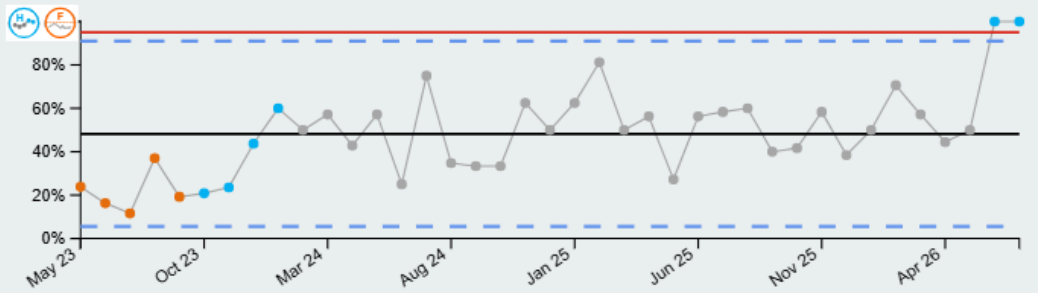
When do we expect to see improvement

No further improvement needed, but routine performance monitoring will continue through Business Unit Performance Oversight Group.

Number of CAMHS Eating Disorder patients breaching the 1-week standard for urgent care



% CAMHS Eating Disorder patients currently waiting less than 4 weeks for routine treatment



What are the risks to delivery?

Higher levels of seasonal demand from September may create pressure, but higher capacity in the team is expected to be sufficient

IAPT – Percentage of People Receiving First Screening Appointment within 2 Weeks of Referral

Leeds Community Healthcare NHS Trust

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

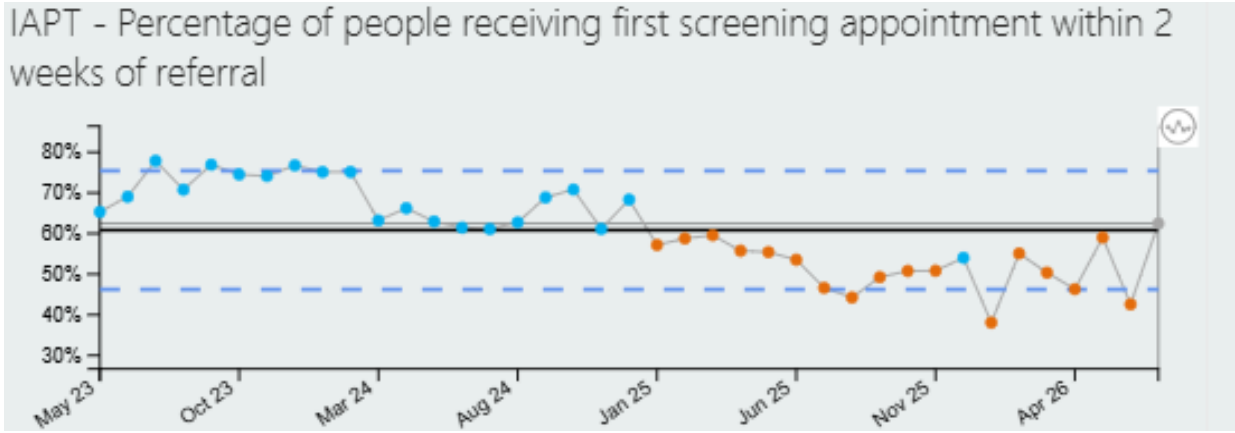
Target: No Target | Actual: 62% | SPC Variation: | SPC Assurance: N/A | Data Quality: Medium Assurance

What is the trend we see?

The data shows that the screening process is under pressure and taking longer than it has historically. This trend has been apparent since Feb 2024 (when service criteria expanded significantly) and then again in the summer of 2025. Pressure has remained on the screening process since then.

Pressure on the screening process is the result of staff shortages; existing screening staff have taken up internal promotions or have moved externally. In addition, there is a significant level of staff sickness.

The staffing level has always been tight. This means that small changes in staffing push demand above capacity and backlogs can build up.



What is being done about it?

The service has utilised Service Delivery Funding from the ICB to appoint an agency member of staff to complete screenings temporarily.

The service is investing in Trainee PWPS across the year to ensure the screening hub staffing is sufficient

A move to "Choose and book" as this is a known pressure point and the service has completed a Step 2 workforce review to ensure we are working towards the most efficient and effective staffing ratio.

When do we expect to see improvement

Improvement should begin to be seen over the next 6 months.

'Choose and book' is due to be implemented in 3 months.

The new cohort of PWP trainees in September will further support improvement.

What are the risks to delivery?

Changes to the wait for initial screening have no impact on the wait for full treatment.

IAPT – Percentage of People Referred Should Begin Treatment Within 6 Weeks of Referral

Leeds Community Healthcare NHS Trust

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

Target: 75% | Actual: 81% | SPC Variation: | SPC Assurance: | Data Quality: Medium Assurance

What is the trend we see?

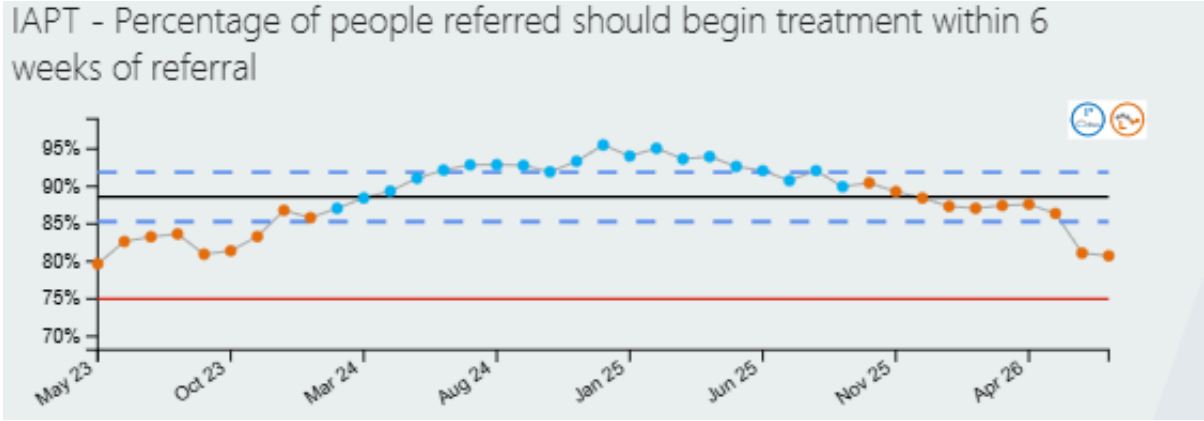
There has been a sustained decline in the percentage of patients commencing treatment within six weeks of referral over the last 12 months. Performance remained consistently above 90% throughout much of 2024 and early 2025 but has reduced steadily since mid-2025. The most recent two months show a more pronounced deterioration, with performance falling to approximately 80%, indicating increasing delays in patients accessing treatment within the required timeframe.

What is being done about it?

The service continues to review and manage capacity across the pathway to maximise access to treatment. Activity and waiting times are monitored closely, with available workforce deployed to prioritise timely progression from screening to treatment. The service is also reviewing processes to ensure capacity is used as efficiently as possible whilst maintaining quality and safe care delivery.

When do we expect to see improvement?

Improvement is dependent on stabilising workforce capacity and the service's ability to respond to increasing patient complexity. Whilst current actions are focused on mitigating the impact of reduced staffing, significant and sustained improvement is unlikely until workforce levels improve and capacity constraints are addressed. The impact of ongoing actions will continue to be monitored through routine performance reporting.



What are the risks to delivery?

Reduced workforce capacity following staff losses during Summer 2025.
Long-term sickness absence within the team, resulting in further capacity pressures.
Increasing complexity of referrals, requiring longer screening and assessment times per patient.
Continued mismatch between demand and available capacity, leading to further deterioration in access standards and treatment waiting times.

Finance & Productivity Domain Summary

Accountable Exec: Andrea Osborne

NHS Leeds Community Healthcare NHS Trust

Summary

The work of the Productivity LCH Steering Group continues. The group is embedding well and is bringing attention to service performance in this area. Analysis is planned in the coming months that will create focus on increasing contacts per WTE specifically. Recruitment to a business intelligence role to support productivity reporting has been successful and a new starter is expected to join the team towards the end of September.

The Data Quality Maturity Index (DQMI) is also included in the NOF measures for 2026/27. We have estimated that LCH will be 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
Percentage Spend on Temporary Staff	Jul-26	No Target	4%		
Data Quality Maturity Index (DQMI) - CSDS dataset score**	Mar-26	No Target	91%	H	
Data Quality Maturity Index (DQMI) - IAPT dataset score**	Mar-26	>=95%	98%	H	P
Data Quality Maturity Index (DQMI) - MHSDS dataset score**	Mar-26	>=95%	87%	H	F
Total agency cap (£k)	Jul-26	No Target	59.00		

Finance & Productivity Domain Summary

Accountable Exec: Andrea Osborne

Leeds Community Healthcare NHS Trust

Income & Expenditure: As at the end of July 2026, the Trust is reporting an adjusted year-to-date surplus of £0.214m against a planned break-even position. This favourable variance is primarily driven by income from one-off activities such as training and specialised patient care within Wharfedale. As these income streams are not expected to continue at the same level throughout the remainder of the year, the Trust is forecasting a break-even position in line with its planned financial position.

Capital: The Trust has incurred £1.835m of YTD capital spend compared to the planned £4.455m. This shortfall is due to the delay in the renewal of a lease at Kippax and lower than planned remeasurement costs for the CHP leases. The Capital forecast spend is £7.558m, £0.800m lower than plan due to the lower CHP remeasurement which as it is inter DHSC cannot be utilised on other capital projects in year.

Cash: The Trust's cash position remains strong, with a closing balance of £51.908m, higher than the planned figure by £2.808m. This was due to receipts from Leeds Council for quarterly contract income raised in June. The cash operating days, which is to pay short-term liabilities, is 79 days. Compliance with the Better Payment Practice Code (BPPC), our requirement to pay suppliers within 30 days or by the due date, is above target at 97.7% by both number and 98.1% by value of invoices.

Quality & Value Programme: As at the end of July 2026, the Trust has delivered £0.535m of recurrent savings against a planned target of £2.853m, resulting in a shortfall to plan at this stage of the year which is fully offset by non-recurrent savings. The full year savings target, including legacy savings of £2.460m, is £8.560m. Notwithstanding the current position, the Trust remains confident of achieving its full-year savings target of £8.560m recurrently. Several major programmes are progressing through implementation, including the Leadership Review, Adults Services staffing reviews, and Procurement and Digital non-pay savings initiatives, with most of the benefits expected to be realised during the second half of the year. The current forecast indicates recurrent savings delivery of £7.984m by year end. The forecast shortfall of £0.055m is expected to be offset through the delivery of additional non-recurrent savings, supporting achievement of the overall financial plan.

Temporary Staffing: As at the end of July 2026, the Trust is reporting a year-to-date overspend of £0.548m on temporary staffing costs, with temporary staffing expenditure representing 4.5% of gross staff costs, 1.0% above plan. The overspend is primarily attributable to the use of temporary staffing to maintain safe service delivery and cover vacancies within Neighbourhood Teams, alongside ongoing recruitment challenges across WYOI, Police Custody, 0-19 Services, Leeds Equipment Service (LES), and hard-to-recruit medical posts within CAMHS and ICAN. Temporary staffing utilisation within the 0-19 Service and Police Custody Service has been necessary to maintain commissioned staffing levels and mitigate the risk of contractual and performance-related penalties associated with understaffing. Whilst the year-to-date position remains above plan, temporary staffing expenditure is expected to reduce over the remainder of the year as substantive recruitment progresses. The successful filling of vacancies within Neighbourhood Teams, together with the cessation of part of the Police Custody Service, is expected to support a return to planned temporary staffing levels by year end. Temporary staffing costs within Leeds Equipment Service are fully rechargeable to the local authority and therefore do not present a net financial pressure to the Trust. A detailed review of temporary staffing usage is underway to develop a comprehensive reduction plan, including clear milestones, targets and delivery actions, with outcomes to be reported at Month 5.

Prior Year	Key Financial Indicators	YTD Plan	YTD Actuals	YTD Variance	Full Year Plan	Full Year Forecast	Full Year Variance
(951)	Adjusted (Surplus)/Deficit	-	(214)	**(214)**	-	-	-
49,922	Closing Cash Balance	49,100	51,908	**(2,808)**	49,387	49,987	**(600)**
10,221	Capital Expenditure (CDEL)	4,455	1,835	**(2,620)**	8,358	7,883	**(475)**
	Quality & Value Programme 26/27						
11,921	Recurrent Savings	2,035	457	1,578	6,100	6,100	-
2,079	Non Recurrent Savings	-	1,578	**(1,578)**	-	-	-
	Quality & Value Programme 25/26 - Legacy						
	Recurrent Savings	818	78	740	2,460	2,492	**(32)**
	Non Recurrent Savings		740	**(740)**	-	-	-
14,000	**Total Savings**	**2,853**	**2,853**	0	**8,560**	**8,592**	**(32)**
	Temporary Staffing						
2,329	Agency	412	636	224	1,233	1,233	-
5,564	Bank	1,600	1,924	324	4,801	4,801	-
7,893	**Total Temporary Staffing**	**2,012**	**2,560**	548	**6,034**	**6,034**	-
177,598	**Total Gross staff Costs**	**57,358**	**56,574**	**(784)**	**172,716**	**171,072**	**(1,644)**
4.4%	**Temp Staffing Costs as a % of gross staff costs**	**3.5%**	**4.5%**	**1.0%**	**3.5%**	**3.5%**	**0.0%**

Data Quality Maturity Index (DQMI) - MHDS Dataset Score

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

Target: 95% Actual: 86.8% SPC Variation: SPC Assurance: Data Quality: High Assurance

What is the trend we see?

Our MHDS DQMI has been low since Apr 2024.

Our overall DQMI score is now included in the NOF. MHDS contributes to the overall score along with a number of other data sets. Our overall DQMI score in March was 87.5%. This places us at 164 out of 193 providers and in segment 4.

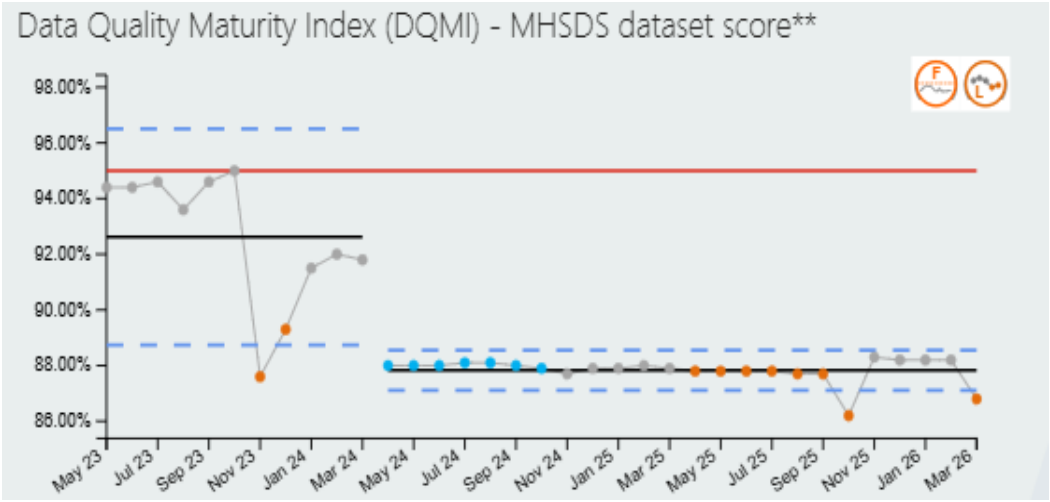
Alongside our MHDS this is being driven by low scores in Commissioning Data Sets (CDS) which include Outpatients (79.7%) and Admitted Patient Care (87.8%). We currently submit these data sets annually. The DQMI assesses data quality for the returns it expects a provider to make. If a provider submits the CDS once, the DQMI will expect that it is submitted for the next 2 months. This means in April and May LCH will score 0% for these data sets and our overall score will be very low. However, in June it is expected that these scores will be omitted again and our DQMI will recover.

The low DQMI scores in the CDS data we have submitted is mostly due to the absence of data fields that relate to consultant-led services e.g. consultant code, treatment code. We currently flow some non-consultant led pathway activity in the CDS. This means that we are unable to provide these fields.

What is being done about it?

The low MHDS DQMI is due to a change in the composition of the data set and relates to the movement of a data field from one table to another. This issue, along with other issues has been rectified in our July return and will result in a much-improved score.

We plan to start submitting the CDS monthly. Before that takes place, we want to review the contents of the data sets and undertake work improve the data quality. An options appraisal to update the contents of the CDS is currently underdevelopment and this will consider the impact on our DQMI. We are aiming to start submitting the aligned and improved CDS for September data in November. This timeframe enables consideration of the data set changes by Digital Programme and Digital Portfolio Board. An assessment of the impact of changes on the DQMI will be carried out as part of this work.



When do we expect to see improvement

We can expect an improvement for MHDS in the June DQMI. Due to the 3-month delay in reporting this will inform Q2 NOF scores.

It is also expected that June's DQMI will omit our CDS scores. This will further improve our Q2 NOF Scores.

If we start to submit monthly data to the CDS from November (September's data) this will contribute to our Q3 NOF score.

What are the risks to delivery?

The Waiting List Minimum Data Set (WLMDS) has recently been included in the experimental DQMI and will be included in DQMI scores from Q2. Since LTHT agreed to take accountability for our Community Gynaecology waits we no longer submit to this data set and therefore have a 0 score. The experimental data set currently counts this towards our overall score. As per the CDS, ultimately, we do not expect the WLMDS to contribute to our score, but it is unclear if it will be omitted in Q2 when the experimental DQMI is implemented.

Effectiveness & Experience of Care Domain Summary

Accountable Exec: Heather McClelland

NHS Leeds Community Healthcare NHS Trust

Summary

NICE Guidance: Compliance with NICE guidance remains high, with 96% of applicable guidance published in the year prior to the last financial year assessed as compliant. Compliance with guidance published in the last financial year is 84.5%, reflecting ongoing implementation and assessment activity for recently published guidance. One guideline, NG197 Shared Decision Making, remains subject to ongoing action. A review is underway to determine whether compliance can be evidenced through existing training, care planning, supervision and audit processes, informed by approaches adopted by Leeds and York Partnership NHS Foundation Trust. Oversight continues through established NICE governance arrangements, with escalation and monitoring of outstanding actions where required.

Level of assurance: High assurance

National Audits: National audit participation remains stable. Eight national audits are currently relevant to LCHT, with full data submitted to five audits. Two audits remain on hold due to external system and capacity constraints (SSNAP and NACR), and work continues to improve data quality for NAED through collaboration with Business Intelligence and Clinical Systems colleagues. Oversight is maintained through established governance arrangements, with ongoing monitoring of participation, barriers to submission and data quality.

Level of assurance: High assurance

Clinical Audits: A total of 16 clinical audits were completed during Quarter 1. The reported completion rate for Priority 2 audits is currently 1%; however, this figure should be interpreted with caution as services are still reviewing audit plans for the current cycle,and a significant number of audits remain with no priority, activity or status being recorded and are pending review. 262 audits are currently recorded across Trust audit plans as part of a rolling audit programme, but not all are expected to be active or complete within the current year. Work is underway to support services to review and update audit plans, improve recording of audit activity and strengthen organisational oversight of progress and completion.

Level of assurance: Moderate Assurance

Sub Domain Summary Performance

Data Quality : **Low Assurance**

Performance: Holding Steady

KPI	Reporting Month	Target	Actual	Performance	Assurance
Total Number of Formal Complaints Received	Jul-26	No Target	8		
Number of Compliments	Jul-26	No Target	49		
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	Jun-26	>=95%	95%		
Number of NICE guidelines with full compliance versus number of guidelines published in the year prior to last financial year applicable to LCH	Apr-26	100% by year end	96%		
Number of NICE guidelines with full compliance versus number of guidelines published last financial year applicable to LCH	Apr-26	No Target	85%		
NCAPOP audits: number started year to date versus number applicable to LCH	Apr-26	100% by year end	75%		
Priority 2 audits: number completed year to date versus number expected to be completed	Apr-26	100% by year end	1%		
Total number of audits completed in quarter	Apr-26	No Target	16		

Number of Compliments

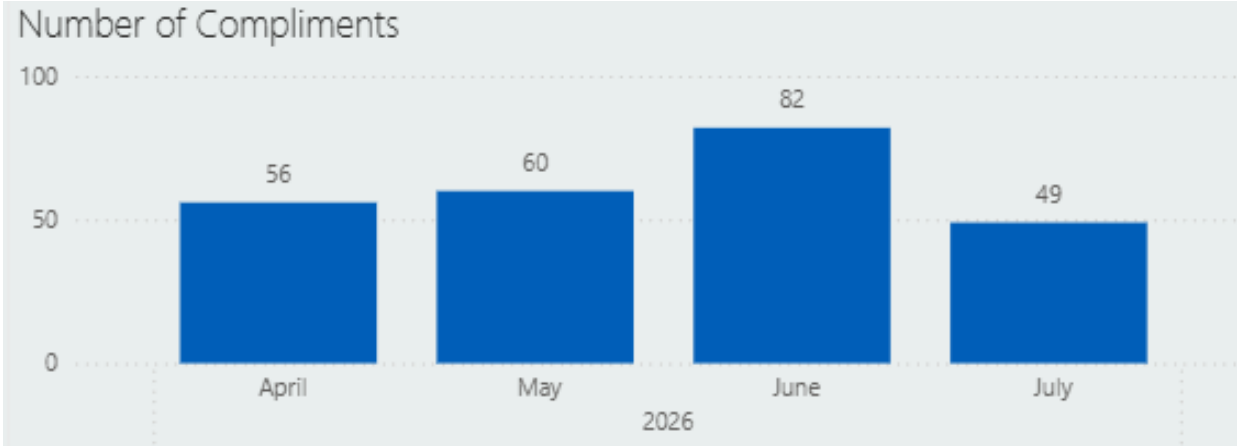
Leeds Community Healthcare NHS Trust

Domain: Effectiveness & Experience of Care | Accountable Exec: Heather McClelland | Author: Helen Rowland

Target: No Target | Actual: 49 | SPC Variation: N/A | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

The number of compliments received in July is 35% lower than the expected monthly average of 75 per month. This is below the mean level for reporting, however, remains within the trust normal variation .



What is being done about it?

Services are regularly encouraged to report compliments. Current joint work with LYPFT to build the new Datix cloud/DCIQ will help to streamline both the process for reporting and improve analysis of data moving forward to create a greater level of assurance for the Trust.

What are the risks to delivery?

When do we expect to see improvement?

Within the next 12 months reporting period.

Total Number of Formal Complaints Received

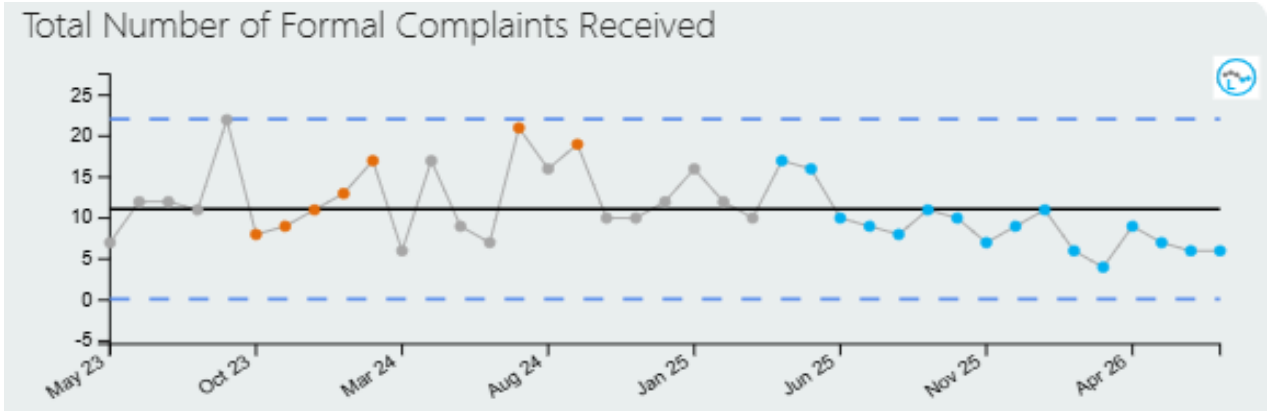
Domain: Effectiveness & Experience of Care | Accountable Exec: Heather McClelland | Author: Karen Otway

Target: N/A | Actual: 8 | SPC Variation: | SPC Assurance: N/A | Data Quality: **Low Assurance**

What is the trend we see?

There were 8 complaints reported in July. It should be noted that due to the progression of the roll out of PHSO pilot complaint process to include additional services within the trust (10 services involved in total) the complaint data appears low.

Although not contained within the SPC chart we also received a further 24 PHSO complaints which would give a total number of complaints reported in July as 32 which is consistent with usual reporting levels just below the mean and is within normal variation for the Trust .



What is being done about it?

Current work is ongoing to map LCH and LYPFT complaints policies/processes to ensure all align.
Plan to continue to roll out PHSO to the remainder of LCH services by December 2026 and then this will create more consistency within datix and BI data systems to provide enhanced assurance .
Joint work has commenced to build the new Datix Cloud DCIQ with LYPFT which will streamline reporting and analysis of data and support an improvement in data quality and greater assurance around data intelligence narratives.

When do we expect to see improvement

By the end of Q4 2026/27.

What are the risks to delivery?

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

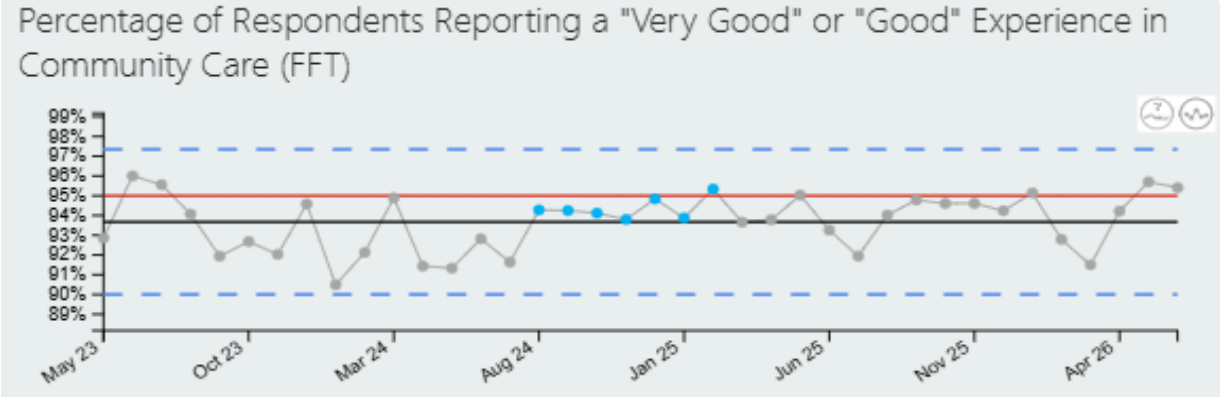
Leeds Community Healthcare NHS Trust

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

Target: 95% | Actual: 95% | 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 an increase noted in the last two months of the data documented whereby the target has been achieved.



What is being done about it?

Services continue to review themes and identify areas and services where "very good" and "good" has dropped below the expected target to inform learning and improvements. To improve data quality assurance levels, work has commenced to standardise the Friends and Family Test (FFT) across all services.

When do we expect to see improvement

The aim for completion on standardisation of FFT is by end Quarter 3 2026/7.

What are the risks to delivery?

The Patient Involvement (previously known as Engagement) Manager's work to standardise the FFT process has been paused since May 2026 to support absence in the wider Clinical Governance Team. The work is intended to strengthen data quality assurance and improve the ability to undertake Trust wide analysis of both quantitative and qualitative feedback. As a result, the original completion timeline has been delayed, with completion now anticipated by the end of Quarter 3 2026/7.

Improving Health & Reducing Inequalities Domain Summary

Accountable Exec: Ruth Burnett

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 consultant-led services are being sustained. Non-consultant led services remain above target, meaning that people in IMD1 remain more likely to wait longer than the rest of the population, and the odds ratio shows early indications of a reversal in the previous quarter's increase in likelihood of longer waits.

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	Jul-26	<=1.0	0.89	L	P
Difference in access to services for patients living in IMD1 vs IMD2-10 - Consultant led 52 week standard	Jul-26	<=1.0	0.74	L	P
Difference in access to services for patients living in IMD1 vs IMD2-10 - Non-Consultant 18 week standard	Jul-26	<=1.0	1.14		F
Percentage of open records with blank or null codes for ethnicity	Jul-26	No Target	1%		
Percentage of open records with residual ethnicity codes	Jul-26	No Target	2%		
Percentage of open records with a valid, non-residual ethnicity code	Jul-26	>=71.6%	97%		P

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

Leeds Community Healthcare NHS Trust

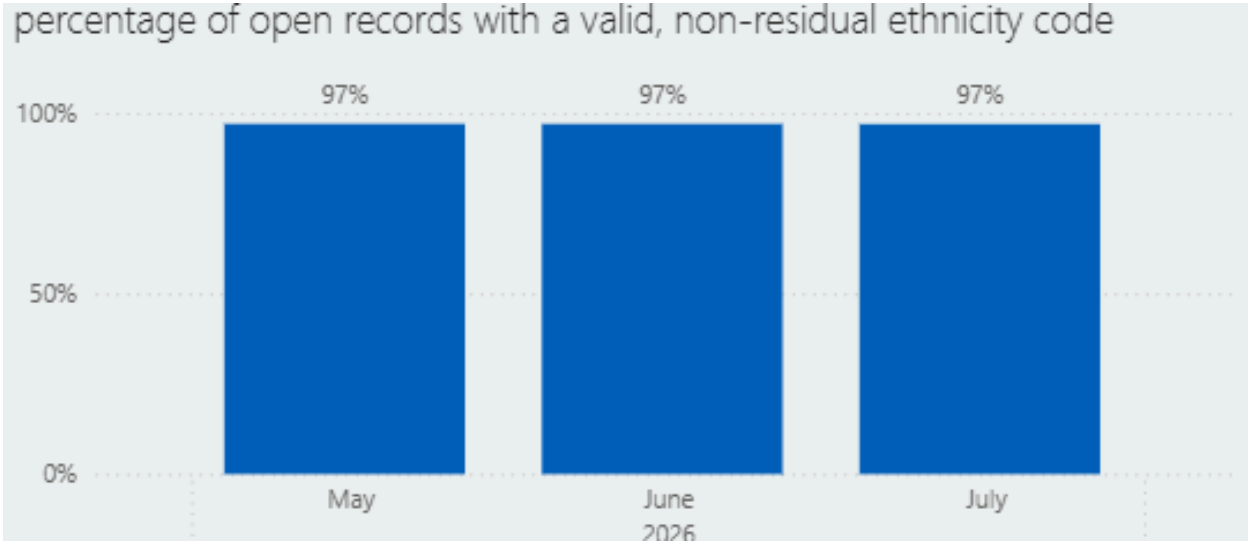
Domain: Improving Health & Reducing Inequalities | Accountable Exec: Ruth Burnett | Author: Victoria Douglas-McTurk

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

What is the trend we see?

Ethnicity data recording is a new measure and at 97% is significantly above the national benchmark (71.6%) for community trusts.

The remaining records are 1% blank or null codes (a code is not recorded or the code entered is not in the data dictionary) and 2% residual ethnicity codes, such as ‘any other background’, ‘not known’ or 'not stated'.



What is being done about it?

Work to further improve recording is aligned to the implementation of About Me and supports delivery of the trust's Racial Equity in Care work plan.

The pilot of the About Me digital questionnaire is underway, with roll-out for all new referrals planned for Q3. A business case is being submitted (September 2026) for resources to deliver the digital questionnaire to all existing open referrals.

The new admin services model will incorporate completion of About Me into the function of the bookings team.

When do we expect to see improvement

The roll-out of the digital questionnaire and the digital questionnaire (pending decision on the business case) being sent to all existing open referrals will make improvements in Q3 and 4.

What are the risks to delivery?

Funding not being allocated for the About Me digital questionnaire to be sent to all existing open referrals will mean that remaining ethnicity data would need to be captured manually either by admin or by clinicians in future appointments.

Timescales of other significant changes such as the admin services restructure and Trust Integration Programme may reduce or delay capacity to consistently complete and report on About Me.

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: 0.74 & 0.89 | SPC Variation: | SPC Assurance: N/A | Data Quality: High Assurance

What is the trend we see?

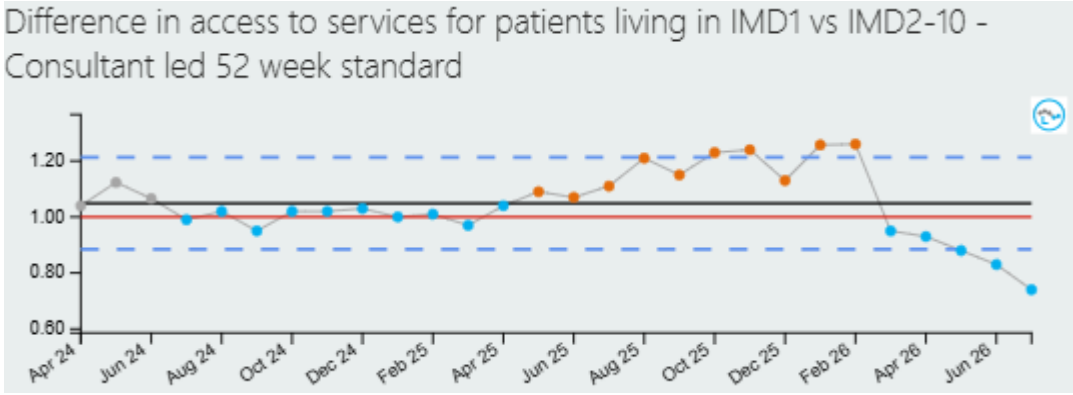
Consultant-led 52-week and 18-week standard waiting times both continue to reduce in likelihood of patients in IMD 1 (our most deprived areas) waiting longer than the rest of the population. Consistently below 1 indicates that people in our most derived communities are not experiencing inequity in waiting times in these services.

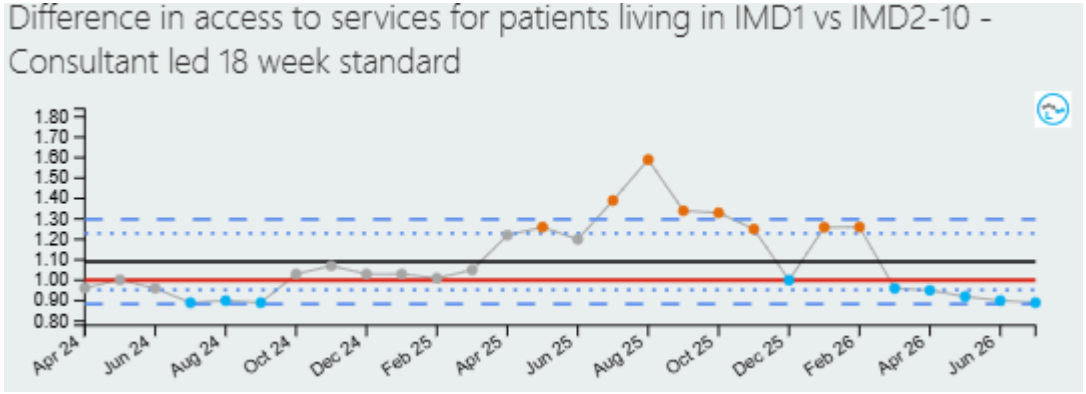
What is being done about it?

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: 1.14 SPC Variation: SPC Assurance: N/A Data Quality: High Assurance

What is the trend we see?

Early indication that an increase in the last quarter of the likelihood of patients in IMD1 (our most deprived areas) waiting longer for access to these services compared to the rest o the population is starting to reverse. The odds ratio is still within standard deviation ranges, but above target of 1.

What is being done about it?

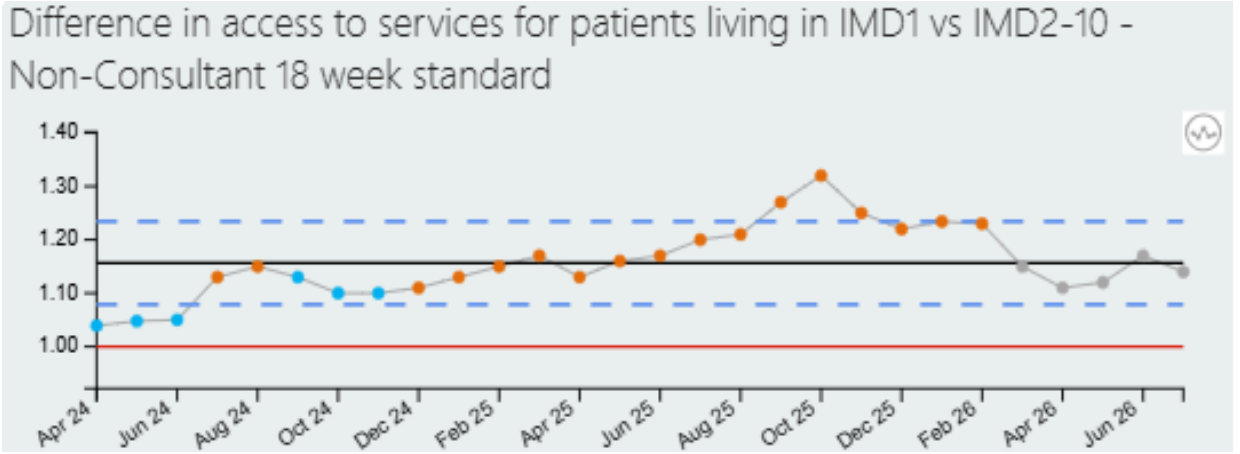
Work to support attendance at appointments continues, with specific focus on intersectionality with ethnicity and deprivation, aligned to our Racial Equity in Care work. Further analysis of missed appointment data will support identification of further areas of focus and improvements that specifically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

Services with the longest waits are reviewing their equity data, driver diagrams and progress on delivery of the improvements identified. This is being reported through the Access LCH group.

Work on increasing recording of reasonable adjustments and communication needs through the 'About Me' template on SystmOne continues to increase awareness of the support people may require to attend and enable adjustments to be put in place in a more timely and consistent manner.

When do we expect to see improvement

Improved recording of About Me and 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

Leeds Community Healthcare NHS Trust

Summary

PSII completions continue to improve but some investigations continue to take longer than planned to complete. This is due to capacity for investigators to complete on time and within the Patient Safety Team. Recruitment is under-way to support this process.

Outstanding PSII actions are reducing and work with the BU's to address and maintain oversight of the actions continues. Teams have reviewed actions and updated completion dates where agreed and are encouraged to monitor completion through Performance Oversight meetings.

The outstanding CAS alert has been reviewed with a plan to close this soon.

Performance in Patient Safety Training and Duty of Candour compliance is high. All teams (100%) have now completed a Medicines Code Assurance.

Domain Summary Performance

Data Quality : **Medium Assurance**

Performance: **Off Track**

KPI	Reporting Month	Target	Actual	Performance	Assurance
Number of Patient Safety Incident Investigations (PSII)	Jul-26	No Target	3		
Attributed MRSA Bacteraemia - infection rate**	Jun-26	0	0		P
Clostridium Difficile - infection rate**	Jun-26	3	0		P
Never Event Incidence**	Jul-26	0	0		P
CAS Alerts Outstanding**	Jul-26	0	1		F
Compliance in Level 1 and 2 Patient Safety Training	Jul-26	>=95%	91%	H	F
Compliance with statutory Duty of Candour	Jul-26	100%	100%		P
Number of overdue PSII actions	Jul-26	No Target	15		
Number of teams who have completed Medicines Code Assurance Check 1st April 2019 versus total number of expected returns	Jan-26	100% by year end	100%		P

Number of Patient Safety Incident Investigations (PSII)

Leeds Community Healthcare NHS Trust

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

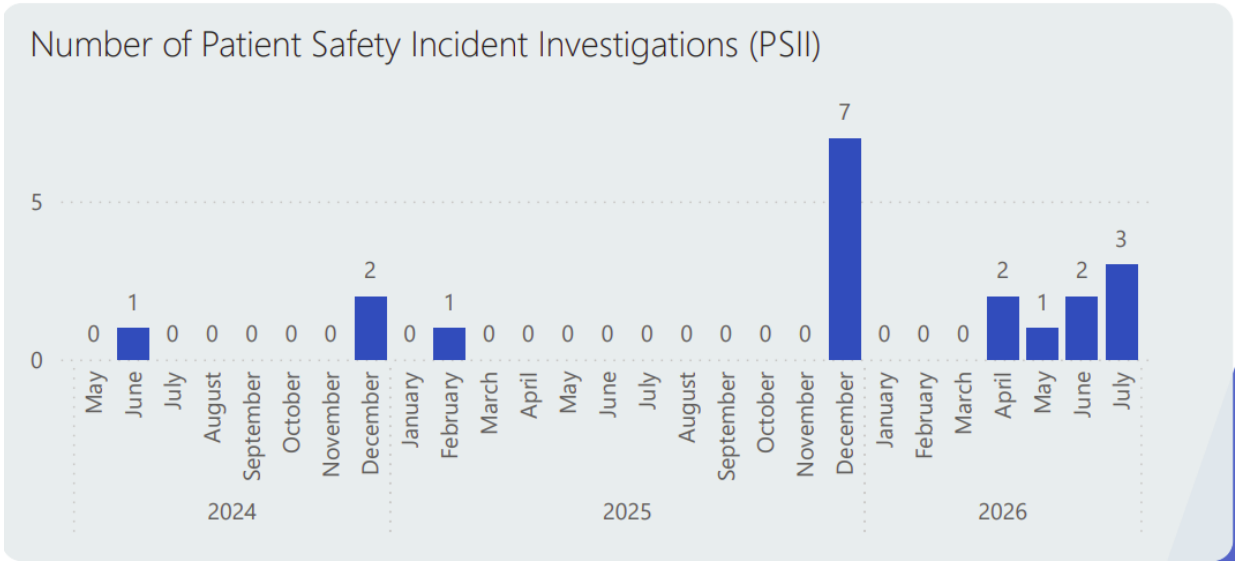
Target: No Target | Actual: 3 | Data Quality: High Assurance

What is the trend we see?

Five Patient Safety Incident Investigations were concluded and approved by an Executive Director in June/July 2026. Whilst investigation activity has continued and cases have been progressed to completion, all five investigations exceeded their original planned completion timescales. Two investigations were completed within six months , while three took longer than six months to conclude.

The trend indicates ongoing pressure on investigation capacity, resulting in extended completion times for PSII. Key contributing factors include:

- Lead investigators undertaking investigations alongside substantive roles, limiting the capacity to progress investigations within planned timescales.
- Unplanned workforce absence
- Delays in receiving information from external providers and extended sign off processes for multi organisational PSIIs
- Patient Safety Team capacity.



What is being done about it?

Risk ID 1357 remains on the Risk Register with a current rating of 12 (Moderate).

A formal PSII extension process has been introduced to strengthen oversight and ensure delays are identified, escalated and approved before completion dates are exceeded.

Early learning and actions are identified through Rapid Review Meetings to support timely patient safety improvements.

Recruitment to a Deputy Patient Safety Manager post is underway to strengthen PSII oversight and overall team capacity to support the Patient Safety workload.

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 and increased Patient Safety Team resource that PSII reports will not meet the agreed timescales for completion.

Number of Overdue PSII Actions

Leeds Community Healthcare NHS Trust

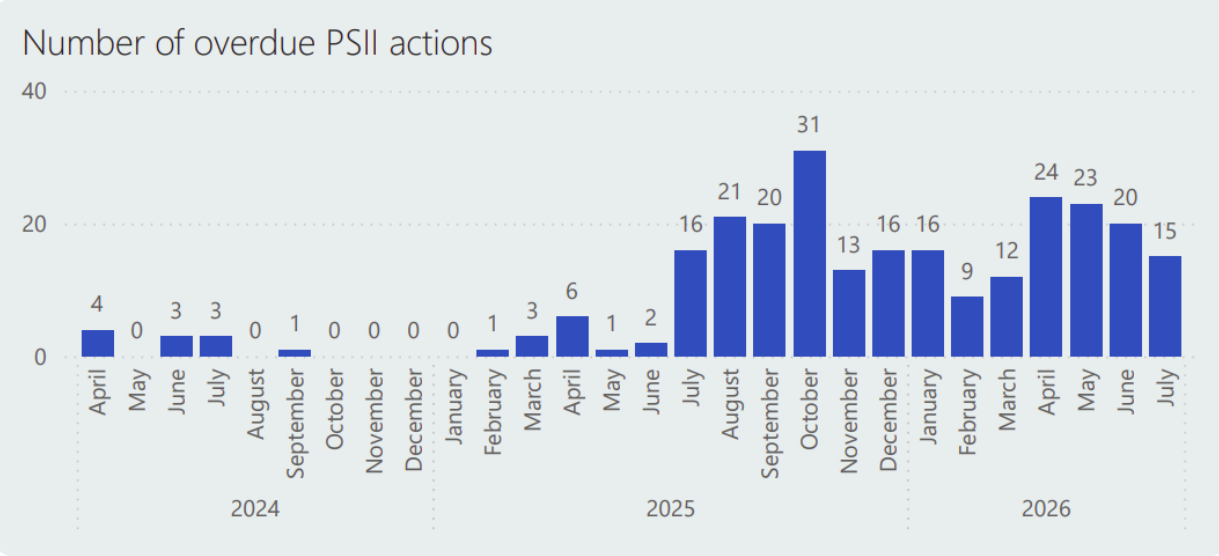
Domain: Patient Safety | Accountable Exec: Heather McClelland | Author: Sarah Yeomans

Target: No Target | Actual: 15 | Data Quality: High Assurance

What is the trend we see?

There are currently 15 overdue PSII actions in the incident reporting system, representing an improvement since the last reporting period. However, performance remains below the expected standard of zero overdue actions.

Overdue actions are distributed across business units with Corporate (7), Adult (5) and Specialist (3). Several actions are significantly overdue , with completion dates ranging from March 2025 to July 2026, indicating that some longstanding actions remain unresolved. While the overall number of actions has reduced, the length of time some actions have remained overdue highlights the need for a continued focus on completion and oversight to ensure learning from investigations is fully implemented and sustained.



What is being done about it?

The Patient Safety Team now notifies action owners when actions are assigned in the incident management system (Datix) to improve awareness and accountability. Business Units are also encouraged to monitor PSII actions through Performance Oversight Groups and local performance meetings. In addition, work is ongoing to ensure services are actively involved in the development of actions arising from PSII investigations, with this process being led by Learning Response Leads. The PSII Action Management One Minute Guide has been shared with all Learning Response Leads to support the development of robust, achievable actions and improve ownership and timely delivery.

When do we expect to see improvement

Improvement is expected over the next 3-6 months as strengthened oversight arrangements are embedded, overdue actions are actively reviewed and Learning Response Leads work with services to develop robust and achievable actions arising from PSII investigations, supporting timely updates and closure.

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.

Compliance In Level 1 and 2 Patient Safety Training

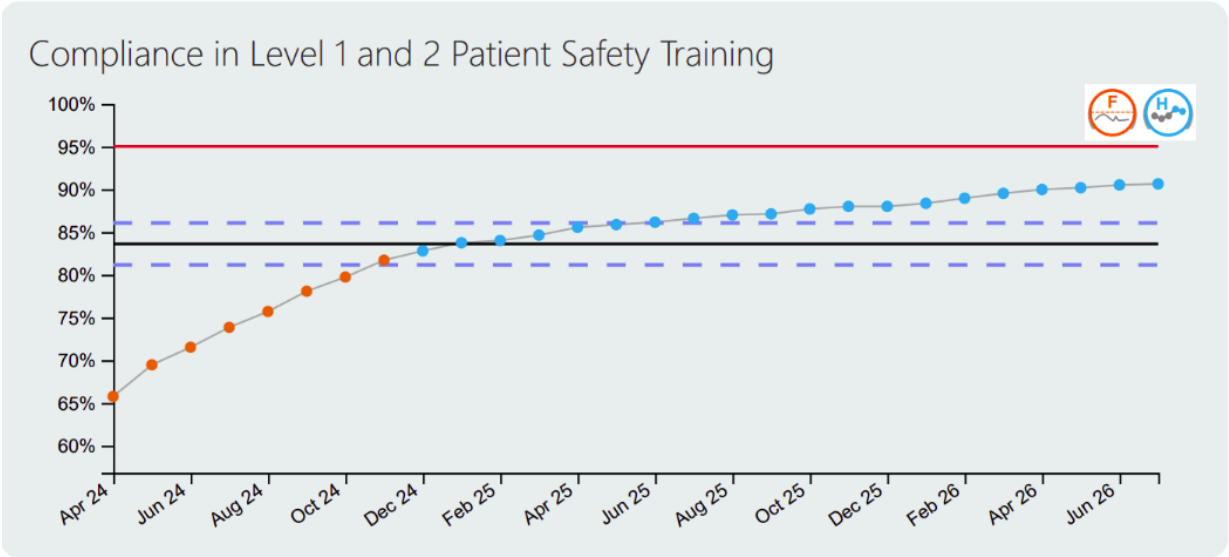
Leeds Community Healthcare NHS Trust

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

Target: 95% | Actual: 90% | SPC Variation: H | SPC Assurance: F | 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?

CAS Alerts Outstanding

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

Target: 0 | 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. This was discussed on 7 July 2026 between the Director of Nursing, Deputy Director of Nursing, Chief Communication Officer and the Medical Device Safety Officer and it was agreed that this CAS should be closed and moved to the risk register where it would be better managed in view the available resources and in accordance with compliance. This will formally take effect at the quality committee meeting in September 2026.

What are the risks to delivery?

None anticipated

When do we expect to see improvement

The time frame for improvement will be dependent on the available resources on this work from September but, whatever the case, work of risk assessment is progressing as fast as possible.

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 three RIDDOR-reportable incidents in June and July. 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
Staff Turnover	Jul-26	<=14.5%	9%	L	P
Total sickness absence rate (Monthly) (%)	Jul-26	<=6.5%	7%	H	?
AfC Staff Appraisal Rate	Jul-26	>=90%	81%	L	F
Statutory and Mandatory Training Compliance	Jul-26	>=90%	90%		?
'RIDDOR' incidents reported to Health and Safety Executive	Jul-26	No Target	2		
Starters / leavers net movement	Jul-26	>=0 in favour of starters	0		?
The overall percentage of staff who have identified as BME (including exec. board members)	Jul-26	14%	16%	H	P

‘RIDDOR’ Incidents Reported to Health and Safety Executive

Leeds Community Healthcare NHS Trust

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

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

What is the trend we see?

Sprained Wrist (Leeds Community Equipment Service) : during a bed exchange, the staff member was loading an Extra Wide Woburn bed onto a tail-lift van parked on a dropped kerb. While operating the tail lift, the bed swung unexpectedly due to the road gradient jarring his left wrist and causing a sprain.

Lower back strain with subsequent sciatica, causing pain radiating from the lower back into the leg (Recovery hub, physiotherapy). While attending a care home, a patient who was sitting on the edge of the bed suddenly attempted to lie back with force. To prevent injury to the patient, the colleague supported and steadied her while other staff adjusted the bedding.

What is being done about it?

Staff reminded of SOP 23a regarding brake application during vehicle loading/unloading. Managers to ensure staff working across teams are briefed on relevant SOPs.

Staff reminded of safe moving and handling practices and the importance of seeking colleague support when assisting patients.

What are the risks to delivery?

When do we expect to see improvement

Workforce Total Sickness Absence rate (Monthly) (%)

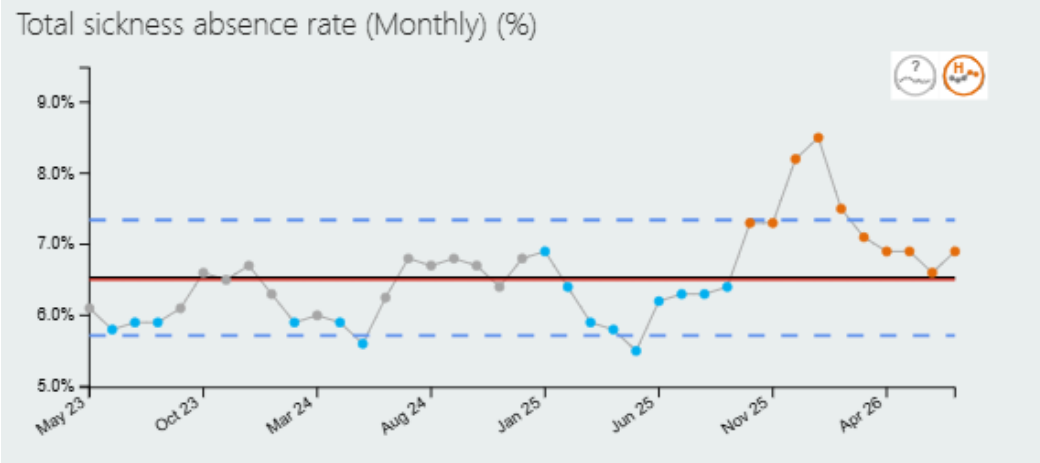
Leeds Community Healthcare NHS Trust

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

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

What is the trend we see?

Since late 2025, sustained reduction has been observed, with absence levels declining steadily throughout 2026. Recent performance indicates that the gap to target has narrowed significantly, with rates now stabilising at around 6.7%, close to the Trust target of 6.5%. Whilst continued monitoring is required, the overall direction of travel in recent months is positive.



What is being done about it?

Data and reporting continue to help identify absence trends and the factors contributing to sickness absence across teams.

A range of measures remain in place to support attendance management, including the Managing Absence with Confidence programme and ongoing Occupational Health guidance to help managers make effective and timely referrals.

Monthly Compass meetings are used to review absence data and provide targeted support to services with higher levels of both short and long-term sickness absence.

While recent improvements have been seen, sickness absence continues to be affected by factors such as service pressures, workforce capacity and management challenges. Ongoing focus and targeted support will therefore be required to sustain and build on the progress made.

When do we expect to see improvement

Recent data indicates that improvement is already underway. Whilst further reductions are expected over the coming months, progress is likely to be gradual given the complex factors that influence sickness absence. Ongoing monitoring and targeted support will remain in place to help sustain the positive direction of travel.

What are the risks to delivery?

Whilst sickness absence has reduced significantly from the peak observed in late 2025 and is now approaching the Trust target, there remain risks to workforce capacity, operational performance and financial sustainability where absence levels continue to exceed target. Ongoing workforce pressures and service demand may impact the sustainability of recent improvements, and targeted support will continue to be required to ensure attendance gains are maintained and further reductions achieved.

AfC Staff Appraisal Rate

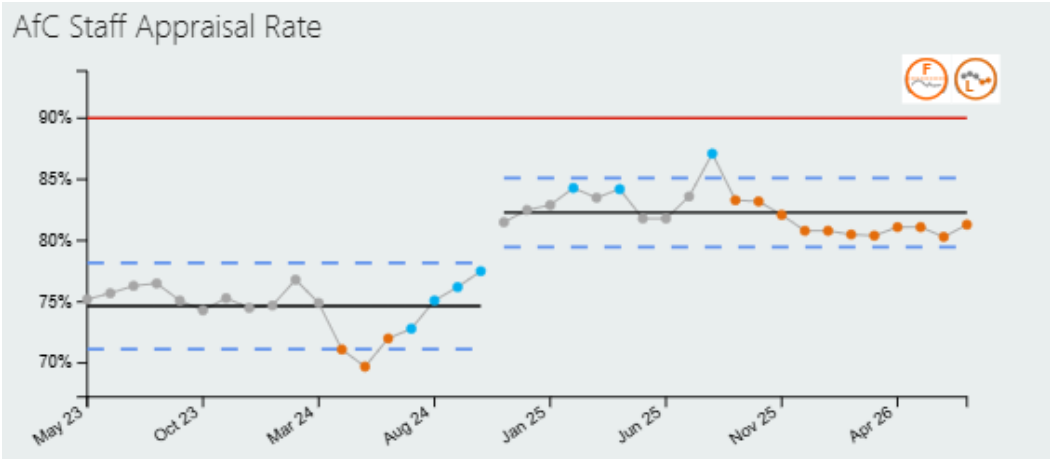
Leeds Community Healthcare NHS Trust

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**

What is the trend we see?

Although compliance has gradually declined since its peak in July 2025, it remains higher than at any point in the previous two years. Based on historical trends, compliance is expected to improve following the summer holiday period, with rates anticipated to return to around 85%.



What is being done about it?

A paper has been prepared for People and Culture Committee to propose lowering the appraisal target to 85%, in line with LYPFT.

Appraisal compliance is consistently monitored through Performance Panels, with targeted messaging and support offered to services whose performance remains significantly below target.

When do we expect to see improvement

It is anticipated that appraisal compliance will improve as a result of the scrutiny and accountability provided through performance meetings.

What are the risks to delivery?

Competing priorities

Operational pressures including sickness absence and staff engagement action planning and increasing demands from Trust integration, may reduce focus on appraisal completion.

Inconsistent local ownership

Variations in local accountability and prioritisation of appraisals may lead to uneven performance and slower overall improvement.

Limited managerial capacity

Managers with large portfolios may lack the capacity to complete appraisals within expected timescales without additional support or clearer prioritisation.

Digital Key Performance Indicators – Summary August 2026

NHS Leeds Community Healthcare NHS Trust

Summary

- This second set of Digital KPIs to be reported and should be considered a developmental as 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.
- The measures for SAR and FOI requests are not accurately reflecting actual performance and will be worked on to ensure this is representative
- 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, although it has become clear that actual performance is impacted by software release cycles, so if the report is run directly after a patch is released, compliance will be low
- Performance around incident detection and response times are impacted by the availability of internal resource.
- IT service desk performance has remained positive but has seen a rise in calls abandoned

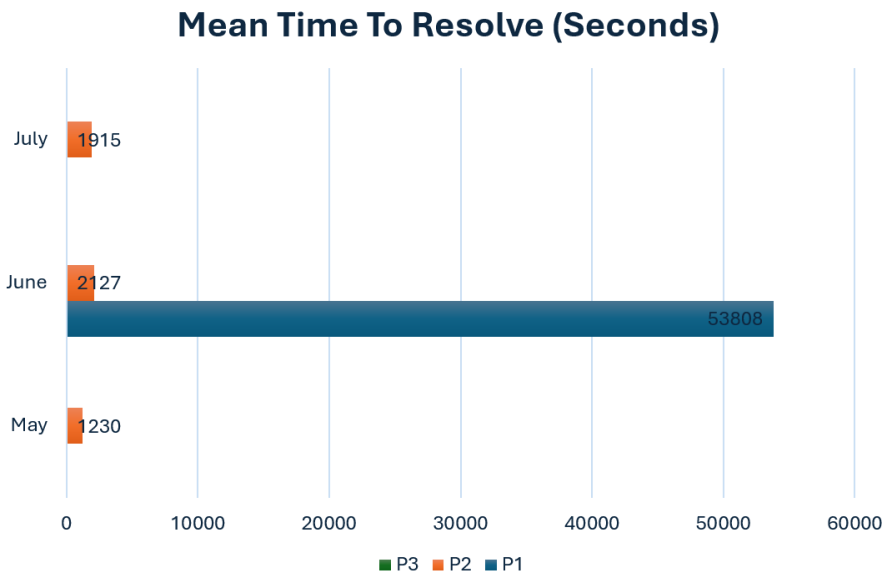
Domain	Metric	May 26			June 26			July 26			Comment
		Value	Target	RAG	Value	Target	RAG	Value	Target	RAG	
Patch Compliance	Confidential										
Exposure Score	Confidential										
Cyber Alerts	Acknowledged within 48 hrs	100%	100%	G	100%	100%	G	100%	100%	G	National Target
	Remediated within 14 days	-	100%	G	-	100%	G	100%	100%	G	National Target
SIEM	Mean time to detect incidents P2	35secs	21 secs	A	11 secs	21 secs	G	24 secs	21 Secs	A	Local target calculated as average of last 3 months
	Mean time to detect incidents P3		46 secs	A	-	-		-	-		
	Mean time to resolve incidents P2	27mins	< 4hrs	G	35 mins	< 4hrs	G	32 mins	< 4hrs	G	Local target based on common SLA standard, P 2 resolved < 4 hours
	Mean Time to resolve incidents P3		<24 hrs		-	-		-	-		Local Target based on common SLA standard, P3 <24 hours
	Response Effort for Incidents P2	16 hrs	40 hrs	G	41 hrs	40 hrs	A	40 hrs	40 hrs	G	Local Target calculated as average of last here months
	Response Effort for incidents P3		7 hrs		-	-	-	-			Local Target
Service Desk	Calls Answered	88.8%	>=85%	G	90.8%	>=85%	G	89.3%	>=85%	G	ITIL Standard
	Average Answer Time	2 mins	2 mins	G	2 mins	2 mins	G	2 mins	2 mins	G	ITIL Standard
	Abandonment	11%	<= 5%	A	10%	<= 5%	A	10%	<= 5%	A	Local Standard
SAR Performance	Late – not within 1 calendar month	0	0								National Target
FOI Performance	Late > 20 working days	0	+95%								National target

Digital Key Performance Indicators – Mean Time to Resolve Incidents

The P1 spike in June was triggered because of a planned penetration test.

The alert was kept intentionally active until the testing was completed to enable the team to distinguish between alerts generated by the penetration test and those resulting from genuine anomaly detections.

The Trust achieved 100% compliance with P2 incident resolution targets during the last two months, demonstrating effective and timely incident management.



P1 Incidents: Cyber incident is a critical event causing a total business outage, active data breach, or catastrophic system failure that requires immediate, round-the-clock emergency response

P2 Incidents: (High/Urgent) – Indicates a security incident that requires immediate attention to mitigate risk, but it has not caused a major failure.

Example – Suspicious or Unauthorised admin logon

P3 Incidents: (Medium) --- Represents a moderate-to-low priority event. It involves suspicious activity that warrants attention but does not indicate imminent compromise.

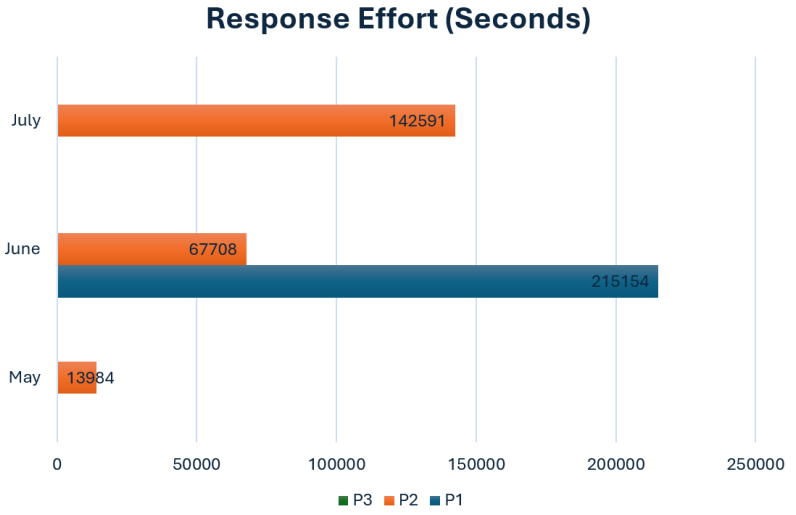
Example – Repeated Failed Login

Digital Key Performance Indicators – Response Effort for Incidents

The total response effort for incidents indicates the resources dedicated to managing issues, from acknowledgement to full resolution.

A higher sum of response effort for high priority incidents indicate their complexity or the need for additional resources, while lower sums for lower priority incidents suggest more efficient handling.

The spike in P2 incidents resolutions times for June was attributed to staff absences, as although the notification was received, there was unavailability of technical resource a symptom of the known poor resilience. Recruitment is underway to strengthen 2nd and 3rd line response



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Example – Repeated Failed Login

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

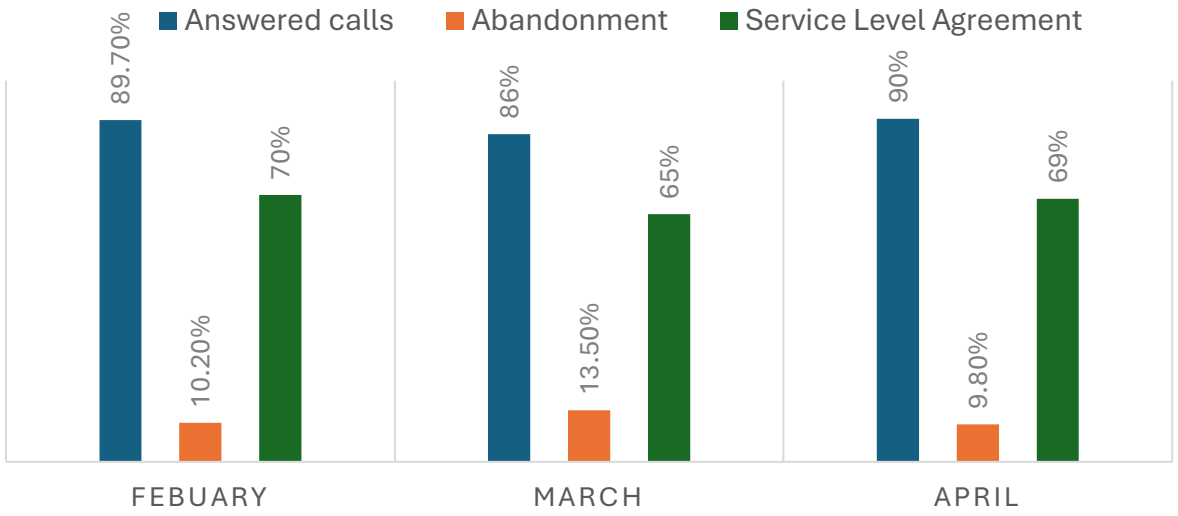
Queue Performance by Month

[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.

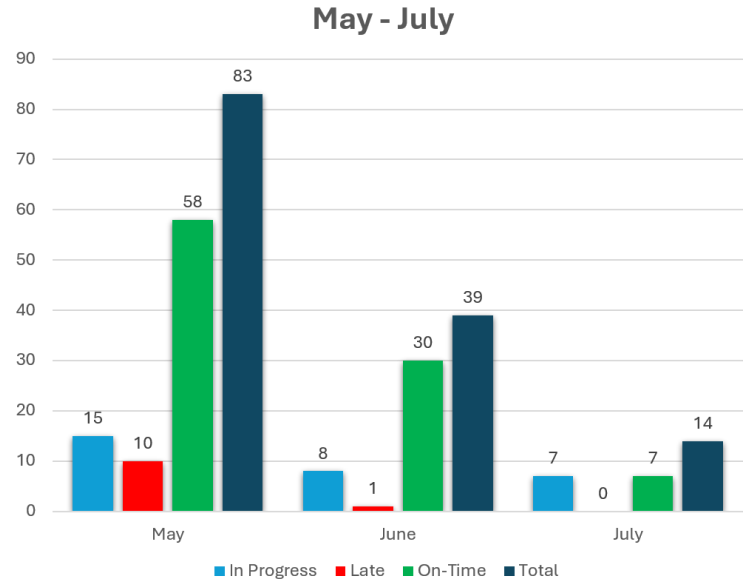
Targets:
>=85% of call answered
Average Answer time <=2 mins
Abandonment <=5%

Digital Key Performance Indicators – Subject Access Requests (SARs) May – July 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.

There are difficulties in accurately reporting "late" SARs because exemptions can be applied, further information or process issues with the requestor can legitimately delay responses. The information continues to be included here, whilst improvements in reporting capabilities are explored, however no overall RAG rating has been applied.

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)

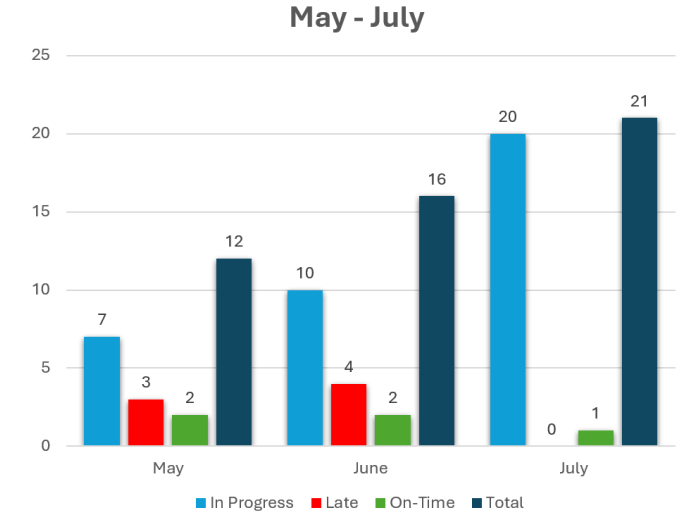
A dedicated initiative to reduce the number of late FOIs in both the Finance and IT departments has been in operation over the past 10months and performance has improved.

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.

There are difficulties in accurately reporting "late" FOIs because exemptions can be applied, further information or process issues with the requestor can legitimately delay responses. The information continues to be included here whilst improvements in reporting capabilities are explored, however no overall RAG rating has been applied.

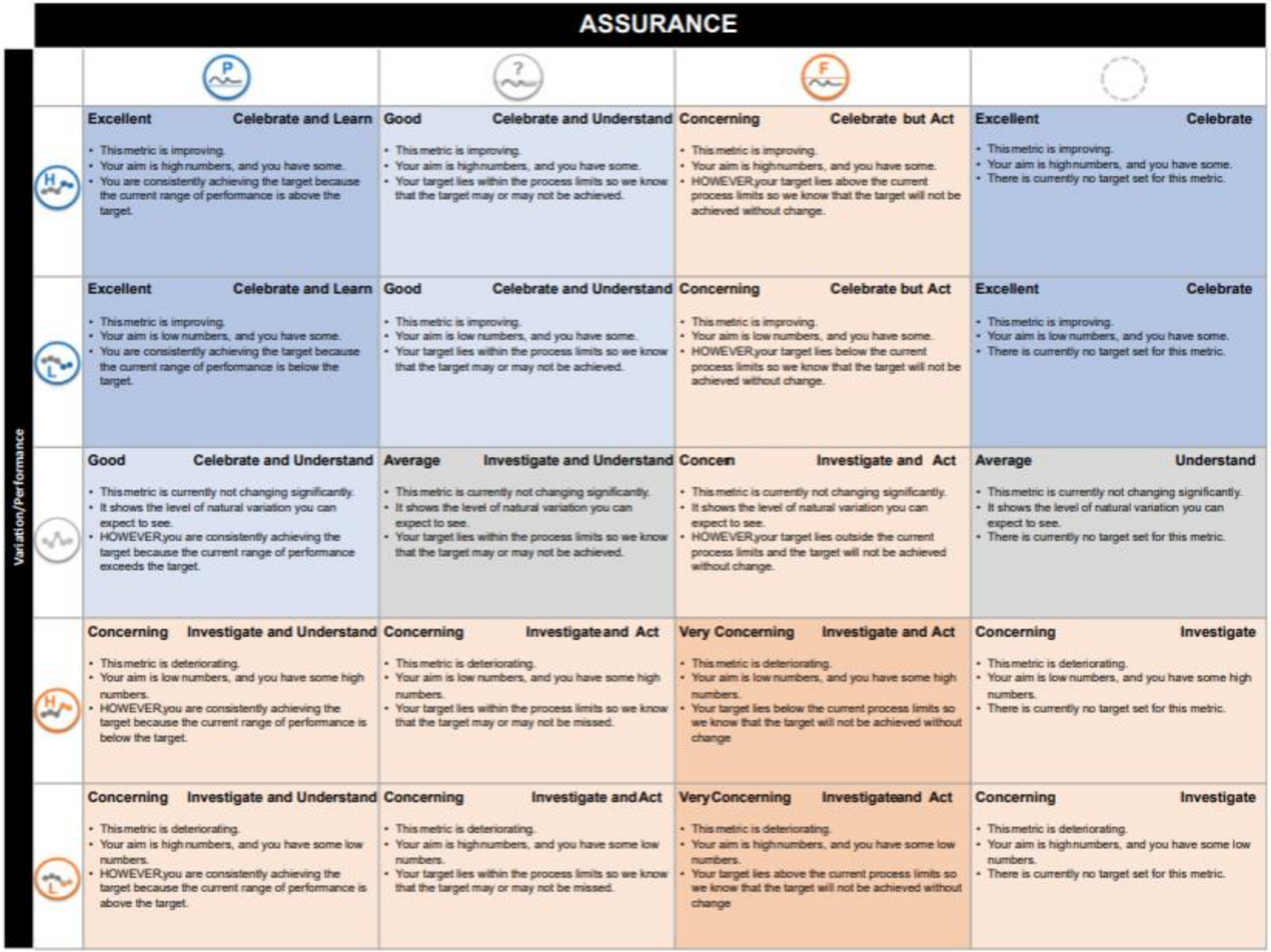
FOI's are required to be responded to within 20 working days, however an extension are permitted where public interest exemptions need to be considered.



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

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.


ASSURANCE
Variation/Performance
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.
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.
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.
Concerning Investigate and Understand
• This metric is deteriorating.
• Your aim is high numbers, and you have some low numbers.
• HOWEVER you are consistently achieving the target because the current range of performance is above the target.
Concerning Investigate and Act
• This metric is deteriorating.
• Your aim is high numbers, and you have some low numbers.
• Your target lies within the process limits so we know that the target may or may not be missed.
Very Concerning Investigate and Act
• This metric is deteriorating.
• Your aim is high numbers, and you have some low numbers.
• Your target lies above the current process limits so we know that the target will not be achieved without change
Concerning Investigate
• This metric is deteriorating.
• Your aim is high numbers, and you have some low numbers.
• There is currently no target set for this metric.

Agenda item:	2026-27 (12bi)
Title of report:	NOF Update - Sickness Absence
Meeting:	Trust Board Meeting Held in Public
Date:	17 September 2026

Presented by:	Jenny Allen Director of People
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 current sickness absence performance, progress made through the Sickness Absence Improvement Project and the forward focus as improvement activity transitions into sustainable BAU arrangements.	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 is 6.92%, above the 6.2% target and remains high despite monthly variation. Long term absence accounts for around 70% of sickness, with anxiety, stress and depression being the leading cause.
- Good progress continues across the improvement project, with manager training embedded as BAU, panel processes strengthened, targeted organisational health work underway and further improvements to sickness data and reporting. The internal audit completed in March 2026 provided significant assurance.
- The next phase will focus on embedding a sustainable BAU approach, refining the Support Framework, while retaining People Partner involvement, service ownership, challenge and oversight, alongside strengthening how wellbeing support, utilisation and outcomes are understood across the organisation.

Previously considered by:	Summary of progress was previously considered by the Public Board on 23 July 2026.
Outcome of previous discussion/s:	The current position, project progress and strengthened oversight arrangements were 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, including the continued contribution of long term absence to overall performance. • Note the progress being made through the sickness absence project • Support the proposed forward focus points, including refinement of the Support Framework, and a more joined up approach to wellbeing support, utilisation and outcomes.

List of Appendices:	N/A

Leeds Community Healthcare NHS Trust

NOF Update - Sickness Absence

Update for Public Board

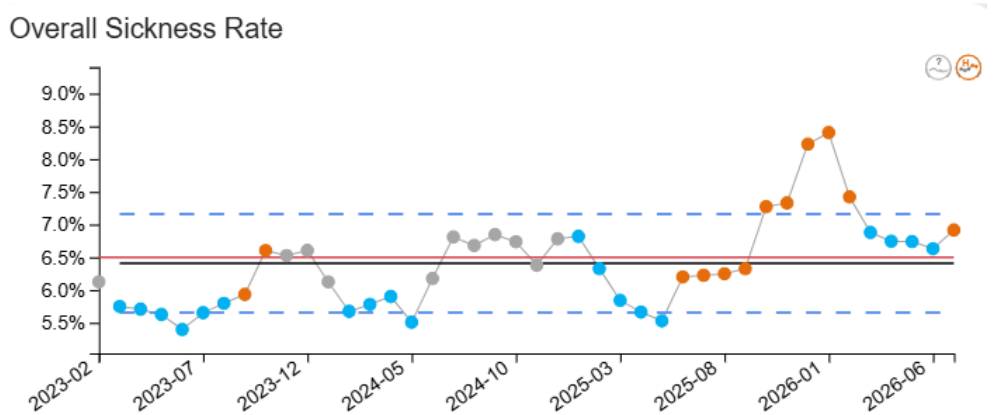
17th September 2026

Current Position

Leeds Community Healthcare NHS Trust

Where we are now

- July 2026 overall sickness absence was 6.92%, up 0.29 percentage points from June (6.63%) and above the 6.2% target. LCH remains in NOF Segment 4.
- Some monthly fluctuation is expected, and a single movement should not be overinterpreted. The current level is nevertheless high: 0.69 points above July 2025, although 1.49 points below the January 2026 winter peak.
- The July increase was mainly short-term absence (2.10%, +0.21 points). Long-term absence was 4.81% (+0.07 points) and still accounts for around 70% of total absence.
- Anxiety, stress and depression remained the leading reason, contributing 2.47 points - around 36% of all sickness. MSK contributed 0.91 points (13%).



What we are doing well

- The internal audit provided Significant Assurance on the organisation's approach to long term sickness absence management.
- Monthly collaborative "Compass" reviews bring together the project team and People Partners, whose service intelligence helps explain what the data alone cannot. The reviews create visibility, constructive challenge, accountability and escalation. The Support Compass dashboard enables us to identify hotspot services earlier and help direct support in a data-driven way, and provides a valuable structure, opportunity to discuss, and maintain oversight – as well as directing the stepped interventions themselves.
- We are strengthening our preventative approach to enable people to feel well at work, and recognise early indications of absence. Our Clinical Psychologist is working more closely with People Partners, so she can be involved earlier in complex cases. We have improved access information for MSK and Thrive@Work services, and are working on strengthening proactive wellbeing communications as well as developing practical resources to support colleagues and leaders through change.

Progress and Next Steps

Leeds Community Healthcare NHS Trust

Progress update

- Managing Absence with Confidence training is embedded and delivered as BAU. Engagement is excellent with strong demand, and the programme is well evaluated.
- Improvements identified through the Sickness Panel Task and Finish group have been implemented, including a more consistent approach to panel allocation, clearer support and guidance for panel members. We have not yet received feedback on their impact so this will need to be reviewed as they embed.
- Occupational Health contract monitoring and EAP promotion and monitoring continue as BAU arrangements.
- Targeted Organisational Health diagnostic work continues, led by Senior People Consultants. In Dental, team and individual interviews have been completed and recommendations provided to the leadership team. People Consultant support is continuing to help progress the agreed actions, with follow up and monitoring in place.
- The new unavailability dashboard is live and provides a timely intelligence on absence patterns. A policy-adherence tab has been built into the draft e-roster dashboard and is awaiting testing. A row-level access permissions for the detailed sickness dashboard are currently being tested to enable General Managers and Heads of Service to access the information relevant to their areas.

Forward focus

- Refine the current Support Compass framework to make it more proportionate and sustainable for BAU delivery, while strengthening service ownership and retaining the elements that are proving most valuable – particularly collaborative review with People Partners, maintaining organisational oversight and clear routes for accountability and escalation.
- Use Clinical and Operational Forums to share the challenge, hear directly from services and identify what further support would help.
- Consider whether existing OH, EAP and Clinical Psychology reporting could be brought together to strengthen understanding of utilisation and available outcomes. As with the Compass, the issue is not the interventions themselves, but the evidence, conversations and oversight needed to understand how they are being used and what difference they may be making.
- Complete the ongoing refresh of wellbeing information and access, including resources to support colleagues and managers through change.

Agenda item:	2026-27 (13)
Title of report:	Freedom To Speak Up Six-Month Report
Meeting:	Trust Board Meeting Held In Public
Date:	17 September 2026

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

Purpose of the report:		
This report provides: the Board with a six-monthly report on Freedom to Speak Up Guardian (FTSUG) work in the trust from 26 March 2026 to 17th September 2026.	Approval	
	Discussion	
	Assurance	x

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

Summary of Key Issues:

There were seventy-nine concerns overall to the FTSUG and the Speaking Up Champions from Leeds Community Healthcare (LCH) staff.

Thirteen concerns were raised formally by Leeds Community Healthcare staff members concerning LCH or LCH services through the Freedom to Speak Up Guardian (FTSUG). Sixty-four concerns were informally discussed or resolved via the FTSUG. The Speaking Up Champions had three concerns.

We have had a special focus on Sexual Safety work, organisational change and integration for the new organisation.

The data and evidence show the trust has a FTSUG service which is known, used and valued by our staff.

Previously considered by:	
Outcome of previous discussion/s:	

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

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

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

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

List of Appendices:	

FREEDOM TO SPEAK UP GUARDIAN REPORT

1 Executive Summary

This report provides the board with an update report on Freedom to Speak Up Guardian (FTSUG) work in the trust from 26 March 2026 to 17th September 2026.

There were seventy-nine concerns overall raised with the FTSUG and the speaking up champions.

Thirteen concerns were raised formally by Leeds Community Healthcare NHS Trust staff members concerning LCH or LCH services through the Freedom to Speak Up Guardian. Sixty- four concerns were informally discussed or resolved via the FTSUG. The Speaking Up Champions had three concerns (one of which came to the Guardian).

Work on Sexual Safety, organisational change and our integration with LYPFT have had a special focus.

The data and evidence show the trust has a FTSUG service which is known, used and valued by our staff.

2 The Work

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

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

The FTSUG attends the Clinical Students Forum and the Preceptorship events. Work alongside LCH Safeguarding, HR and Security on Sexual Safety is developing. The FTSUG has been involved in the Quality and Value Programme and Leadership Restructure work in the trust. The FTSUG attends the Organisational Change and People Impact meeting with the Director of People, Staffside, the Associate Director of People Solutions, the Associate Director of Strategy, Change and Improvement and the Head of HR to triangulate information about staff experiences of change work in the organisation.

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

of Operations, Director of People and the Head of HR to look at themes from workforce concerns. These forums look at themes from informal and formal concerns and can be escalated where necessary to the board. These meetings are working well and are a good source of triangulation and shared learning.

There has been positive work attending the People and Culture Committee.

There has been focussed work in certain areas of the trust based on staff raising concerns which has led to good outcomes.

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

Work extending our speaking up champions has been successful and we now have twelve speaking up champions.

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

An external peer review requested by an NHS organisation has been completed. The FTSUG presented at the national NHS Workforce Crisis conference in July this year alongside NHS England and other NHS colleagues. There is underway a review of the Ockenden Nottingham report and its lessons in terms of speaking up for the trust.

3 Impact

Below is the basic data around concerns raised between 26 March 2026 and 17th September 2026.

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

Adult Business Unit - 5
Children and Families Business Unit - 0
Corporate Services - 1
Specialist Business Unit - 2

Five concerns were raised formally about the trust itself. There were thirteen formal concerns overall. Six of these concerns related to health conditions. There were two formal concerns from members of the global majority. One related to race, culture and religion.

The themes of the overall formal concerns included staff wellbeing, team behaviours, leadership, service changes.

Sixty-four concerns were informally discussed or resolved through the FTSUG work. There were fifteen informal concerns regarding health and neurodiversity. There were thirteen informal concerns from staff from the Global Majority and out of these none concerned races, culture or faith.

Three concerns were raised with the Speaking Up Champions (one of which came to the Guardian).

This brings the overall concerns raised to seventy-nine for the FTSUG and the champions.

There were two concerns raised by members of the public about different LCH staff members. Both were raised to the Chief Executive, Deputy Chief Executive and relevant directors.

There was also a staff member from a Third Sector organisation and a staff member from another NHS organisation who contacted the FTSUG, Meetings and signposting occurred in both cases.

Formal evaluations of the service and verbal and email feedback are consistently positive. This correlates with the positive staff survey results last year.

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

- **Equity**

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

4 Next steps

To focus on the Leadership Restructure work.

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

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

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

5 Recommendations

The Board is recommended to:

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

John Walsh
Freedom To Speak Up Guardian
8/9/2026

Agenda item:	2026-27 (14i)
Title of report:	Annual Medical Director's report 2025-2026
Meeting:	Trust Board Meeting Held In Public
Date:	17 September 2026

Presented by:	Dr Ruth Burnett Executive Medical Director
Prepared by:	Dr Ruth Burnett Executive Medical Director

Purpose of the report:		
To provide Board with an update and overview regarding our responsibilities as an employer of Medical and Dental staff within the Trust.	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:
• Appraisal and medical revalidation • Managing concerns • Pre-employment checks

Previously considered by:	Quality Committee – 8th September
Outcome of previous discussion/s:	Approved at 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?	The Trust has a highly diverse workforce.
	No		Why not/what future plans are there to include this information?	

Recommendation(s)	Board is recommended to: • Note the contents of the 2025/26 Annual Executive Medical Director's Report • Note the requirements by NHS England to include the statement of compliance from the Board. • Approve the statement of compliance and submission to NHS England

List of Appendices:	Appendix 1 – Professional Standards Framework for Quality Assurance and Improvement 2025-2026 Leeds Community Healthcare NHS Trust (Statement of Compliance)

Medical Directors Annual Report
(including NHSE Statement of Compliance 25-26)

1 Introduction

This Executive Medical Director's report covers the period 01/04/25 to 31/03/26 and includes information and activity relating to the Trust responsibilities regarding employment of medical and dental staff; based on the four key principles identified in the handbook and guidance regarding "Effective Clinical Governance to support revalidation" published by the GMC in 2024.

It is accompanied by the recommended template for the Statement of Compliance for 25/26. Whilst this template formally refers to our employment of medical professionals, for the purpose of the report it also references our employment of dentists, unless specifically noted otherwise.

The report details key areas of progress and further identified work against each of the four key principles identified in the GMC document of 2024 as those that underpin effective clinical governance in this context. These are:

- **Principle 1: An effective environment**
  Organisations create an environment which delivers effective clinical governance for doctors.
- **Principle 2: Continuous Improvement**
  Clinical governance processes for doctors are managed and monitored with a view to continuous improvement.
- **Principle 3: Fairness**
  Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination.
- **Principle 4: Supporting Process**
  Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practice.

Leeds Community Healthcare NHS Trust is a Designated Body responsible for the appraisals of all doctors employed by the Trust. Regulations require that all Designated Bodies must nominate or appoint a Responsible Officer, who must be a licensed doctor. This post is held in LCH by the Executive Medical Director and is therefore represented on the Board.

The Responsible Officer is supported by a Deputy Medical Director and a Head of Medical Education and Revalidation. The Deputy Medical Director has undergone NHSE approved Responsible Officer training.

During the reporting period 01/04/25 - 31/03/26, LCH had a prescribed connection with 40 doctors, and responsibilities to 9 dentists who undergo annual appraisal but whose regulatory body the General Dental Council (GDC) does not have a revalidation process.

Of the 40 doctors that were due an appraisal, 100% (40 doctors) completed their appraisal within 25/26. 9 dentists were due an annual appraisal for 25/26 of which

100% were completed. 5 doctors were due for revalidation in 25/26, 100% of which were successfully revalidated for five years.

LCH had three dentists in a remediation or MHPS process during 25/26. The Trust Board have been regularly updated in private session.

2 Current position/main body of the report

Analysis of the Medical and Dental Workforce in LCH can be seen below, this includes **40** doctors with a prescribed connection to the Trust, **9** dentists, and **22** training posts (10 LCH employed Higher Trainees and 12 Lead Employer Agreement posts who hold Honorary Contracts with LCH - 3 GP VTS Trainees, 3 Core Psychiatry Trainees, and 6 Paediatric Higher Trainees).

Medical and Dental Workforce						
	24/25 Data			25/26 Data		
Ethnic Group	Headcount	%	FTE	Headcount	%	FTE
White	26	37.68	17.18	**21**	**36.21%**	**14.76**
Ethnic Minority	13	18.84	9.63	**12**	**20.69%**	**9.53**
Unspecified/Not Stated	30	43.48	20.78	**25**	**43.10%**	**21.75**
Grand Total	69	100.00	47.58	**58**	**100.00%**	**46.04**

Overall headcount has reduced between 24-25 and 25-26; however FTE has remained consistent. This is due to several resident doctor posts in 24-25 being shared appointments and therefore counted as multiple individuals occupying partial posts, in 25-26 these posts were filled on a full-time basis. The analysis of the workforce based on ethnicity demonstrates a highly diverse workforce.

Age profiles of Medical and Dental Workforce 25/26						
Age Band	24/25 Headcount	24/25 %	24/25 FTE	25/26 Headcount	25/26 %	25/26 FTE
<36	14	20.29%	10.55	**12**	**20.69**	**10.30**
36-40	12	17.39%	9.06	**6**	**10.34**	**4.65**
41-45	9	13.04%	5.55	**11**	**18.97**	**9.60**
46-50	16	23.19%	8.64	**12**	**20.69**	**7.60**
51-55	9	13.04%	8.38	**10**	**17.24**	**9.13**
56+	9	13.04%	5.41	**7**	**12.06**	**4.76**
Grand Total	**69**	**100.00%**	**47.58**	**58**	**100.00**	**46.04**

The number of staff recorded as <36, and 36-40 fluctuate year on year due to changes in resident doctors rotating in and out of the Trust. The number of staff identified as 56+ reduced by 2 due to retirements.

Medical Job Planning

NHSE renewed their focus on the importance of job planning for the medical workforce as a means to effectively deliver clinical services. The Trust has well-established job planning processes in place, with annual job planning and review arrangements embedded across medical and dental staffing groups. These

processes support effective workforce deployment, service planning, and the alignment of clinical activities with organisational priorities.

During 2025/26, the Trust implemented an electronic job planning solution for medical and dental staff as part of its commitment to meet NHS England's National Levels of Attainment requirements. The introduction of the e-job planning system has enabled the Trust to progress from Level 0 to Level 2 maturity, providing a more standardised, transparent, and data-driven approach to job planning. The system is expected to improve the quality and consistency of job plans, increase productivity through better alignment of programmed activities to service demand, and deliver efficiency gains through streamlined administration and enhanced reporting capabilities.

The 'Levels of Attainment' are benchmarks used to measure a trust's progress in adopting and using e-job planning software. They are:

- Level 0: No e-job planning
- Level 1: Basic individual e-job planning
- Level 2: Advanced individual e-job planning
- Level 3: Team e-job planning
- Level 4: Organisational e-job planning

In 2026/27, the Trust will undertake a formal benefits realisation project to evaluate the impact of the e-job planning implementation. This work will assess the extent to which anticipated productivity improvements and efficiency gains have been achieved and identify opportunities for further optimisation and continuous improvement.

Quality Assurance

During the 2025/26 year, the Trust further strengthened its quality assurance arrangements for medical appraisal by implementing a triangulated peer review process in partnership with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Healthcare NHS Foundation Trust. This collaborative approach was designed to provide an independent and objective assessment of appraisal quality, ensuring that assurance processes were robust, consistent and free from organisational bias.

As part of this arrangement, a sample of ten appraisals from the Trust was reviewed against NHS England's 'Appraisal Summary and PDP Audit Tool' (ASPAT) by the Executive Medical Director, Responsible, Deputy Medical Director and Clinical Director from Derbyshire Community Health Services NHS Foundation Trust. The review found that no appraisals fell below the agreed benchmark score of 30 out of 50, providing assurance that the quality of appraisal documentation and supporting evidence met the required standards. Appraisal scores ranged between 48 and 50 out of 50 which represents the work undertaken with appraisers to improve the quality of appraisal output forms.

Reciprocal arrangements were also undertaken with Birmingham Community Healthcare NHS Foundation Trust, with LCH's Head of Medical Education and Deputy Medical Director reviewing a sample of appraisals from Birmingham using the same ASPAT methodology. This triangulated approach has supported shared learning between organisations, promoted consistency in appraisal standards, and

provided additional assurance regarding the effectiveness and quality of the Trust's medical appraisal processes.

Temporary Staffing

Over the last year the following services have been supported by temporary bank staff:

CLASS Data 25/26	
Service Worked for	**Total Hours worked (previous year)**
CYPMHS	2675 (2280)
Leeds Sexual Health	15 (18.5)
Covid Vaccinations (Medic Duties)	0 (469)
ICAN Service	707 (536)
Clinical Services LTC'S	0 (49.75)
Community Diabetes Service	0 (20)
Community Dental Service	120 (1220.5)
Community Gynaecology Service	397.5 (0)
Total Hours	**3914.50 (4593.75)**

The Children and Young People's Mental Health Service (CYPMHS) experienced an increased reliance on bank staffing during the reporting period due to two Consultant posts being on long-term parental leave. This created additional clinical capacity pressures, which were mitigated through the use of bank staff to maintain service delivery and ensure continuity of care.

The COVID-19 Vaccination Service has now been formally disbanded following the conclusion of the programme. As a result, there is no longer any requirement for bank staff utilisation within this service area.

In the ICAN service following the retirement and return of a SAS doctor to LCH Bank for ad-hoc sessions, ICAN were able to increase capacity by delivering additional Initial Health Needs Assessment (iHNA) clinics and seeing expedited Paediatric Neuro Disability Clinic patients. Previously, without paediatricians on Bank, the service relied solely on locums, so this has provided a more flexible staffing solution.

Within the Community Dental Service, the successful recruitment of three new Dentists has significantly improved substantive staffing levels. Consequently, the service's reliance on bank staff has reduced, providing greater workforce stability and reducing temporary staffing expenditure.

The increase in Community Gynaecology was the result of work to decrease the waiting list in the service.

Education

In the year 25/26 Leeds Community Healthcare was able to offer the following educational placements:

Medical Education Undergraduate and Postgraduate Placement Figures 2025-2026 (Previous Year)			
Service	**Undergraduate***	**Foundation Year**	**Postgraduate****
ICAN	400 (380)	1 (1)	10 (10)
LSH	150 (150)	0 (0)	3 (3)
Community Gynaecology	70 (70)	0 (0)	1 (1)
CYPMHS/Psychiatry	37.5 (37.5)	1 (1)	8 (8)
Elderly Medicine/Neuro Rehabilitation	192 (192)	0 (0)	0 (0)
GP VTS Trainees	0 (0)	0 (0)	3 (3)
MSK	264 (120)	0 (0)	0 (0)
Falls	96 (0)	0 (0)	0 (0)
Total	**1209.5 (949.5)**	**2 (2)**	**25 (25)**

*Undergraduate placements are calculated based on 6 cohorts per academic year, multiplied by number of students per cohort, multiplied by days to give a representation of 'placements' provided, the same students may have been at LCH in different services during different cohorts.
**Postgraduate – The Trust has 22 formal training posts, but headcount can fluctuate due to LTFT trainees job sharing posts.

The Trust continued to enhance its undergraduate medical education offer by introducing new and innovative community-based placements. In Musculoskeletal (MSK) services, placements were expanded beyond the existing spinal classroom teaching model to include experiential learning opportunities with Advanced Practice Physiotherapists (APPs). These placements provide medical students with exposure to both spinal and peripheral MSK practice, enabling them to gain a broader understanding of assessment and management pathways within community settings. Feedback from students has been particularly positive, with some identifying the community element as the favourite part of their placement experience.

A new Falls placement was also introduced to complement the existing Elderly Medicine provision delivered within Community Care Beds (CCBs). The placement enables students to observe and participate in a holistic, multifactorial approach to falls assessment and prevention, including understanding and managing falls risk within patients' own environments. Student feedback has been exceptionally positive, with the placement described as "amazing" and "a fantastic way to emphasise the importance of holistic care".

Overall, LCH continues to receive very positive feedback on its community-based undergraduate placements. The expansion of these opportunities further demonstrates the Trust's commitment to delivering high-quality, innovative educational experiences that showcase the value of community care and multidisciplinary working.

Education Governance

The Trust has a medical education governance structure, led by the Medical Director, and supported by the Associate Director for Teaching and Student Support (ADTSS) for undergraduates and Director Medical Education (DME) for postgraduates, clinical staff, trainers and a dedicated administration team focussed on delivering and supporting high quality education and training.

LCH hosts over 400 Undergraduate Medical Students with over 1,000 teacing days of placement opportunities, 2 Foundation Year, and 22 Postgraduate training posts across 7 different services per year. Community placements provide experience of delivering care in a wide range of settings including in people's own homes as well as in clinics, Community Centres and schools.

Teaching and training standards, and support are reviewed annually via the NHS England Self-Assessment Return (SAR), in which organisations carry out their own quality evaluation against the National Quality Framework. It is based on continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

The Quality Framework identifies the standards that organisations are expected to meet to provide high quality learning environments. The education placements offered by LCH have been reviewed by Leeds University for undergraduate placements, and in May by NHSE for postgraduate and these reviews have been very positive.

The **GMC National Training Survey (NTS)** is an annual survey run by the General Medical Council (GMC). It is the largest insight into postgraduate medical training in the UK, gathering confidential feedback from thousands of doctors in training and their trainers to evaluate and improve workplace education, support, and patient safety.

TRAINEES - Trust Ranks

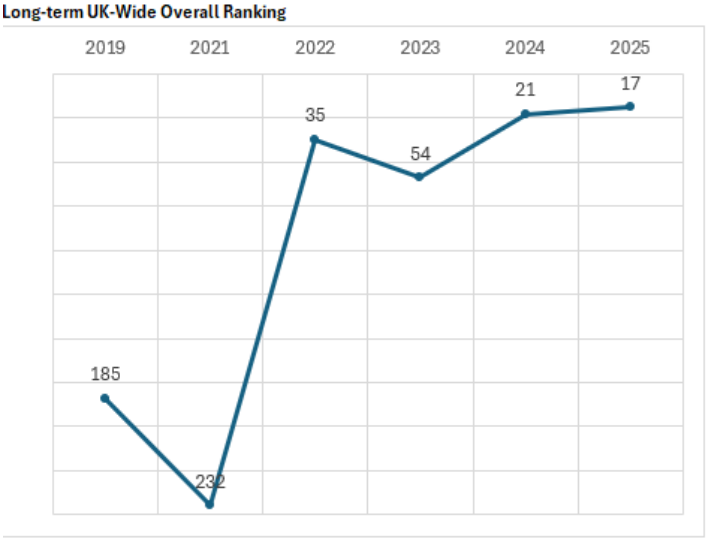
This section provides UK-wide, England only and local rankings by trust based on the overall survey mean score for 2019 to 2025.

Included: acute and mental health trusts, community and social care partnerships that also cover acute, mental health and in-patient services

Excluded: councils, commissioners, charities and non-NHS organisations, primary, community and social care organisations

UK-Wide Rankings by 2025		**Eng Rankings by 2025**		**Local Rankings by 2025**	
Trusts are ranked 1-226	17	Trusts are ranked 1-197	15	Trusts are ranked 1-21	3

Long-term UK-Wide Overall Ranking



UK-Wide Ranking by Indicator (2025)

Indicator	Rank	Out of
Overall Satisfaction	27	226
Clinical Supervision	63	225
Clinical Supervision out of hours	9	220
Reporting systems	173	223
Workload	3	226
Teamwork	12	222
Handover	14	221
Supportive environment	6	226
Induction	8	226
Adequate Experience	10	226
Educational Governance	65	226
Educational Supervision	222	226
Feedback	51	226
Local Teaching	109	225
Regional Teaching	24	225
Study Leave	6	226
Rota Design	7	222
Facilities	88	224

Source: GMC NTS Results 2025

Trust Score Compared to National Mean (2025)

Indicator	Trust	National Mean
Overall Satisfaction	83.18	78.4
Clinical Supervision	90.75	89.05

Clinical Supervision out of hours	91.67	86.8
Reporting systems	69.38	73.26
Workload	69.7	49.58
Teamwork	83.71	75.24
Handover	75.69	69.91
Supportive environment	87.73	75.09
Induction	87.73	81.76
Adequate Experience	85.23	78.53
Educational Governance	73.49	71.54
Educational Supervision	80.68	86.76
Feedback	80.42	76.88
Local Teaching	70.76	71.99
Regional Teaching	74.62	66.5
Study Leave	88.64	71.31
Rota Design	79.86	59.21
Facilities	67.14	65.83

Source: GMC NTS Results 2025

The results of the GMC National Training Survey demonstrate a significant improvement in the Trust's performance and reputation as a training provider. The Trust has improved its national position, moving from 21st to 17th place in the UK rankings. At a regional level, the Trust is now ranked 3rd within the Yorkshire and Humber region, reflecting continued progress in the quality of the educational experience provided to doctors in training.

Overall, the Trust performed very positively across the survey, achieving positive outlier status across the majority of performance indicators. These results indicate that trainees continue to report high levels of satisfaction across key domains and recognise the Trust's commitment to providing a supportive learning environment and high-quality training opportunities.

The survey identified two areas of negative outlier performance: Reporting Systems and Educational Supervision. While these findings are limited to specific domains, they highlight opportunities for further improvement. Both areas have therefore been incorporated into the Trust's education action plan and will be a key focus over the coming year to ensure that trainees are supported effectively and that processes for reporting concerns and educational supervision continue to develop and improve.

The Trust is currently awaiting the results of the 2026 survey.

3 Impact

Position statement for 25/26

Principle 1: An effective environment (Organisations create an environment which delivers effective clinical governance for doctors)

LCH has a combination of individual service and central mechanisms which hold information pertinent to effective clinical governance for medical and dental staff. Each service is responsible for meetings and discussions regarding these, and medical and dental staff of all employment statuses are encouraged to participate and actively contribute.

The Trust process in relation to incidents ensures that the Medical Directorate is informed when a doctor is involved in an incident, this allows appropriate support and oversight to the individual and the Business Unit involved.

The four Trust policies related specifically to the employment of medical and dental staff have been approved by SMT:

Policy	Date ratified by Senior Leadership Team (SLT)	Next Review Date
Maintaining High Professional Standards	December 2025	December 2027
Medical and Dental Appraisal and Revalidation Policy	May 2026	May 2028
Medical and Dental Job Planning Policy	December 2025	December 2027
Remediation, Reskilling and Rehabilitation Policy	November 2025	November 2027

All Medical and Dental policies will be reviewed in line with LYPFT as part of the Trust Integration Programme to create a new set of aligned policies from 1st April 2027.

The Trust has robust processes in place to ensure appropriate checks are undertaken to confirm all doctors and dentists undertaking employed work in the Trust are appropriately qualified and fit for role.

The Revalidation Team coordinate with Workforce and QPD colleagues to share information in order to provide central assurance of any issues relating to medical and dental staff. Revalidation Panels were carried out as required during 25/26, linking with Trust systems to ensure that appropriate submission and reflection on incidents and complaints was included in the relevant appraisals.

The Trust has strong processes in place to support individuals who speak up and raise concerns; from the operational or clinical line manager of the individual, directly with an Executive Director or with the Freedom to Speak up Guardian.

Principle 2: Continuous Improvement (Clinical governance processes for doctors are managed and monitored with a view to continuous improvement)

Leeds Community Healthcare meets regularly with the GMC to discuss issues regarding incidents relating to doctors, and doctors in an MHPS process. Verbal feedback at the last meeting was complimentary of the processes in place and the open nature of the discussion, also reflective of the complexity of cases seen in this environment.

The Medical Directorate proactively sought out partnering organisations to undertake a peer review of appraisal and revalidation processes. The Trust partnered with Birmingham Community Healthcare NHS Foundation Trust and Derbyshire Community Health Services NHS Foundation Trust. The partnering organisations have built on that relationship to arrange a Mutual Quality Assurance process. The new process ensures that samples remain anonymous and are reviewed by people outside of the Trust, removing the risk of bias.

The Trust has presented information to both the University and NHSE on the quality of education provided at both an undergraduate and postgraduate level. There has been positive feedback from both meetings. Doctors are supported in their job plans to participate in education and training.

Principle 3: Fairness (Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination)

Revalidation Panels ensure that all revalidation recommendations are supported by a thorough consideration of all aspects of the five years of appraisal preceding the recommendation. The panels strengthen the Trust processes and reduces the possibility of bias or discrimination with the introduction of an independent observer from a peer Trust.

The Trust has a 'Freedom to Speak Up Guardian' (FTSUG). In 25/26 there was one individual concern and two informal concern conversations from doctors, doctors in training and dentists with the FTSUG, this is on a background of 261 raised across the Trust. The number of staff raising concerns from medical and dental workforce is lower than the previous year of five reports in 24/25.

No concerns have been raised by any doctor in relation to decisions regarding the clinical governance of doctors; decisions relating to deferral of revalidation are usually made in conjunction with the doctors and in line with GMC guidance.

During 25/26 there were 3 grievances in total, 2 concluded and 1 still in process.

Principle 4: Supporting Process (Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practice)

LCH has a longstanding history of robust clinical governance processes to support medical revalidation and has continued to perform well in this regard. Revalidation submission and recommendations are in line with the National average.

Submissions summary - GDE (gmc-uk.org)

There are systems in place to respond and manage concerns related to the fitness to practice of doctors. These systems work in conjunction with the GMC and the Practitioners Performance Advice, part of NHS Resolution. This system will also address concerns related to locum doctors and doctors in training in conjunction with NHS England

4 Recommendations

Board is recommended to:

- Note the contents of the 2025/26 Annual Executive Medical Director's Report
- Note the requirements by NHS England to include the statement of compliance from the Board.
- Approve the statement of compliance and submission to NHS England

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses.

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: Leeds Community Healthcare NHS Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	No update required
Comments:	Dr Ruth Burnett is LCHs appointed Responsible Officer, with Dr Stuart Murdoch as Deputy, both are fully trained.
Action for next year:	No update required

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes	Y
Action from last year:	No update required	
Comments:	Sufficient funds, capacity and resources are available for the RO to carry out the responsibilities for the role. The Trust utilises the SARD Medical Appraisal System.	
Action for next year:	No update required	

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	No action required
Comments:	The SARD system is maintained to provide an accurate up to date overview of the appraisal and revalidation position within the Trust, backed up by a limited access, password protected Excel database.
Action for next year:	No action required

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Carry out a cross check with other Medical Workforce Policies.
Comments:	Medical and Dental Policies are up to date and have been ratified by the Trusts Senior Leadership Team.

Action for next year	No Action required

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	Further collaborative work planned with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust for 25/26 to include ongoing Quality Assurance and membership of Revalidation Panels.
Comments:	Peer Review completed with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust, the peer review gave opportunity to share procedures, policies and best practice, and has resulted in an ongoing peer partnership with mutual quality assurance also completed to ensure that samples remain anonymous and are reviewed by people outside of the Trust, removing the risk of bias.
Action for next year:	Maintaining the peer relationship with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust for 26/27.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	No action required
Comments:	LCH now offers appraisal support for Locum and Short-Term Contract Doctors. Scope of work letter completed to support doctors' full scope of work when employed elsewhere when requested. All doctors, regardless of employment status, are involved in

	governance processes relating to incidents and complaints. The Trust encourages them to be actively involved in any issues raised by patients; will ensure they have access to the relevant clinical record and will provide copies of documentation relating to these incidents for the purposes of appraisal. Training and development opportunities are available and will be supported as appropriate for all doctors regardless of employment status. Every member of LCH staff has access to regular support from their clinical and operational line managers, including discussion regarding development needs and opportunities, clinical supervision and encouragement, and opportunities to be involved in local governance and service improvement processes. Doctors working for the Trust who have an alternative Responsible Officer connection to their locum agency or alternative employer are offered support for appraisal and revalidation in the form of a "Scope of Work" letter provided by their Medical Lead, detailing their work within the Trust.
Action for next year	No action required

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	No action required
Comments:	All doctors are supported to have a Medical Appraisal within the SARD system, where they can store supporting information and reflect. Complaints, concerns and incidents are reviewed at Revalidation stage.
Action for next year:	No action required

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	No action required
Comments:	In any instances where a doctor had not had an appraisal, they would be required to have an understandable reason for this and submitted plans to complete this within an approved timeframe.
Action for next year:	No action required

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	No action required
Comments:	The Trust has a 'Medical and Dental Appraisals and Revalidation Policy' in place, this is regularly reviewed in line with National guidelines, and is discussed at the Trust's Local Negotiating Committee, before being ratified by Trust Board.
Action for next year:	No action required

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance

Y/N	Yes
Action from last year:	Work to future proof the appraiser network, train at least one new appraiser for 25/26 appraisal cycle.
Comments:	One new appraiser was added to the appraiser network for 25/26.
Action for next year:	No actioned required

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	No actioned required
Comments:	Appraisers are all supported to attend appraisal network/development attempts and are provided with both individual feedback and anonymised Trust feedback from the quality assurance process. Regular 'Trust Appraiser Updates' are held to provide an opportunity for supported peer discussion and development in the context of appraisal. Appraisees have been reminded about the need to have a whole of practice appraisal, including leadership or education roles in addition to work in other settings.

between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action for next year:	No actioned required

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Complete the 25/26 Quality Assurance process with a reversed triangulation of the three Trusts, Leeds Community Healthcare NHS Trust, Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust.
Comments:	Peer review carried out with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust. Mutual quality assurance programme completed with feedback provided.
Action for next year:	Complete the 26/27 Quality Assurance process with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Continue to engage with the GMC appropriately.
Comments:	Regular Revalidation panels are held as required. The Executive Medical Director, Deputy Medical Director, and Head of Medical Education and Revalidation meet with the GMC Employee Liaison Advisor quarterly.
Action for next year:	Continue to engage with the GMC appropriately.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	No update required
Comments:	The outcome of Revalidation Panels is communicated directly with the doctor, indicating their revised revalidation date. The Responsible Officer made 5 positive recommendations to the GMC during the period covered by the report, all in a timely manner and supported by a Revalidation Panel. This covers all doctors for who recommendations were due during this period.
Action for next year:	No update required

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	No update required.
Comments:	The SARD system records all Designated Body Doctors appraisal and revalidation data. LCH has robust pre-employment processes in place for all new medical staff joining the Trust on a permanent or temporary basis. Concerns raised in relation to doctors are reviewed as appropriate and escalated within the organisation. The Medical/Dental Lead role job description is updated and is in use.

Action for next year:	No update required.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	No update required.
Comments:	LFPSE Framework is embedded alongside PSIRF. The Revalidation Team regularly liaises with the Trust's Patient Experience Team. We now get information from Datix with regards to individually named doctors. This happens infrequently.
Action for next year:	No update required.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	No action required
Comments:	The SARD Medical Appraisal system is used to ensure doctors can access their appraisal information easily. SARD acts as a repository for supporting information.
Action for next year:	No action required

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	No action required
Comments:	Concerns raised in relation to doctors are reviewed as appropriate and escalated within the organisation. The Maintaining High Professional Standards (MHPS) policy and the Remediation, Reskilling and Rehabilitation policy are both current. The RO has regular meetings with the GMC ELA and PPA advisors to discuss any potential cases of concern.
Action for next year:	No action required

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	Inclusion of neutral panel member from a Partnering Trust in Revalidation Panels.
Comments:	The trust invited staff from partnering community trusts from Peer Review to Revalidation panels to provide an unbiased viewpoint. Due to the size of the organisation concerns are infrequent, we have an independent non-exec board member who supports the process.
Action for next year:	No action required

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	No action required.
Comments:	The Trust can respond promptly to any request; this is signed off by the Responsible Officer (RO) prior to the transfer of information. LCH has robust processes for requesting appropriate information from partner organisations on transfer to the Trust of new Designated Body doctors, and for providing it when doctors transfer out. - Any concerns are raised with the RO or Deputy RO if there are concerns, externally concerns are raised with the DBs RO.
Action for next year:	No action required.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	Continue to invite peer partner members to panels.
Comments:	The Trust holds this information and is able to triangulate RO Team, HR and Workforce, panels now have a member from a peer partnering Trust to ensure the processes are fair and free from bias and discrimination

Action for next year:	Continue to invite peer partner members to panels.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Continue to review guidelines as appropriate.
Comments:	As the Trust receives outputs from National reviews, reports and enquiries they are reviewed at appropriate committees and groups and incorporated into the organisation as necessary. Recent work has focussed on 'Letby' with a paper discussed at Quality Committee and Trust Board.
Action for next year:	Continue to review guidelines as appropriate.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Support the review of the Professional Registration Policy in time for renewal next year.	
Comments:	Professional Registration Policy has been implemented.	
Action for next year:	No action required.	

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	No action required
Comments:	The Trust has robust processes in place to ensure that appropriate checks are undertaken to confirm that all doctors and dentists undertaking employed work in the Trust are appropriately qualified and fit for role. These processes are in line with NHS mandatory pre-employment checks. The Workforce Directorate ensures that the processes undertaken with regards to bank and agency doctors and dentists is robust. These applications are reviewed by the Medical or Dental lead (or appropriate deputy) for fitness for role prior to any employment commencing and a new form has been developed that ensures additional checks are incorporated in line with best practice (e.g. Confirmation of Responsible Officer).
Action for next year:	No action required

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	No action required

Comments:	The Trust strives to ensure that all staff are engaged in providing community healthcare services to the population we serve. We support our staff to develop and present opportunities to them so that they can develop in their careers and their ability to support colleagues and trainees.
Action for next year:	No action required

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	Continue to monitor compliance with the Equality act and work with the human resources team and groups within the organisation to ensure fairness is being delivered.
Comments:	All policies within the Trust detail how adjustment should be made to ensure equality for all staff as set out in the Equality Act of 2010. The Trust pays due regard for the need to • Eliminate unlawful discrimination, harassment and victimisation • Advance equality of opportunity for all staff This includes removing or minimising disadvantages to staff and taking steps to protect people with different needs.
Action for next year:	Continue to monitor compliance with the Equality act and work with the human resources team and groups within the organisation to ensure fairness is being delivered.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	Continue to monitor concerns raised

Comments:	The Trust has in place a Speaking Up-Raising Concerns Policy which enables all staff to speak up at the earliest opportunity. It is authored by the Freedom to Speak up Guardian who addresses concerns from all staff groups. The Trust has a cultural approach called Speaking Up is a Practice Not a Position. This means that there are several speaking up channels at the trust. Staff are encouraged to use any of these channels to ensure their voice is heard. The mechanisms are: • Managers and colleagues • Easy Access to Senior Managers and Directors • Ask the CEO anonymous Q and A on the trust intranet • Trade Unions • Workforce Department (HR) • Freedom To Speak Up Guardian • Race Equality Network Speaking Up Champions In addition to this there are regular engagement meetings between all medical staff and the Medical Director, and the Resident doctors have regular meetings with the Guardian of Safe working hours, and the education team in which concerns can be raised.
Action for next year:	Continue to monitor concerns raised

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	Continue to monitor processes. In the last four years there have been no formal complaints and feedback is consistently good.
Comments:	The Trust policy on appraisal has an ability for doctor to raise a complaint or grievance from the appraisal process with the Responsible Officer or Deputy Medical Directors. If this process does not result in a satisfactory outcome the complaint can be raised with the Chief Exec of The Trust.

	The appraisal system utilised by the Trust allows feedback from appraisers to appraisees which is analysed and fed back. Any issues identified are addressed with individuals.
Action for next year:	Continue to monitor processes.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	Continue to monitor concerns and processes in relation to involvement by doctors and protected characteristics.
Comments:	The Trust is aware of differential raising of concerns, entry into MHPS processes and referral to the GMC, in relation to country of primary medical qualification and protected characteristics. The number of doctors with a connection to LCH is relatively small and the number of doctors involved in incidents is small. It would be difficult to identify any concerns about issues, but we are vigilant and continue to question our processes and decisions.
Action for next year:	Continue to monitor concerns and processes in relation to involvement by doctors and protected characteristics.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes

Action from last year:	Continue to build on relationship with other Trusts and attend appropriate meetings
Comments:	The Trust attends the regional RO and Appraisal Leads Networks. The RO regularly meets with the regional GMC liaison officer.
Action for next year:	Continue to build on relationship with other Trusts and attend appropriate meetings

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	40
Total number of appraisals completed	40
Total number of appraisals approved missed	0
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	5
Total number of late recommendations	0
Total number of positive recommendations	5
Total number of deferrals made	0
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	2
Total number of trained case managers	1
Total number of concerns received by the Responsible Officer[2]	0
Total number of concerns processes completed	1
Longest duration of concerns process of those open on 31 March (working days)	N/A
Median duration of concerns processes closed (working days)[3]	N/A
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	0
Total number of new employment checks completed before commencement of employment	0
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Leeds Community Healthcare NHS Trust has a robust system in place for ensuring appraisal and revalidation of doctors employed by the Trust, for the appraisal of dentists and ensuring appropriate fitness to practice and fitness for role of other medical staff who work for the Trust. 40 doctors and 9 dentists have had an annual appraisal for the year April 2025 and March 2026. 5 doctors have been successfully revalidated. The Trust has continued to provide high-quality appraisal, supported and developed doctors and dentists regarding both appraisal and their general wellbeing, improved engagement with medical and dental staff and continued to further improve our systems to better support our medical and dental staff.
Actions still outstanding
During the 2025/26 year, the Trust further strengthened its quality assurance arrangements for medical appraisal by implementing a triangulated peer review process in partnership with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Healthcare NHS Foundation Trust. This collaborative approach was designed to provide an independent and objective assessment of appraisal quality, ensuring that assurance processes were robust, consistent and free from organisational bias.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Current issues
Actions for next year (replicate list of ‘Actions for next year’ identified in Section 1):
• Maintaining the peer relationship with Derbyshire Community Health Services NHS Foundation Trust and Birmingham Community Health NHS Foundation Trust for 26/27. • Continue to engage with the GMC appropriately. • Continue to invite peer partner members to panels. • Continue to review guidelines as appropriate. • Continue to monitor compliance with the Equality act and work with the human resources team and groups within the organisation to ensure fairness is being delivered. • Continue to monitor concerns raised • Continue to monitor processes. In the last five years there have been no formal complaints and feedback is consistently good. • Continue to monitor concerns and processes in relation to involvement by doctors and protected characteristics. • Continue to build on relationship with other Trusts and attend appropriate meetings
Overall concluding comments (consider setting these out in the context of the organisation’s achievements, challenges and aspirations for the coming year):
Achievements Leeds Community Healthcare meets regularly with the GMC to discuss issues regarding incidents relating to doctors, and doctors in an MHPS process. Verbal feedback at the last meeting was complimentary of the processes in place and the open nature of the discussion, also reflective of the complexity of cases seen in this environment. LCH has a longstanding history of robust clinical governance processes to support medical revalidation and has continued to perform well in this regard. Revalidation submission and recommendations are in line with the National average. During 2025/26, the Trust implemented an electronic job planning solution for medical and dental staff as part of its commitment to meet NHS England’s National Levels of

Attainment requirements. The introduction of the e-job planning system has enabled the Trust to progress from Level 0 to Level 2 maturity, providing a more standardised, transparent, and data-driven approach to job planning. The system is expected to improve the quality and consistency of job plans, increase productivity through better alignment of programmed activities to service demand, and deliver efficiency gains through streamlined administration and enhanced reporting capabilities.

Challenges

The small number of medical staff in the organisation mean that remaining up to date with MHPS processes can be a challenge when looking for case investigators, as well as the familiarity with colleagues.

Aspirations A further peer review and mutual quality assurance process is planned for 2026/27 with Birmingham and Derbyshire Community Trusts, with a view to ensuring processes are free from discrimination and bias.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Leeds Community Healthcare NHS Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Agenda item:	2026-27 (15)
Title of report:	Significant Risks and Risk Assurance Report
Meeting:	Trust Board Meeting Held In Public
Date:	17 September 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 25 August 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 (25 August 2026): • There are 121 open risks on the risk register, 32 of which have been managed to the target level. • One risk scores 15 (extreme) and 14 risks score 12 (high) • There are 2 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 3 September 2026 Quality Committee 8 September 2026 Business Committee 15 September 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 (July 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 (July)
Total Open Risks	121	121
Risks Scoring 15 or above	1	1
New Risks	6	12
Closed Risks	6	14
Risk Score Increasing	2	4
Risk Score Decreasing	10	9

2.2 There is one extreme risk on the risk register (scoring 15 or more). The following update has been provided to the risk since the last risk register report in July 2026.

Risk	Risk Type	Current Score	Months at current score	Risk Appetite
1383: Mind Mate Neurodevelopmental Referral Triage Waiting List	**Operational**	**15**	**11**	**Cautious (4 – 6)**
As of July 2026, the following was reported regarding the ND backlog work undertaken by Northpoint. 1152 families remain on the waiting list. A staged plan for the remaining waiters has been agreed to review information across clinical systems, contact all families/young people to identify those who wish to progress to assessment or needs led support and for those who meet clinical suitability progress to a provider of choice. Clinicians will retain clinical oversight for risk. This work is due to begin on the 1st of August 26 and will be completed by 30th October 26. (update 30/7/26)				

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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
1383	Mind Mate Neurodevelopmental Referral Triage Waiting List		15 →	15 →	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 →
1242	Fire Evacuation Arrangements of LCH owned premises	8 →	8 →	8 →	8 →	8 →	8 →	8 →	8 →	8 →	8 →	8 →	12 ↑
1336	The reporting of Health and Safety, Fire Safety, Security and Moving and Handling accidents and incidents	6 ↓	6 →	6 →	6 →	6 →	6 →	6 →	6 →	6 →	12 ↑	12 →	12 →
1366	Manual STI test requests risk patient safety and increase operational burden			12 →	12 →	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 accepted at the current level, above target, acknowledging the controls in operation. The risk will continue to be managed and monitored.

Ref	Title	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
1379	Civil unrest / protests, staff safety			12 →	12 →	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 ↑	12 →	12 →
1419	Primary care reduced staffing levels - Wetherby YOI, Adel Beck and Aldine House Staffing levels below safer staffing numbers					12 →	12 →	12 →	12 →	12 →	9 ↓	9 →	12 ↑
1462	Occupational health support and compliance								12 →	12 →	12 →	12 →	12 →
1467	Clinical And Safeguarding Supervision Portal (CASSP) - Compliance Data								12 →	12 →	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 →	12 →	12 →
1494	Demand exceeds capacity in the Speech and Swallowing Team for patients with swallowing (dysphagia) needs.												12 →
1503	Inconsistent Clinical Assessment, Documentation, Incident Reporting and Safeguarding Management for Children and Young People within WYOI												12 →

3.3 Since the previous report in July, the number of risks with a score of 12 has reduced from 19 to 14. This reflects the addition of two new risks scoring 12 and a further two existing risks that have increased to a score of 12. Offsetting this increase, seven risks previously scored at 12 have reduced to below 12 and two risks scoring 12 have been closed.

3.4 In the previous report, three risks scoring 12 or above had remained at the same score for more than 12 months and were therefore classified as static. Since that time, one of these risks has been closed, reducing the number of static risks scoring 12 or above to two.

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 50 clinical risks and 71 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	1	1	0	0	2
4 - Major	1	6	4	0	0	11
3 - Moderate	2	25	35	10	0	72
2 - Minor	0	12	16	4	0	32
1 - Negligible	1	1	1	1	0	4
Total	4	45	57	15	0	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, 29 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

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 19 November 2026.

[1] Risks: 1109, 1125, 1168,1169, 1187, 1196, 1285, 1307, 1319, 1353, 1356, 1357, 1365, 1366, 1369, 1374, 1392, 1393, 1395, 1414, 1419, 1426, 1437, 1453, 1470, 1478, 1485, 1501, 1503

[2] Risks: 902, 1206, 1221, 1242, 1336, 1379, 1400, 1415, 1422, 1428, 1434, 1444, 1462, 1463, 1465, 1467, 1468, 1479, 1486

[3] Risks: 772, 954, 1098, 1179, 1311, 1383. 1433, 1494, 1495, 1502

[4] Risks: 1412, 1459, 1490

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: 1 September 2026

Agenda item:	2026-27 (16i)
Title of report:	Board Assurance Framework Quarterly Update
Meeting:	Trust Board Meeting Held In Public
Date:	17 September 2026

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

Purpose of the report:		
To share the output of the first quarterly review of the 2026/27 Board Assurance Framework.	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:
• First quarterly review of the 2026/27 BAF undertaken during July/August 2026. • Updated BAF attached as an appendix. • Quarterly reviews will continue throughout 2026/27.

Previously considered by:	Strategic risks reviewed with individual responsible Directors during late July/Aug 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	Yes		What does it tell us?	
	No	✓	Why not/what future plans are there to	The Trust continues to have a strategic risk

and/or workforce)?			include this information?	focussing on reducing inequalities experienced by the population we serve

Recommendation(s)	The Board is asked to: • Receive the BAF and to be assured of the appropriateness of updates, including risk scoring and mitigating actions.

List of Appendices:	Appendix 1 – BAF_2026-27_Sep_2026

Board Assurance Framework – Quarterly Update

1. Introduction

1.1 In July 2026 the Board received a report summarising the processes undertaken to review the BAF in readiness for the 2026/27 financial year. At that meeting the Board approved the nine Strategic Risks for 2026/27, along with the Risk Appetite statements for each strategic risk.

2. Quarterly Review of Strategic Risks

2.1 During late July and August 2026, meetings were held with the Executive Directors in order to undertake the first quarterly review of the 2026/27 BAF. Each strategic risk has been reviewed in terms of the following:

- Operation of the current controls / whether any additional or gaps in controls need to be added
- Progress against the actions
- Impact of the actions on the score
- Any further actions identified to reduce the risk to target
- Whether there are any missing sources of assurance that need to be added.

The key changes for each strategic risk are outlined on pages 2 and 3 of the attached BAF.

2.4 During June and July 2026 the Audit, People & Culture, Quality and Business Committees reviewed the strategic risks for which they have oversight, considered the sources of assurance and allocated an assurance rating to each risk from the information presented to them, shared with Board via their Committee Escalation and Assurance reports. The outputs of those discussions is visible on pages 4 and 5 of the attached BAF.

2.5 The Board is reminded that the BAF is presented here for assurance on its completeness as of September 2026.

3. Next Steps

3.1 All strategic risks will continue to be assigned to a Director and to a Committee(s) for oversight. The Directors will maintain oversight of the strategic

risks assigned to them and will review these risks on a quarterly basis to continually evaluate the effectiveness of the controls in place that are managing the risk and identify any gaps that require further action.

3.2 The Committees will continue to be required to report to the Trust Board following each meeting via the Committee Escalation and Assurance reports on whether the risks to the success of its strategic objectives are being managed effectively.

3.3 From 2026 onwards, the Risk Management Group will also be receiving and reviewing the BAF following each quarterly review with the individual Directors. The Group considered the current version of the BAF on 3 September 2026.

3.4 The BAF will subsequently be reviewed on a quarterly basis and the outcome shared with the Board.

4 Recommendations

The Board is recommended to:

- Receive the BAF and to be assured of the appropriateness of updates, including risk scoring and mitigating actions.

Helen Robinson
Company Secretary

7 September 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 24 August 2026

Ref	Strategic Risk	Lead Director	Current Score (August 2026)	Target Score (2026/27)	Position following Quarter 1 review
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. • There is currently insufficient evidence of sustained improvement to justify reducing the risk score. • The benefits of the Quality and Value (Q&V) transformation programme have not yet been fully realised, with mitigation actions still progressing. • Ongoing service mobilisation and demobilisation activity continues to affect the risk profile and create challenges in maintaining consistent service delivery. • Planned Trust integration activity is expected to introduce further organisational change, potentially impacting the consistency of high-quality care delivery.
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	• Focused waiting list reduction initiatives have resulted in achievement of the national Referral to Treatment (RTT) standard. Current RTT performance is 81%, exceeding the national target of 78%. • Access performance is now aligned with Segment 1 of the National Oversight Framework (NOF). • A small number of patients continue to experience waits of more than 52 weeks across two service areas. Current plans indicate that all waits exceeding 52 weeks will be eliminated by December 2026. • The risk score will remain at 12 until sustained improvement is demonstrated and the number of long waiters is further reduced.
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	The risk score remains at 9, reflecting the significant volume of organisational change taking place across the Trust. New actions have been added in response to national expectations, including the implementation of staff standards. These actions are expected to strengthen existing arrangements and provide greater assurance as organisational changes become embedded. The Best of Both staff engagement programme, which supports organisational change and staff engagement, is now approaching the end of Phase 1. The programme has continued to support staff through the transition period and will help inform the next stage of embedding organisational changes across the Trust.
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 operational risks associated with the 2026/27 financial position have reduced from 12 to 8. However, the strategic risk remains focused on the Trust's medium-term financial sustainability. There is currently no change to the overall risk score, as two key actions are not due for completion until Quarter 3. The risk rating will therefore remain unchanged at this stage and will be reviewed following completion of the planned actions, including the development of financial modelling to support the Trust Integration Programme and the establishment of a pipeline of Quality and Value (Q&V) initiatives.
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	Actions and controls remain in place and continue to provide assurance that the risk is being effectively managed. However, external factors beyond the Trust's direct control continue to influence the likelihood of incidents occurring. Gaps in assurance have been identified regarding business continuity arrangements for leased third-party buildings. To address this, independent assurance will be sought on Community Health Partnerships' building strategy for climate risks, including extreme weather events (this action is assigned against SR9: Infrastructure). As the overall risk profile has not materially changed during the reporting period, there is no change to the risk score, which remains under regular review.
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 continues to progress, supported by targeted interventions and aligned to the Trust's health and wellbeing agenda. Overall sickness levels are improving; however, performance remains in NOF Segment 4, requiring sustained improvement. Internal Audit has provided positive assurance that appropriate arrangements are in place to deliver the programme's objectives. Ongoing organisational transformation and sickness levels remaining above national expectations mean the risk score remains unchanged at 12. Sustained reductions in sickness absence and positive outcomes from staff engagement initiatives may support a future reduction in the risk score.

Ref	Strategic Risk	Lead Director	Current Score (August 2026)	Target Score (2026/27)	Position following Quarter 1 review
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	At the end of August 2026, the risk score remains unchanged, reflecting the continued likelihood that inequity is embedded within existing systems and processes. However, the position has improved from the start of 2026/27, with evidence that targeted actions and enhanced data analysis have enabled the Trust to identify and successfully reduce inequities in some areas of service delivery. While population-level improvements remain slow to emerge, there is increased confidence that mitigating actions are having a positive impact. The return of the Public Health Consultant in June 2026 has strengthened capacity to support this work, and improvements in equity data and reporting are providing earlier identification of inequities and reducing the risk of issues remaining unaddressed. Although external factors, including system changes at ICB/DHSC level, integration with LYPFT and development of the Provider Alliance, continue to affect progress, the overall trajectory towards achieving the target risk score by the end of Q4 has improved.
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	6 ~~3~~	Current risk score remains at 8, reflecting ongoing internal and external organisational change. Progress continues with the Trust's integration programme with Leeds and York Partnership NHS Foundation Trust (LYPFT). Next formal integration checkpoint scheduled for September 2026. Place Provider Partnership implementation has been delayed until April 2028 due to ongoing changes within the ICB. A gap in control regarding vacancies within the ICB Place-Based Integrator Team, although recruitment is planned with appointments expected from September 2026. Ongoing external uncertainty and large-scale organisational change mean the current risk score remains appropriate. Target risk score increased from 4 to 6 (2x3) by the end of 2026/27. Change reflects the extended timeline for the Place Provider Partnership, now expected in April 2028. While integration with LYPFT is expected to reduce risk over time, this is offset by continued uncertainty associated with NHS England and West Yorkshire ICB changes. External factors remain outside the Trust's control and may limit progress towards the agreed risk appetite within the next 12 months.
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 score remains 12. The Digital Strategy and Estates Transition Plan have been completed, and digital KPIs have been developed and are now reported, strengthening oversight of infrastructure performance. An operational risk relating to recent incidents relating the extreme heat in leased third-party buildings has been added to the risk register; assurance relating to wider climate risks relating to leased buildings will be discussed with Community Health Partnerships. A further control gap exists in the reporting of Health and Safety incidents via Datix, which may limit visibility of estate-related incidents linked to this strategic risk. This is being managed through Risk 1336 and interim workarounds pending implementation of the new Datix system for the merged organisation. Risks have also been identified relating to fire zoning arrangements across the estate. Two operational risks concerning fire zoning compliance and fire evacuation arrangements have been linked to this strategic risk, reflecting the potential impact of these issues on estate infrastructure. The risk associated with the availability of capital funding has reduced following review of the 2026/27 capital forecast. However, the overall risk score remains unchanged due to ongoing estate constraints and outstanding assurance requirements.

Board Assurance Framework Levels of Assurance

Details of strategic risks (description, ownership, scores)								Level of Assurance				
Risk		Risk ownership		Current risk score				Committee agreed level of assurance				
Strategic Goal(s)	Risk	Responsible Director(s)	Responsible Committee(s)	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	Additional Information
Work with communities to deliver personalised care/ To embed equity in all that we do	**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.	DoN	QC	4	4	**16**				✓		July Quality Committee - Reasonable overall but: • Incident Management and investigation oversight –It was noted that assurance remained limited because there was not yet 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.
Work with communities to deliver personalised care/ To embed equity in all that we do	**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.	DoO	QC/BC	3	4	**12**				✓		
Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do	**Risk 3 Culture of Engagement, inclusivity and continuous improvement**: 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.	CEO/DoP	P&CC	3	3	**9**				✓		
Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do	**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.	DoF	BC	3	4	**12**				✓		June Business Committee: Reasonable assurance provided around sound financial grip and control in relation to Q&V programme.
Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do	**Risk 5 Failure to maintain business continuity:** If we are unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.	DoO	BC/AC	3	4	**12**				✓		July Audit Committee: The Committee noted overall confidence regarding the DSPT approach, due to progress and activity reported around the gaps. The overdue EPRR recommendation was noted, however assurance remained reasonable overall.

Details of strategic risks (description, ownership, scores)								Level of Assurance				
Risk		Risk ownership		Current risk score				Committee agreed level of assurance				
Strategic Goal(s)	Risk	Responsible Director(s)	Responsible Committee(s)	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	Additional Information
Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do	**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.	DoP	P&CC	4	3	**12**				✓		June People & Culture Committee: Reasonable assurance overall but noted the ongoing risk around the need to appoint a Sustainability Manager. The positive aspects from the Employee story were highlighted.
Work with communities to deliver personalised care / Use our resources wisely and efficiently both in the short and longer term / Collaborating with partners to enable people to live better lives / Enable our workforce to thrive and deliver the best possible care / To embed equity in all that we do	**Risk 7 Failure to reduce inequalities experienced by the population we serve:** If the Trust fails to address the inequalities built into 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.	MD	QC/TB	4	3	**12**				✓		
Collaborating with partners to enable people to live better lives / To embed equity in all that we do	**Risk 8 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.	CEO	TB	2	4	**8**				✓		
Use our resources wisely and efficiently both in the short and longer term / To embed equity in all that we do	**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.**	DoF	BC	3	4	**12**				✓		

Strategic Risk 1:

High-Quality Care:

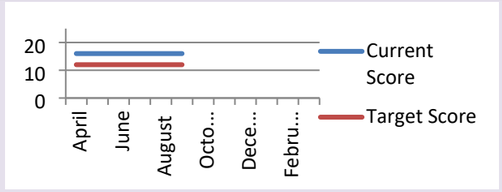
If we fail to identify, deliver, and sustain high-quality care – supported by a strong culture of learning and continuous improvement in relation to patient care - there is an increased risk of unsafe or ineffective services. This may lead to preventable harm, poor patient outcomes, and a diminished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

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

Committee with oversight: Quality Committee

Date last reviewed: 13/8/26

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

Quarter 1 review
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 remain in place and continue to provide assurance on key trends and themes, there is not yet sufficient 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, with actions continuing to progress. In addition, ongoing service mobilisation and demobilisation activity continues to influence the risk profile and presents challenges in maintaining consistency of service delivery during periods of change. For example, mobilisation of three new Recovery Hub sites across the city commenced on 1 July, representing a significant service development that requires ongoing oversight to ensure quality and safety are maintained throughout implementation.
Forthcoming Trust integration activity is also expected to introduce further organisational change, which may affect the consistency of delivering high-quality care. Additionally, there remains increased risk associated with recent changes in Executive leadership and capacity constraints within the clinical governance team.
Given these factors, and with risk mitigation actions ongoing, there has been no change to the likelihood or consequence ratings. The current risk score is therefore 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

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. The Quality Challenge programme is in place aligned with current assessment framework	Executive Director of Nursing and AHP's.	~~July 2026~~ Complete
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. Phase 1 approved at TLT 5th August	Executive Director of Nursing and AHP's and Executive Director of Operations	Sept 2026
Due to concerns raised about the learning from deaths process an 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

- Duty of candour monitoring process
- Quality improvement programme – in response to incidents / external recommendations
- Patient experience process

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: o CQC Inspection Preparedness (Q3) o Quality and Clinical Governance (Q4) o Safeguarding Sexual Safety (Q2) o Recording and learning from deaths (Q4) o Datix advisory (Q3) • 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. The development, build and testing of data capture processes will continue over the next two months to ensure reporting arrangements are robust, reliable and embedded within services. An update scheduled for September Quality Committee through Matters Arising and a further paper planned for the November Quality Committee.	Executive Director of Nursing and AHP's.	Nov 2026

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

1383: Mind Mate Neurodevelopmental Referral Triage Waiting List (15)
954: Diabetes Service waiting times (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)
1395: Decommissioning and disposing risk of non-concordance with the organisational process for medical devices (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 (12).
1487: ICAN Admin Typing Backlog (12)
1494: Demand exceeds capacity in the Speech and Swallowing Team for patients with swallowing (dysphagia) needs (12).

Strategic Risk 2:

Demand for services:

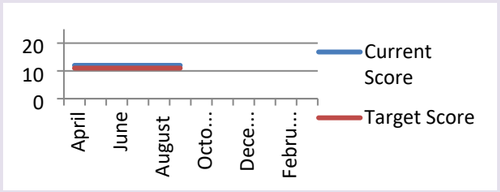
If we fail to respond to changes in population growth and presentation, and changing delivery models such as Neighbourhood Health, then the impact will be potential harm to patients due to long waits, inability to strengthen equity of access, additional pressure on staff, financial consequences and poor 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: 30/7/26

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:
Quarter 1 Review
The focused work to reduce waiting lists has resulted in the Trust achieving the national standard for referral-to-treatment (RTT) performance, with 81% of patients currently receiving care within 18 weeks, exceeding the required threshold of 78%. Access performance is therefore aligned with Segment 1 of the National Oversight Framework (NOF).
Despite this improvement, a small number of patients continue to wait longer than 52 weeks in two service areas. As a result, the risk score will remain at 12 until further sustained progress is demonstrated and the number of long waiters is reduced. The current trajectory indicates that waits exceeding 52 weeks will be eliminated by December 2026.

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): 1383: Mind Mate Neurodevelopmental Referral Triage Waiting List (15) 954: Diabetes Service waiting times (12) 1470: Staff shortages and high demand in the Triage Hub and Response Team leads to patients not receiving timely and necessary care. (12)			1494: Demand exceeds capacity in the Speech and Swallowing Team for patients with swallowing (dysphagia) needs.

Strategic Risk 3:

Culture of Engagement and inclusivity:

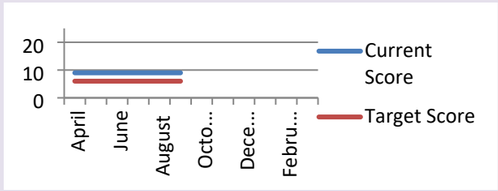
If we fail to foster and support an organisational culture of learning, continuous improvement, inclusivity, and speaking up—particularly during periods of organisational change—there is a risk of reduced staff engagement and could impact on our ability to provide high-quality, safe care for the people who use our services.

Lead Director/risk owner: Chief Executive Officer / Director of People

Committee with oversight: People and Culture Committee

Date last reviewed: 10/8/26

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:
Quarter 1 review
The risk score remains at 9, reflecting the significant volume of organisational change taking place across the Trust. New actions have been added in response to national expectations, including the implementation of staff standards. These actions are expected to strengthen existing arrangements and provide greater assurance as organisational changes become embedded.
The Best of Both staff engagement programme, which supports organisational change and staff engagement, is now approaching the end of Phase 1. The programme has continued to support staff through the transition period and will help inform the next stage of embedding organisational changes across the Trust.

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
- Best of Both staff engagement programme
- 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
Develop and implement an organisational Inclusion and Belonging Improvement Framework aligned to the NHS Staff Standards and Lord Mann Review recommendations, including clear measures, governance oversight, and reporting mechanisms to monitor progress and address identified gaps.	DoP	30 Nov 2026
Undertake a gap analysis against the NHS Management and Leadership Framework and develop a phased implementation plan to address identified development needs across leadership and management cohorts.	DoP	30 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
• 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 • TIP update – People and Culture elements (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 • Annual report to Board (Board)	• 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
Incorporate the NHS Staff Standards into the NOF scoring methodology and reporting framework, with regular reporting through the NOF report to the People and Culture Committee (PCC) to provide assurance on implementation and compliance.	DoP	30 Oct 2026

	• 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:

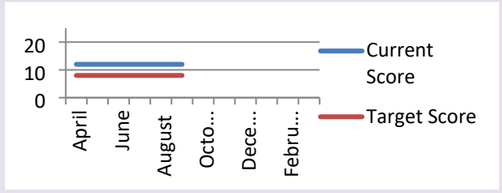
There is a risk that a lack of financial efficiency and sustainability results in the destabilisation of the organisation and an inability to meet our objectives.

Lead Director/risk owner: Executive Director of Finance and Resources

Committee with oversight: Business Committee

Date last reviewed: 13/8/26

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

Quarter 1 review
The operational risks associated with the 2026/27 financial position have reduced from 12 to 8. However, the strategic risk remains focused on the Trust's medium-term financial sustainability. There is currently no change to the overall risk score, as two key actions are not due for completion until Quarter 3. The risk rating will therefore remain unchanged at this stage and will be reviewed following completion of the planned actions, including the development of financial modelling to support the Trust Integration Programme and the establishment of a pipeline of Quality and Value (Q&V) initiatives.

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.
- 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. Implementation of IPR process	EDFR	~~June 26~~ Complete
2. Financial modelling to inform development of full business case (FBC) in relation to Trust integration programme. On track	EDFR	October 2026
3. Develop a systematic approach to using benchmarking data to inform the Q&V programme. Pipeline Q&V programme is in development however remains incomplete due to competing priorities– review date October 2026	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 o Quality and Value programme structure (Significant Assurance) o Key Financial Controls (Q2) o 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. The new approach to IPR has been implemented to address this.	EDFR	~~September 2026~~ Complete

Link to Risk Register (material risks scoring 12 or above):
The following risks have reduced from 12 to 8 since the last review:
1489: Achievement of financial balance 2026/27 - Likelihood score reduced to 2 - Unlikely following review of financial position at Month 4 close.
1490: Availability of capital 2026/27 - Likelihood score reduced to 2 - Unlikely following review of forecast

Strategic Risk 5:

Failure to maintain business continuity:

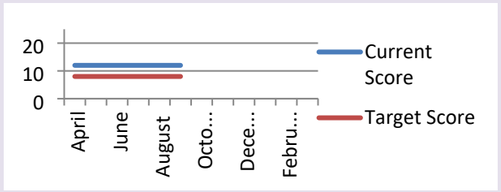
If the Trust is unable to maintain business continuity in the event of significant disruption, in the short (less than one week) or longer term (above 1 week), then essential services will not be able to operate, leading to patient harm, reputational damage, and financial loss.

Lead Directorate/risk owner: Executive Director of Operations

Committee with oversight: Business and Audit Committees

Date last reviewed: 30/7/26

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:
Quarter 1 Review
Actions and controls remain in place and continue to provide assurance that the risk is being effectively managed. However, external factors beyond the Trust's direct control continue to influence the likelihood of incidents occurring. An operational risk relating to recent incidents relating the extreme heat in leased third-party buildings has been added to the risk register; assurance relating to wider climate risks relating to leased buildings will be discussed with Community Health Partnerships. As the overall risk profile has not materially changed during the reporting period, there is no change to the risk score, which remains under regular review.

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
- EPRR Exercising programme
- EPRR Training plan
- EPRR operating with LYPFT as joint service

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. By 31/5/26 the exercising programme was in place and will continue throughout 26/27 – established as a control	Executive Director of Operations	~~31 March 2027~~ Complete
A control gap was identified through the EPRR Internal Audit relating to the completion and evidencing of the EPRR self-assessment. A joint EPRR appointment has been established with LYPFT, and a peer review process has been agreed as an audit action to support a consistent approach across both organisations. This will ensure alignment on the evidence requirements for self-assessment completion, strengthen assurance arrangements, and improve the robustness and consistency of compliance reporting.	Executive Director of Operations	31 Dec 2026

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 six monthly compliance updates to Business Committee and Board • Cyber Security Report (AC) • Sustainability and Climate Adaptability Steering Group AAA report (BC) • Digital strategy update (BC)	• Scrutiny of Major Incident Plan (annual) (BC then Board) • Reports regarding major incident exercises and deep dives (included in Emergency preparedness report (annual) (BC then Board) • Performance Brief (Responsive) (BC) • Information Governance Approval Group minutes (AC) • Statutory/mandatory training compliance (Performance Brief) (BC)	• Internal audit (BC/AC) o 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

	• 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)

The risk score for the operational risk detailed below is 9, which is below the standard threshold of 12 for material risks. However, it has been included due to its direct relevance during periods of extreme heat and the potential impact on this strategic risk. At some sites, the risk score increases to 12, reflecting the assessment that extreme heat is considered 'Almost Certain' to affect the delivery of some services.
1486: Warm Third-party Buildings (9)

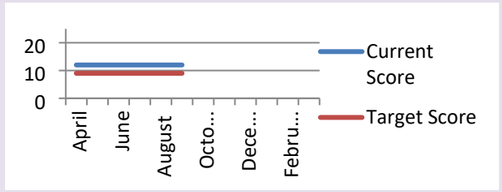
Strategic Risk 6:
Staff health and wellbeing:
There is a risk that insufficient focus on the health, wellbeing, and engagement of staff will lead to increased sickness absence, burnout, and workforce instability. This may result in reduced capacity and diminished quality of care.

Lead Director/risk owner: Director of People

Committee with oversight: People and Culture Committee

Date last reviewed: 5/8/26

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:
Quarter 1 review
The sickness reduction programme continues to progress and remains aligned to the broader organisational health and wellbeing agenda. Work on sickness management continues across services, supported by the established evidence-based approach that uses sickness absence data to identify trends and target interventions where they are most needed.
Whilst overall sickness performance continues to improve, sickness reporting within the NHS Oversight Framework (NOF) remains in Segment 4, indicating that sustained improvement is still required. As a result, the risk score remains unchanged at 12.
Positive assurance has been received through Internal Audit, which concluded that the sickness reduction programme is appropriate and that arrangements are in place to support delivery of the programme's objectives. This provides increased confidence that the controls and improvement actions currently in place are proportionate and effective.
While these developments provide assurance that the risk is being actively managed, the ongoing scale of organisational transformation, combined with continued high sickness levels relative to national expectations, means the current risk score of 12 remains appropriate at this time. Further sustained reductions in sickness absence and evidence of positive impact from staff engagement actions would support consideration of a future reduction in the 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. Staff survey engagement activity has been completed, with all services reviewing their results and submitting intention plans to address identified priorities. Looking ahead, preparations for the next Staff Survey will focus on embedding actions arising from the current survey,	DoP	~~Jun 26~~ Complete
Implement and monitor delivery of the Internal Audit action plan for sickness absence to address identified control gaps to strengthen the control framework. Implementation of the Internal Audit action plan remains in progress, with actions being delivered to address the control gaps identified through the audit review.	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 • Staff survey analysis at service level via annual staff survey results (PCC) • Organisational health deep dive in hot spot services (PCC)	• IPR (staff turnover figures, recruitment timescales, sickness absence, appraisal rate) • Safe staffing report • Guardian for safe working hours report • 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)	• Internal Audit Sickness Absence – Significant Opinion

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

Action	Owner	Due by

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

1336: The reporting of Health and Safety, Fire Safety, Security and Moving and Handling accidents and incidents (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)
1494: Demand exceeds capacity in the Speech and Swallowing Team for patients with swallowing (dysphagia) needs (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:

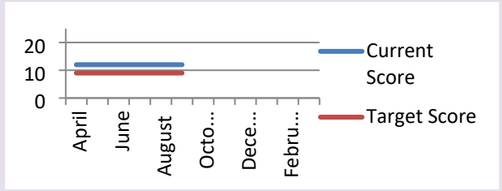
If the Trust fails to address the inequalities built into our own systems and processes, there is a risk that we are inadvertently delivering unfair access or care and exacerbating inequalities in health outcomes within some cohorts of the population.

Lead Director/risk owner: Medical Director

Committee with oversight: Quality Committee / Trust Board

Date last reviewed: 13/8/26

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

Quarter 1 Review

- 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 have begun to successfully reduce inequity in these areas, while needing to continue to identify and drive action to reduce inequalities in other areas.
- 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 impact at population health levels is slow to show in data.

At the end of August 2026 there is no change to the risk score. 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 was vacant from August 2025 to June 2026.

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. The trajectory for reducing the risk to the target score by end Q4 is supported by improved equity data and reporting that enables earlier identification of any inequity and reduces the likelihood of any such inequity remaining unmitigated.

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

- Elevation of the equity agenda to a Trust strategic objective
- We have a 5-year Tactical Plan and links with Quality and Value programme
- Programmes of work delivering on statutory duties
- Development of measurement framework for equity
- Active member of the Leeds Tackling Healthcare 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 now structured into standing equity agenda item at SLT
- Equity measures in Access LCH Productivity workstreams and reported through IPR

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. Service and trust-level reporting are now available enabling targeted support to services with lowest completion rates. The digital patient questionnaire is being piloted in Q2 with roll-out for all new referrals in Q3 and a business case is due for decision in August 2026 for a one-off SMS campaign to complete this for all existing patients with an open referral. This would be undertaken in Q3.	Medical Director	30 December 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 framework. 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. Implementation of the Health Equity Index for missed appointments, 18 week waiting times and 52 week waiting times by IMD and ethnicity is planned for the November 2026 IPR. LD will follow. Further work on the completeness of data is required to report by armed forces status and for people with a disability.	Assistant Director of Insight and Intelligence	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. Technical implementation of the Health Equity Index is underway and measures using the index are planned for inclusion in the IPR from November 2026.	Assistant Director of Insight and Intelligence	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. Public Health Consultant role was filled in the interim, the substantive holder has since returned.	Medical Director	~~1 June 2026~~ Complete

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

1. Service Level Assurance	2. Specialist Support / Oversight Assurance	3. Independent Assurance
• 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~~ Complete
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 has been revised to produce a 5-year health inequalities tactical plan. The draft health inequalities tactical plan was presented at the Trust Board meeting on 6 November 2025, further work to be taken to the Board to address the comments raised. Workshop deferred by Board from March to May 26, and update paper will be provided to September Board. 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 has been undertaken with significant assurance. The action plan is being developed for delivery in Q3 and Q4.	Medical Director	End Q4 2026/7.

Link to Risk Register (material risks scoring 12 or above):
1383: Mind Mate Neurodevelopmental Referral Triage Waiting List (15)

Strategic Risk 8

System change (including Trust Integration Programme):

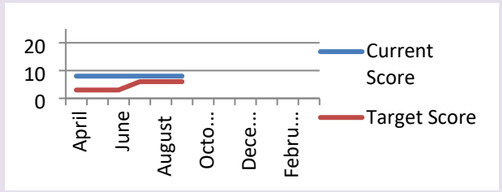
There is a risk that the Trust is unable to deliver on its medium-term plan if it cannot adequately engage in, influence and adapt to the significant changes that are taking place within NHSE/DHSC, the West Yorkshire ICB and the Trust Integration programme with LYPFT.

Lead Director/risk owner: Chief Executive

Committee with oversight: Trust Board

Date last reviewed: 10/8/26

Risk Rating
(likelihood x consequence)
Current score:
2 x 4 = 8
Target score (end of 2026/27):
2 x 3 = 6



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

Quarter 1 review
The risk score remains at 8. The risk continues to be driven by three key factors: two external factors relating to ongoing changes within NHS England and the West Yorkshire ICB, and one internal factor relating to the Trust's integration programme with Leeds and York Partnership NHS Foundation Trust (LYPFT).
At NHS England regional level, organisational changes continue, with the Chief Executive participating in a core working group focused on provider relationships, performance oversight and improvement arrangements. At ICB level, implementation of the Place Provider Partnership has been deferred until April 2028 due to ongoing organisational change within the ICB. A gap in controls remains in relation to vacancies within the ICB Place-Based Integrator Team; however, recruitment to these roles is planned, with appointments expected from September 2026.
Progress continues against the Trust's integration programme with LYPFT. The Strategic Outline Case (SOC) has been approved, enabling further integration actions to progress, with the next formal checkpoint scheduled for September 2026. Due diligence activity has also been completed, with no material risks identified. The outcomes of this work have been shared through Board-to-Board discussions.
Given the ongoing external uncertainty and the scale of organisational change across the system and within the Trust, the current risk score remains appropriate.

Rationale for target score (including any constraints to reaching risk appetite within the next 12 months):
The risk appetite for this risk reflects the Trust's willingness to pursue opportunities through system-wide partnership working, collaboration and new ways of working to improve outcomes and service delivery.
The target score for the end of 2026/27 has been increased to 6 (2x3) to reflect the extended timescales for implementation of the Place Provider Partnership, now scheduled for April 2028. While the level of risk associated with the Trust's internal integration programme is expected to reduce as milestones are achieved and changes become embedded, this is offset by the continued uncertainty and unpredictability associated with organisational changes at both NHS England and West Yorkshire ICB over the coming months.
Progress against the integration programme and wider partnership arrangements is expected to provide greater assurance over time. However, external factors remain outside the Trust's direct control and may constrain the pace at which the risk can be reduced towards the agreed 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
- Joint executive roles with GP Confed
- IPR / schedule of assurance reports to maintain oversight on delivery of Trust medium-term plan / objectives
- 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
- Integrated Neighbourhood Health pilot and future design
- Wildly Important Goals – oversight and reporting through SLT
- Best of Both engagement programme
- Strategic Outline Case (SOC) and due diligence

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 to address this the CEO is involved in a core NHSE regional working group reviewing the future relationship with providers, oversight of performance and improvement.	CEO	30 November 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
• 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) • TIP update (PCC) • Transition Committee AAA (TB)	• 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) • MHLDA Committees in Common minutes and report (TB) • Place based partnership maturity assessment (with ICB)	• 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

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:

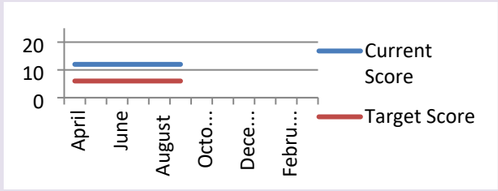
If the Trust is unable to provide access to safe and fit for purpose digital and estate infrastructure, then there is a risk that the quality and continuity of service provision will be compromised which may further impact achievement of all of the Trusts strategic goals and priorities.

Lead Director/risk owner: Executive Director of Finance and Resources

Committee with oversight: Business Committee

Date last reviewed: 13/8/26

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

Quarter 1 Review
The risk score remains 12. The Digital Strategy and Estates Transition Plan have been completed, and digital KPIs have been developed and are now reported, strengthening oversight of infrastructure performance.
An operational risk relating to recent incidents relating the extreme heat in leased third-party buildings has been added to the risk register; assurance relating to wider climate risks relating to leased buildings will be discussed with Community Health Partnerships.
A further control gap exists in the reporting of Health and Safety incidents via Datix, which may limit visibility of estate-related incidents linked to this strategic risk. This is being managed through Risk 1336 and interim workarounds pending implementation of the new Datix system for the merged organisation.
Risks have also been identified relating to fire zoning arrangements across the estate. Two operational risks concerning fire zoning compliance and fire evacuation arrangements have been linked to this strategic risk, reflecting the potential impact of these issues on estate infrastructure.
The risk associated with the availability of capital funding has reduced following review of the 2026/27 capital forecast. However, the overall risk score remains unchanged due to ongoing estate constraints and outstanding assurance requirements.

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 - Digital Strategy and Estates Transition Plan
- 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:	EDFR	
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.		~~May 2026~~ Complete
2. Finalise year 2 priorities in the Digital Strategy (BC May)		~~May 2026~~ Complete

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. The development of KPIs is complete and reported to the Trust Board	CDIO	~~July 2026~~ Complete
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 In progress	EDFR	Oct 2026

Link to Risk Register (material operational risks scoring 12 or above):
Risk 1336: The reporting of Health and Safety, Fire Safety, Security and Moving and Handling accidents and incidents (12)
Risk 1242: Fire Evacuation Arrangements of LCH owned premises (12)
Risk 1505: Fire Zoning (12)

The following risks have reduced from 12 since the last review:

- 1473: Water Safety (6) – Likelihood score reduced to 2 (Unlikely) Whilst there is always a risk the controls are operating effectively and will continue to be monitored.
- 1490: Availability of capital 2026/27 (8) - Likelihood score reduced to 2 - Unlikely following review of forecast

The risk score for the operational risk detailed below is 9, which is below the standard threshold of 12 for material risks. However, it has been included due to its direct relevance during periods of extreme heat and the potential impact on this strategic risk. At some sites, the risk score increases to 12, reflecting the assessment that extreme heat is considered 'Almost Certain' to affect the delivery of some services.

1486: Warm Third-party Buildings (9)

Agenda item:	2026-27 (17)
Title of report:	Board Members Service Visits
Meeting:	Trust Board Meeting Held In Public
Date:	17 September 2026

Presented by:	Dr Sara Munro, CEO
Prepared by:	Rakhi Palliyath, Corporate Governance Officer/Helen Robinson, Company Secretary

Purpose of the report:		
This report provides the Board with an update on the Board members service visits framework, including visits undertaken to date, key themes arising, and the planned programme of future visits.	Approval	
	Discussion	
	Assurance	x

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

Summary of Key Issues:
The Board Service Visits Framework provides opportunities for Non-Executive Directors (NEDs) and Executive Directors (EDs) to engage directly with services, staff and patients across the Trust. The programme supports Board assurance, strengthens visibility and relationships with frontline teams, and enables insights into both areas of excellence and challenges experienced by services. During 2026/27, a programme of Learning Visits and Leadership Visits has been established, with visits undertaken across a range of clinical and corporate services. Feedback from visits is shared through the Trust's governance structures to support organisational learning and service improvement.

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

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

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

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

Recommendation(s)	The Board is asked to note the progress made in delivering the Board Service Visits Framework and the planned programme of future visits.

List of Appendices:	N/A

Board Members Service Visits

1 Background

The Trust has committed to undertaking:

- A minimum of six Learning Visits per year led by NEDs, with at least one visit undertaken within a non-clinical service.
- A minimum of six Leadership Visits per year involving EDs and NEDs working in partnership, subject to availability.

Services are selected for Learning Visits either through the bimonthly Chair/NED meetings or via discussions undertaken through their annual and mid-year reviews with the Chair. Leadership Visits are focused on areas identified through emerging organisational priorities.

2 Visit Process

The Corporate Governance Team coordinates all Learning and Leadership Visits.

This includes:

- Identifying availability with participating NEDs and EDs.
- Liaising with services to identify appropriate visit opportunities and contacts.
- Coordinating arrangements and agreeing mutually convenient dates and times.
- Issuing calendar invitations and confirming visit logistics.

Visits are typically scheduled for up to two hours, although this may vary depending on the nature of the service and discussions during the visit.

Prior to each visit, participating NEDs are provided with:

- A summary of key service information, such as workforce, sickness absence and appraisal data.
- Details of the service location and access arrangements.
- Contact details for key staff supporting the visit.
- A structured feedback template.

The feedback forms support reflection on key observations and learning, areas of good practice and reasons to be proud, issues requiring escalation or further consideration, and opportunities for improvement.

Completed Learning Visit feedback forms (NED only visits) are reviewed through the Senior Leadership Team (SLT), while Leadership Visit feedback forms (NED and ED visits) are reviewed through the Trust Leadership Team (TLT). Feedback is subsequently shared with the visited services, providing an opportunity for learning and continuous improvement. Feedback is also sought from visited teams regarding their experience of the process to inform future development of the framework.

3 Learning and Leadership Visits Undertaken

The first round of Learning and Leadership Visits undertaken during 2026/27 are outlined below:

No.	Type of visit	Name of the NED/ED	Services visited
1	Learning Visit	Prof. Ian Lewis, NED	• 'Enhance' Provision at Crossgates Good Neighbour Scheme. • Finance Corporate Team.
2	Learning Visit	Lynne Mellor, NED	• Meanwood Neighbourhood Team • Morley Neighbourhood Team
3	Learning Visit	Rachel Booth, NED	• Safety Team • Corporate Governance Team
4	Learning Visit	Khalil Rehman, NED	• HR team
5	Leadership Team	Alison Lowe, NED and Andrea Osborne, Executive Director of Finance and Resources	• Dentistry Team

4 Impact and Benefits

The programme provides valuable opportunities for Board members to gain direct insight into service delivery, hear first-hand staff experiences and perspectives, recognise and celebrate good practice, understand challenges facing teams, strengthen Board visibility and engagement, inform future Board discussions and decision-making.

The visits also provide services with an opportunity to showcase achievements, highlight innovation, and discuss areas where additional organisational support may be required.

5 Key Themes

- Key themes from the Learning and Leadership Visits included strong staff commitment and pride, the importance of community-based care, effective partnership working, innovation in service delivery, workforce resilience, and the valuable contribution of corporate support services.
- The visits also reinforced the importance of quality, safety and governance arrangements, while providing Board members with greater insight into the opportunities and challenges facing services across the Trust.

6 Next Steps and Future Pipeline

The following services have been identified for upcoming NED learning visits:

- Diabetes
- Respiratory and Virtual Ward
- Community Intravenous Administration Service (CIVAS)
- Adel Beck
- Children's Speech and Language
- Children's Physiotherapy and OT
- Admin Services
- Corporate Nursing
- Research and Development
- Medicines Management
- Communications

7 Recommendation

The Board is asked to note the progress made in delivering the Board Service Visits Framework and the planned programme of future visits.

Rakhi Palliyath
Corporate Governance Officer
3 September 2026

Leeds Community Healthcare NHS Trust

Trust Board Workplan April 2026 -March 2027
Version: 7 10 September 2026

Agenda Item 2026-27 (19)

Topic	Frequency	Lead Officer	BAF Strategic Risk	21 May 2026	24 June 2026 (End of Year Sign Off)	23 July 2026	17 September 2026	19 November 2026	21 January 2027	18 March 2027	
STANDING ITEMS											
Declaration of interests	Each meeting	CS	N/A	X	X	X	X	X	X	X	
Minutes of previous meeting	Each meeting	CS	N/A	X		X	X	X	X	X	
Action log	Each meeting	CS	N/A	X		X	X	X	X	X	
Patient Led Experience	Each meeting	EDN&AHPS	N/A	X		X Armley NT	X Community Stroke Rehabilitation Team	X CDAT/TOC/BED BUREAU	X	X	
STRATEGY AND PARTNERSHIPS											
Chief Executive's report	Each meeting	CEO		X		X	X	X	X	X	
Organisational Strategy Development	Annual (November)	EDO						X			
Medium Term Plan/Operational Priorities -Wildly Important Goals (WIG)	2X per year (November and ?)	EDFR						X			
Estate Strategy	Six monthly (May/November)	EDFR		X				X			
Learning and Developement Strategy	Annual (March)	EDN&AHPS								X	
Health Equity Strategy	Annual (September)	EMD					X				
Quality Strategy	Six monthly (July/ January)	EDN&AHPS				X			X		
People Headlines and Strategy update	3 X per year (March, July and November)	DOP				X		X		X	
QUALITY AND SAFETY											
Quality Committee Chair's Assurance Report	Each meeting	CS		X		X	X	X	X	X	
Quality account	Annual (June)	EDN&AHPS			X						
Mortality reports	Quarterly (May + annual report, July, ~~September~~ November and January)	EMD		X4 + Annual Report - Deferred		X Blue Box Q1		X Q2	X Q3		
Patient safety (including patient safety incident investigations) update report	Six monthly (September and March)	EDN&AHPS					X			X	
Infection prevention control assurance framework	Annual (May)	EDN&AHPS		X							
Infection prevention control annual report	Annual (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	X	
Audit Committee Chair's Assurance Report	Quarterly (May, July, November and January)	CS		X		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				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	X	
Performance brief: High Level Performance Indicators for inclusion in the performance brief	Annual (March)	EDFR								X	
Financial Plan	Annual (March)	EDFR								X	
Annual report	Annual (June)	EDFR			X						
Annual accounts	Annual (June)	EDFR			X						
Letter of representation (ISA 260)	Annual	EDFR			X						
Audit opinion (Internal)	Annual	EDFR			X						
National Oversight Framework -Segmentation Update	Each meeting	CEO		X		X	X Included in CEO report	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	July + Annual Report, November and March	GoSWH				X +Annual Report		X		X	Resident doctors rep: Dr Salma Ehag to be invited - might need to check with Ruth
Medical Director's annual report	Annual (September)	EMD					X				
People Inclusion Improvement Plan 2025 – 2026(incorporating WRES / WDES and Pay Gap reporting)	Annual (November)	DW						X			
GOVERNANCE											
Code of Governance Compliance	Annual (March)	CEO		X							
Provider Licence Compliance	Annual (May)	CS		X							
Audit Committee annual report inlcluding Committee terms of reference review	Annual (May)	CS		X							
Standing orders/standing financial instruction	Annual TBC	CS									
Going concern statement	Annual (March)	EDFR									
Declarations of interest/fit and proper persons test	Annual (March)	CS									
Register of sealings	As required	CS									
Significant risks and risk assurance report	Each meeting	CS		X		X	X	X	X	X	
Board Assurance Framework -quarterly update report	Quarterly May, September, January and March	CS		X Deferred to July in 2026		2026-27 for approval X	X		X	X	
Risk appetite statement	Annual (May)	CS		X							
Management of Risk Policy & Procedure (3 yearly)	(Next due for review in Nov 2028)	CS									
Declaration of interests - information from declare	Annual (November) - from 2026	CS						X			
Board Members Service Visits Report	3 x year (September, Janaury, May)	CEO		From 2027			X		X		
Business Continuity Management Policy	As required	EDO									
Policy for the Development and Management of Policies (3 yearly)	(Next due for review Feb 2026)	EDN&AHPS									
Health and Safety Annual Plan	Annual	EDFR									
Health & Safety Policy (3 yearly)	(Next due for review Feb 2026)	EDFR									
Senior Information Risk Officer - Annual Report	Annual (May)	EDFR		X							
Work plan	Each meeting	CS	X	X		X	X	X	X	X	
ADDITIONAL ITEMS											

GLOSSARY

AGENDA ITEM 2026-27 (20)

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